SOP Template: Patient Admission and Initial Assessment Procedures

This SOP details the **patient admission and initial assessment procedures**, covering patient registration, medical history review, vital signs measurement, initial physical examination, risk assessment, documentation protocols, and communication with healthcare teams. The objective is to ensure a thorough and efficient process for admitting patients, enabling accurate assessment and appropriate care planning from the outset.

1. Purpose

To standardize and ensure quality in the process of admitting patients and conducting initial assessments for accurate diagnosis, risk identification, and care planning.

2. Scope

This SOP applies to all healthcare personnel responsible for patient admissions and assessments in [Facility Name].

3. Responsibilities

- **Reception Staff:** Complete patient registration and verify identification.
- **Nursing Staff:** Perform initial assessment, document findings, and report abnormalities.
- **Physicians:** Review assessments, initiate treatment plans, and escalate concerns as necessary.

4. Procedure

1. **Patient Registration**
    - Verify patient identity using at least two identifiers (e.g., name, date of birth).
    - Complete all demographic fields in the registration system.
    - Provide patient with information on facility policies and their rights and responsibilities.
2. **Medical History Review**
    - Obtain and document comprehensive medical, surgical, and family history.
    - Record allergies, current medications, and relevant social history.
3. **Vital Signs Measurement**
    - Measure and record body temperature, blood pressure, pulse, respiratory rate, and oxygen saturation.
4. **Initial Physical Examination**
    - Conduct a focused or complete physical examination as per presenting complaint.
    - Document all findings in the appropriate medical records.
5. **Risk Assessment**
    - Screen for clinical and psychosocial risks (e.g., falls, pressure ulcers, infection risk).
    - Use validated assessment tools as applicable.
6. **Documentation Protocols**
    - Ensure all findings and assessments are promptly and accurately documented in the patient record.
    - Obtain required signatures and time-stamps on all entries.
7. **Communication with Healthcare Teams**
    - Communicate key findings and concerns to the multidisciplinary team during handover or referral.
    - Escalate urgent or abnormal findings immediately according to facility policy.

5. Documentation and Records

Document	Responsibility	Retention Period
Admission Form	Reception Staff	As per facility policy
Initial Assessment Record	Nursing Staff	As per facility policy
Physician Notes	Physicians	As per facility policy

6. References

- Facility admission policy
- Local/national healthcare guidelines
- Relevant accreditation standards

7. Revision History

Date	Version	Description of Change	Author
2024-06-10	1.0	Initial SOP template creation	[Author Name]