Interdisciplinary Admission Assessment and Reassessment of Patients

Audience
Information in this document is to be used by all clinical personnel involved in the assessment and care of patients.

Policy
The assessment of patients is an interdisciplinary process. Assessment data is documented in a common location and shared among disciplines to enhance the continuity of care and decrease duplication of data collection.

Patients will receive care based on a documented assessment of their needs/current state. Assessment data is used to determine and prioritize the patient’s need for and plan of care as addressed in Policy 9.13.8.

Data received from the patient, as well as from the patient’s family/significant others are included in the assessment.

Admission Assessment
An admission assessment will be completed on all patients upon admission to UTMB hospitals including all patients hospitalized as observation.

Upon the patient’s admission, the Interdisciplinary Admission Assessment Form is initiated and the General Information section (including date and time of admission, the patient’s vital signs, allergies, language, education, occupation, age, physician notification, advance directives and guardianship, and disposition of valuables) will be completed.

Documentation of the remainder of the Interdisciplinary Admission Assessment will be completed within 12 hours of admission to the unit. A shorter time for completion of the admission assessment may be identified by the individual units as appropriate for the patient population and individual patient’s needs (e.g., critical patients, prior to surgery, etc.).

Data that is not obtainable within twelve (12) hours of admission may be documented on the form up to twenty-four (24) hours post admission. After 24 hours post admission, data should be documented in appropriate discipline’s notes.

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Interdisciplinary Admission Assessment and Reassessment of Patients, Continued

Admission Assessment (cont’d)

The Interdisciplinary Admission Assessment Form will be initiated on the Day Surgery Unit and Labor and Delivery, prior to patient surgery, for all patients who are scheduled for same-day surgery admission. Data collection may begin at the pre-op visit but must be reviewed and confirmed if collected more than 30 days pre-admission.

The Interdisciplinary Admission Assessment Form will be initiated in the Emergency Department for patients who will be admitted but who are experiencing extensive delays in the ER.

The Interdisciplinary Admission Assessment Form will be initiated on Chronic Home Dialysis patients on the first day of training and will be completed within three days.

Admission assessment for patients admitted to the Newborn Nurseries and ISCU will be documented on the Neonatal Nurseries Admission Flow Sheet. For infants born at UTMB, the mother’s Interdisciplinary Assessment Form will be copied to the infant’s medical record. For newborn infants transferred from other facilities, the Neonatal Transport Note will be filed in the medical record.

Any discipline may document on the Interdisciplinary Admission Assessment Form. It is the responsibility of the RN assigned to the patient to ensure that the form is completed within the time frame specified. Because of the time frame, it is likely that the RN will be the healthcare team member collecting and documenting most, if not all, of this information.

The Admission Assessment form will be filed in the physician’s history and physical (H&P) section of the patient’s medical record.

If the admission assessment and screening identifies the need for a referral and an in-depth assessment by another discipline, a referral will be made to that discipline by any of the interdisciplinary plan of care individuals. (Refer to Scope of Responsibility for Assessment for specific information.)
Interdisciplinary Admission Assessment and Reassessment of Patients, Continued

Admission Assessment (cont’d)

Care will be taken not to duplicate data collection.

The Physician History and Physical (H&P) is a part of the interdisciplinary assessment process, and data is shared between the H&P and the Interdisciplinary Admission Assessment Form.

Components of the Admission Assessment

UTMB hospitals admission assessment includes the following:

• Date/Time Admission
• Vital Signs
• Allergies (food, drug, latex, etc.)
• Language
• Occupation
• Level of Education
• Age
• Advance Directives
• Guardianship
• Disposition of Valuables
• Medical History
• List of Current Medications
• Review of current health status including biophysical, psychological/emotional and behavioral status
• Braden Scale
• Fall Risk Assessment
• Pain Screen
• Sensory/Communication Screen
• Functional Screen
• Spiritual/Cultural Screen
• Abuse/Neglect Screen
• Nutritional Screen
• Pulmonary Care Screen
• Social Screen
• Discharge Considerations

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Components of the Admission Assessment (cont’d)

This data will be documented on the Interdisciplinary Admission Assessment form and filed in the H&P section of the chart.

The Physician H&P is completed as part of the admission assessment process.

Additionally, developmental, age-appropriate and patient population specific assessments will be completed as indicated upon admission, and will be documented on the appropriate admission assessment addendum (e.g., Pediatric Assessment Addendum, OB Triage Assessment, etc.).

Each patient's health care learning needs, readiness to learn, and barriers to learning will also be assessed on admission and documented on The Interdisciplinary Patient-Family Teaching Tool.

Each patient's actual and potential needs pertaining to post discharge will be assessed. A discharge considerations screen will be completed as part of the interdisciplinary admission assessment and discharge needs will continue to be assessed and addressed throughout the hospital stay and upon discharge. (Refer to IHOP Policy 9.1.14, Discharge Planning).

Reassessment

Reassessment is any assessment completed after the initial assessment. Reassessments are performed by all members of the interdisciplinary team.

a) The timing, scope and intensity of reassessment are based on the patient's diagnosis, desire for care, response to any previous care, and change in condition and/or diagnosis.
Interdisciplinary Admission Assessment and Reassessment of Patients, Continued

**Perioperative Assessment**

Before surgery, the patient’s H&P is completed and recorded in the medical record.

A pre-anesthesia assessment is completed on all patients for whom anesthesia is contemplated. This information is collected by an anesthesia resident, certified registered nurse anesthetist (CRNA) or physician's assistant under the direction of a faculty anesthesiologist, and documented.

Patients are reevaluated immediately before the induction of anesthesia by a faculty anesthesiologist, anesthesia resident, or CRNA. This information is documented.

Perioperative Nursing Assessment is completed by the circulating registered nurse and documented on the *Perioperative Nursing Assessment Form.*

The postoperative status of the patient is assessed on admission to the Post Anesthesia Care Unit (PACU), during PACU stay, and upon discharge from the PACU. This assessment data is documented in the progress notes by the physicians and on the nursing PACU record by the nurses.

**Addressing Identified Problems**

Assessment data is used to determine and prioritize patient’s need for and plan of care. All actual and potential healthcare concerns identified through assessment will be documented on the Interdisciplinary Plan of Care (Refer to IHOP Policy 9.13.8, *Interdisciplinary Plan of Care*) and filed in the progress notes section of the chart.

**Required Documentation**

The Physician H&P will be documented and filed in the H&P section of the medical record.

The Interdisciplinary Admission Assessment will be completed and filed in the H&P section of the medical record.

All further assessments will be documented and filed in the assigned section of the medical record (e.g., progress notes, nurses notes, consult section, etc.)
Required Documentation (cont’d)

| UTMB hospitals use approved, standardized, discipline-specific assessment forms. These forms are consistent for all users (regardless of reporting structure) and are non-duplicative of other assessment or screening tools. (Refer to *Scope of Responsibility for Assessment* for more specific information.) |
Interdisciplinary Admission Assessment and Reassessment of Patients/Scope of Responsibility for Assessment

**Physician**

A complete history and physical examination shall, in all cases, be completed by a physician and placed in the record within twenty-four (24) hours after admission of the patient. If a complete history and physical has been obtained within 30 days prior to admission, in a physician staff member's office on campus, or in an on-campus private or staff clinic, a durable, legible copy of this report may be used in the patient's hospital medical record, provided there have been no subsequent changes or if there were changes, the changes have been recorded at the time of admission.

This history and physical examination includes at a minimum the patient’s chief complaint, present illness/injury, review of systems, past history, family history and physical examination. The patient’s biophysical, psychosocial, cultural, spiritual, developmental, educational, functional, nutritional, and pain/comfort needs will be addressed as appropriate. The physician H&P will be filed in the H&P section of the medical record.

All inpatients are reassessed by a physician daily, with changes in patient condition and/or diagnosis, and to determine the patient's response to interventions. The physician reassessment of a patient will reflect a minimum of a review of patient specific data, pertinent changes, and response to interventions. More frequent reassessments will be completed as appropriate for patient population and/or individual patient need. The physician reassessments will be documented in the progress notes section of the medical record. For patients undergoing surgery, the history and physical examination will be on the medical record before the time of the operation.

A pre-anesthesia assessment is completed on all patients for whom anesthesia is contemplated. This information is collected by an anesthesia resident, CRNA, or physician's assistant under the direction of a faculty anesthesiologist, and documented.

Patients are reevaluated immediately before the induction of anesthesia by a faculty anesthesiologist, CRNA, or the anesthesia resident.
Interdisciplinary Admission Assessment and Reassessment of Patients/Scope of Responsibility for Assessment, Continued

Physician (cont’d)

This information is documented.

The postoperative status of the patient is assessed upon admission to PACU, during PACU stay, and upon discharge from the PACU. This assessment data is documented in the progress notes by the physicians.

Refer to Rules and Regulations of the Medical Staff and to division and departmental policies and procedures for more detailed information.

Nursing

All nursing assessments will be completed by an RN licensed by the Board of Nurse Examiners of the State of Texas. The RN may delegate subjective and objective data collection to another licensed nurse or to unlicensed nursing personnel as appropriate to their credentials and training. Delegation of data collection will be in accordance with the Delegation of Selected Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel, Rule 218, of the Texas Nursing Practice Act.

All patients will be assessed upon admission by an RN.

Nursing will assume primary responsibility for the completion of the Interdisciplinary Admission Assessment Form. The RN assigned the care of the patient will ensure the completion of the form within 12 hours of the patient's admission to the patient care unit. This form will then be filed in the H&P section of the medical record.

Nursing admission assessment will include a minimum of biophysical, psychosocial, cultural, spiritual, developmental, and educational needs assessments, as well as sensory, functional, abuse/neglect, nutritional, fall risk, and pain screens, the Braden Scale and assessment of discharge needs.

All patients will be reassessed by an RN a minimum of every shift, with changes in patient condition and/or diagnosis, and to determine the patient's response to intervention. Nursing reassessment of a patient will reflect a minimum of a review of patient-specific data, pertinent changes, and response to interventions. More frequent reassessments will be completed as appropriate for the patient population and/or individual patient need. Nursing reassessment will be documented on the appropriate unit flow sheet or on the nursing progress records and filed in the nurses' notes section of the medical record.
Interdisciplinary Admission Assessment and Reassessment of Patients/Scope of Responsibility for Assessment, Continued

Nursing (cont’d)

A registered nurse will assess each patient's care needs before delegating appropriate aspects of the patient's nursing care.

Social Work

A Social Work Assessment is indicated when a discharge need is identified and/or when any item is checked in the Social Work high risk screen. Assessments are also completed upon consultation from any member of the health care team and when needs are identified by the social worker from case finding or rounds.

Social work consultation is needed for high risk indicators that imply possible problems in:

- Transition planning and continuity of care, including monitoring needed for appropriate resource utilization.
- Issues related to adjustment to illness and disability, coping with chronic medical/mental health problems, compliance counseling, parent/caretaker counseling and training and long term care considerations, including end of life decisions.
- Social, economic, cultural and religious/ethical factors which prevent or interfere with medical or psychosocial care planning and intervention.
- Accessibility to health care resources and lack of revenue reimbursement coverage for medical/hospital care and post-hospital care.
- Abuse, neglect and/or exploitation of children or adults.
- Need for health education regarding disease prevention, health maintenance and lifestyle modifications.
- Need for community liaison to establish linkages between individuals and resources, including advocacy, mediation and resource development.
- Support system for activities of daily living.

The Social Work Assessment is a comprehensive evaluation of the patient's psychosocial care needs as these impact his/her health, and is used as the basis to initiate appropriate intervention to maximize the patient's functional abilities. Social Work Assessments are completed by social workers who...
Interdisciplinary Admission Assessment and Reassessment of Patients/Scope of Responsibility for Assessment, Continued

Social Work (cont’d)

are licensed/licensure-eligible by the Texas State Board of Social Work Examiners. Assessment will be initiated within response time guidelines established in the Department of Social Work Standard Operating Procedures.

Components of the Social Work Assessment include:

- Presenting problem (includes diagnosis/reason for treatment, reason for social work involvement)
- Living situation (includes location and accessibility)
- Social resources (includes persons/community resources)
- Financial resources (includes employment, income and insurance status)
- Functional status (includes cognitive, emotional and physical assessment)
- Complicating factors (includes compliance, educational/communication, abuse/neglect, substance abuse and sensory deficit issues)
- Intervention/treatment plan

Age and population specific guidelines are used in completing the Assessment and the Plan of Care. The patient/family are included in treatment planning process and goals are developed with their input.

The Social Work assessment is documented on either the Department of Social Work Psychosocial Evaluation or Psychosocial Evaluation/Update, and is filed in the consult section of the medical record. Standardized labels are used for routine plan of care activities, such as nursing home placement, skilled nursing facility placement, rehab placement, guardianship, counseling, APS/CPS referral. These labels are also used for progress notes, brief documentation to record receipt of consult, referral to interview/consult completed, and for psychosocial situation update activity.

Reassessment will occur as indicated by standard operating procedures and/or when there are changes in the patient's condition or treatment goals. Reassessment will be documented in the progress notes or on the standard evaluation forms cited above if indicated.
Interdisciplinary Admission Assessment and Reassessment of Patients/Scope of Responsibility for Assessment, Continued

Nutrition Services

Nutrition screening is the process of using criteria pre-established by registered dietitians to identify patients at nutritional risk. Nutrition screening is conducted on all inpatients as part of the Admission Assessment. Nutrition screens may be completed by any member of the healthcare team educated on the use of the screening tool.

Nutrition assessment is the comprehensive analysis of nutritional risk factors to determine the severity of risk/potential risk as well as to initiate appropriate treatment and intervention to maintain or improve nutritional status. Nutrition assessment is performed by dietitians who are registered/registry-eligible by the Commission on Dietetic Registration of The American Dietetic Association and are licensed/licensure-eligible by the Texas State Board of Examiners of Dietitians.

Renal patients will be assessed by renal dietitians who meet the qualifications established by the Texas Department of Health. For patients on nutritional support, the assessment process may be completed by a pharmacist who is registered by the Texas Board of Pharmacy and has completed specialty training for board-eligibility as a Nutrition Support Specialist. The collection of data to be used in nutrition assessment may be performed by a variety of members of the healthcare team including dietetic technicians.

Components of nutrition assessment include:

- Evaluation of intake/dietary history
- Evaluation of anthropometric measurements
- Review of medications
- Evaluation of laboratory data
- Estimation of nutrition requirements
- Development of a plan of care

The components of the nutrition assessment are completed using age- and disease-specific standards of care. The plan of care is developed with the patient's input and with goals for treatment considered.

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Interdisciplinary Admission Assessment and Reassessment of Patients/Scope of Responsibility for Assessment, Continued

Nutrition Services (cont’d)

Nutrition assessment is triggered by identification of risk/potential risk during nutrition screening. Upon identification of risk, the screener notifies the dietitian or pharmacist of the need for that assessment. Completion of nutrition assessments will be prioritized based on severity of risk factors. The assessment will be documented on the Nutrition assessment form or in the progress notes.

Reassessment will occur at intervals established in standards of care and unit/service policies as well as when results of routine monitoring indicate changes in condition or treatment goals. Reassessment will be documented in the progress notes or on an additional Nutritional Assessment Form when changes in patient care dictate.

Physical Therapy

Physical Therapy Assessments are initiated by a physician's referral. All assessments are performed by a physical therapist who is licensed to practice in the State of Texas. Assessments are based on referral, patient diagnosis, and clinical presentation. Evaluations may include, but are not limited to:

- Physical performance, including muscle strength, joint range of motion, muscle excursion, balance, mobility, sensation, coordination, and motor control.
- Functional performance including bed mobility, transition between positions, transfers, function in the upright position, and gait.
- Nature, location, and factors impacting the patient's pain/pain perception.
- Occupational performance including ability to perform physical tasks of job, endurance, pain tolerance, and cardiovascular function.
- Use of mobility devices such as gait-assist devices, wheelchairs, lifts and/or transfer aids.
- Extent of and nature of wounds, burns and other deficits in integrity of skin and subcutaneous layers.
- Need for technological devices (including prosthetics, orthotics, environmental control systems, and power mobility systems).

Reassessments will occur informally with each patient interaction, and formally when the patient has a significant change in status, the patient
Interdisciplinary Admission Assessment and Reassessment of Patients/Scope of Responsibility for Assessment, Continued

Physical Therapy (cont’d)

undergoes a surgical procedure, a new problem is identified, and/or prior to discharge.

Assessments will be documented on UTMB-approved physical therapy evaluation forms and will be filed in the consult/rehabilitation section of the medical record.

Occupational Therapy Assessment

Occupational therapy assessments are initiated by a physician’s referral.

All assessments are performed by a registered occupational therapist who is licensed to practice in the State of Texas. Assessments are based on referral, patient diagnosis, and clinical presentation. Evaluations may include, but are not limited to:

- Activities of daily living, self-care and maintenance, and personal, home and family management.
- Sensorimotor performance, including muscle strength, range of motion, coordination and joint mobility, balance, sensation and perception.
- Cognitive performance, including memory, sequencing, problem solving, concentration, and attention.
- Psychosocial performance, including behavior management, social skills and communication skills.
- Human development.
- Assessment of driving abilities.
- Work readiness and need for job analysis or work redesign.
- Need for technological devices (including prosthetics, orthotics and environmental control systems).

Reassessments will occur informally with each patient interaction and formally when the patient has a significant change in status, the patient undergoes a surgical procedure, a new problem is identified, and prior to discharge.

Assessments will be documented on UTMB-approved occupational therapy forms and filed in the consult/rehabilitation section of the medical record.
Therapeutic Recreation Assessments

Therapeutic recreation assessments are triggered by a physician's referral. All assessments are performed by a certified therapeutic recreation specialist. Evaluation may include:

- Gross motor performance.
- Social skills/interaction skills.
- Development.
- Community awareness.
- Leisure habits/skills.

Reassessment will occur informally with each patient interaction, and formally when the patient exhibits a significant change in status, and/or prior to discharge. Reassessment will include re-evaluation of the area being addressed in ongoing treatment or new areas of concern.

Assessments will be documented on UTMB-approved therapeutic recreation forms and will be filed in the consult/rehabilitation section of the medical record.

Speech Pathology Services

A speech pathology assessment is indicated when any one of the speech pathology screen questions is checked on the functional screen section of the Interdisciplinary Admission Assessment Form.

All assessments are performed by speech-language pathologists, who are certified by the American Speech-Language-Hearing Association and licensed by the State of Texas. By policy, all consults are answered within 48 hours, with the written evaluation filed in the consult section of the patient's chart within 72 hours.

Assessment and intervention is provided for:

- Delayed speech/language
- Articulation disorders
- Cognitive-communication disorders
- Stuttering
- Motor speech disorders
### Interdisciplinary Admission Assessment and Reassessment of Patients/Scope of Responsibility for Assessment, Continued

#### Speech Pathology Services (cont’d)
- Adult swallowing disorders
- Speech disorders of head & neck cancer patients
- Aphasia
- Pediatric feeding disorders
- Cleft palate/craniofacial disorders
- Language/learning disabilities

Assessments are based on referral, patient’s age, diagnosis and clinical presentation, and may include:
- Speech/language evaluation
- Bedside swallow examination
- Modified barium swallow
- Oral mechanism examination
- Pre-feeding assessment
- Palate study
- Videostrobe evaluation
- Voice evaluation
- Patient/family education

Reassessments are documented in the patient progress notes when a significant change in status occurs or when a new problem is identified. Prior to discharge, reassessment is documented in the progress notes section of the chart or on UTMB-approved speech-pathology forms, which are filed in the consult section of the inpatient medical record.

#### Audiology Services
Assessment by the Audiology Department is indicated when any one of the audiology screen questions is checked on the Functional Screen section of the Interdisciplinary Admission Assessment Form.

Formal audiological assessments are performed by audiologists who are licensed by the State of Texas and certified by the American Speech-Language-Hearing Association.

Initial assessment includes but is not limited to:
- Basic audiological assessment
- Immittance testing
- Counseling regarding test results

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Interdisciplinary Admission Assessment and Reassessment of Patients/Scope of Responsibility for Assessment, Continued

Audiology Services (cont’d)

- Recommendations and follow-up plans.
- Patient education materials as needed.

The initial audiological assessment, by policy, is to be performed within 72 hours of the receipt of an inpatient consult.

Based on basic audiological assessment findings, further evaluation may include:

- Site of lesion testing
- Electrophysiological testing
- Hearing aid evaluation and repair
- Central auditory testing
- Aural rehabilitation
- Ongoing audiometric monitoring (e.g., Post medical management, toxicity)

All test results are recorded on an Audiology Report form and filed with the consult in the consult section of the inpatient medical record. Patient contact is documented in the progress notes with a reference to the consult section for test results.

Pulmonary Care

Assessments by Pulmonary Care Services are triggered by either a new order for pulmonary services by a physician or upon request by a physician.

Formal assessments are performed by respiratory care practitioners who are licensed by the State of Texas.

The initial assessment is, by policy, to be performed within 24 hours of the order being written.

The initial assessment includes the patient's current and past medical history, a cardiopulmonary exam and a determination of the most appropriate therapy for the individual patient's needs.

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Interdisciplinary Admission Assessment and Reassessment of Patients/Scope of Responsibility for Assessment, Continued

**Pulmonary Care Services (cont’d)**

Reassessment will occur a minimum of 72 hours post initial assessment and to determine the patient's response to intervention. Reassessment will include a review of patient-specific cardiopulmonary data and pertinent changes.

Assessments from the Pulmonary Care Services department are documented on a department-generated form that is not part of the medical record.

Assessments are documented in the medical record in the physician's progress notes in the form of a **SOAP** (subjective, objective, assessment, plan) note.

**Pastoral Care Services**

Spiritual screening is conducted on all hospitalized patients as part of the initial assessment.

At the patient, family, or staff request, pastoral care is consulted. Any staff member may consult Pastoral Care Services or patients and/or family may contact them directly.

Spiritual assessment/reassessment by clergy persons generally includes:

- What does the patient's concept of God (higher power, source) mean in his/her life and how does it affect his/her life?
- What does this illness/injury mean in the patient's life?
- Methods that the patient uses to manage their life in stressful times.
- The amount of despair/hope the patient is experiencing.

Assessments may vary slightly based on religious/spiritual orientation.

As the clergy person determines appropriate, the assessment data will be documented in the progress notes section of the medical record.
Interdisciplinary Admission Assessment and Reassessment of Patients/Scope of Responsibility for Assessment, Continued

Pharmacy

A Pharmacy assessment is initiated when identified by a pharmacist via order entry and/or rounds or upon consultation from any member of the healthcare team.

Types of pharmacy assessments:

- Drug regimen review
- Medication education
- Medication history
- Pharmacokinetic dosing
- Nutrition assessment

An assessment of the drug regimen may be triggered by an admission with polypharmacy (more than six medications), by patients taking medication brought from home, STAT drug orders for antidotal medication, acute changes in the patient’s medical status, a creatinine clearance of less than 30 ml/min, or when switching a therapy from IV to oral. Medication education assessment may be triggered by an admission due to drug therapy, by a patient being placed on a self-medication program, or by request of a family member. An assessment of the drug specific pharmacokinetics may be triggered by non-therapeutic peak and/or trough levels. A parenteral nutrition assessment is triggered by a patient being placed on total parenteral nutrition (TPN) or upon request.

The initial assessment may include but is not limited to:

- Review of the patient's current medication regimen.
- Review of the patient's past medication history.
- Review of pertinent clinical data or documentation.
- Review of appropriate laboratory data.
- Review of nutritional history for nutritional assessment.
- Determination of appropriate route of nutrition for nutrition assessment.
- Determination of tolerance to nutrition for a nutrition consult assessment.
Interdisciplinary Admission Assessment and Reassessment of Patients/Scope of Responsibility for Assessment, Continued

Pharmacy (cont’d)

Pharmacy assessments are completed by a pharmacist licensed by the Texas State Board of Pharmacy who have also successfully completed the pharmacy staff development training program. Pharmacy nutrition assessments are completed by a pharmacist with the aforementioned credentials, plus specialty training in nutrition support, or by a pharmacist who has successfully completed an in-house pharmacy nutrition training program.

Pharmacy assessments will be documented as applicable to the type of assessment, on the interdisciplinary Plan of Care form and/or as a progress note in the progress note section of the patient medical record, on the interdisciplinary patient education form, or on a consult form located in the consult section of the patient medical record.

Reassessment of a patient will occur informally with each patient interaction, and formally when requested by a healthcare team member and will include a review of patient-specific data, any pertinent clinical changes and will assess response to the initial intervention.

Reassessments will be documented as applicable to the type of reassessment on the Interdisciplinary Plan of Care form and/or as a progress note in the progress note section of the patient medical record, on the interdisciplinary patient education form, or on a consult form located in the consult section of the patient medical record.