

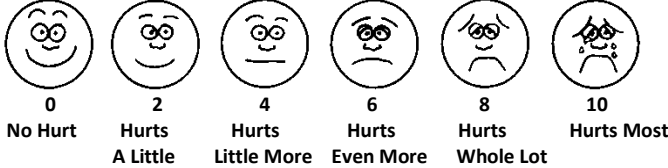
Patient Name	Date	Time in	Time Out	Total Hours
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VITAL SIGNS

Time	Temperature <input type="checkbox"/> Oral <input type="checkbox"/> Axillary <input type="checkbox"/> Other	Pulse <input type="checkbox"/> Apical <input type="checkbox"/> Radial	Respiration	Blood Pressure <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Sitting <input type="checkbox"/> Lying

PAIN ASSESSMENT

Wong-Baker FACES Pain Rating Scale ©



Location: _____ Current Pain Regime: _____
 Is pain regime effective: Yes NO
 Comment: _____

NUTRITION ASSESSMENT

Diet: NPO Regular Restricted/Type: _____
 Breast Formula-Type: _____ Other: _____
 Amount: _____ Frequency: _____
 Nutritional Risk Screening: LOW MED HIGH
 Appetite: Good Fair Poor
 Food Allergy: _____
 Blood Sugar: _____ N/A
 Patient/Caregiver independent in diabetes management
 Comment: _____

NEUROLOGICAL

Verbal Nonverbal Oriented Alert Agitated Confused
 Lethargic Sedated Comatose Semi-Comatose
 Appropriate for age: Yes No
 Tone: Active Flaccid Jittery Rigid
 Fontanel: Flat Soft Sunken Tense Bulging N/A
 Seizure Activity: N/A No Yes If yes, see seizure record
 Moves extremities: Upper Right Upper Left
 Lower Right Lower Left
 Comment: _____

CARDIOVASCULAR

Heart Tones: Strong Regular Irregular Murmur
 Other: _____
 Skin: Pink Flushed Pale Cyanotic Other: _____
 Skin Temp: Warm Cool Cold Other: _____
 Capillary Refill: Less than seconds Greater than 3 seconds
 Other: _____
 Peripheral Pulses: Strong Weak Absent Other: _____
 Comment: _____

RESPIRATORY

Regular Labored Shallow Grunting Panting Nasal flaring
 Deep Retractions
 Breathing Sounds: Clear Rhonchus Diminished
 Wheeze If not clear indicate where: _____
 Cough: None Productive Non productive
 Secretions: N/A
 Amount: Small Moderate Large
 Consistency: Thin Thick Tenacious Frothy
 Color: Clear White Yellow Green Blood tinged
 Apnea Monitor: N/A Alarm setting: High _____ Low _____
 Pulse Oximetry: Continuous Intermittent
 Oxygen: _____ L/min Via: NC Mask Trach Intermittent
 Continuous Other: _____

HEAD (Circle R for RIGHT and L for LEFT)

Face: Symmetrical Asymmetrical
 Ears: Unremarkable Low R L Other: _____
 Eyes: Cornea: Clear R L Opaque R L
 Sclera: White R L Jaundiced R L
 Hemorrhage R L
 Nose: Patent Congested Bleeding Other: _____
 Pharyngeal: Unremarkable Sore throat Hoarseness
 Comment: _____

RESPIRATORY CARE

Tracheostomy Type: _____ Size: _____
 Cuffed Uncuffed Date last changed: _____
 Trach. Care: ½ strength H₂O₂ + H₂O Warm soapy H₂O
 Technique: Clean/Aseptic Sterile Trach ties changed
 Trach. Ties Changed: _____ (date) Clean Sterile method
 Trach. Site: Dry Intact Redness Excoriation Drainage
 Intervention: MD Notified RN Notified Other: _____

GASTROINTESTINAL

Abdomen: Soft Tense Flat Distended
 Bowel Sounds: Present Hyper Hypo Absent
 Feeding Tube: N/A NG J Tube G Tube Mickey Button
 Feeding Tube Care: ½ strength H₂O₂ + H₂O NS
 Other: _____ Tube size: _____
 Flushes: Solution _____ Amount _____ Frequency _____
 GT Site: Dry Intact Redness Excoriation

GENITO-URINARY

Unremarkable Discharge Circumcised
 Urine Color: Clear Yellow Cloudy Hematuria
 Bladder Frequency: _____ Urgency Burning Diaper
 Foley Cath Suprapubic Intermittent
 Continent Incontinent Last void: _____
 Comment: _____

VENTILATOR

N/A Hours/d on ventilator: _____
 Type: _____ Rate: _____ CPAP: Rate _____
 TV: _____ PEEP: _____ PIP: _____
 Alarm Checked-Audible/ Set at: _____ High _____ Low _____
 Comment: _____

INTRAVENOUS

Access: N/S Peripheral CVL PICC Port
 Other: _____ Location: _____
 Solution Admin _____ @ _____ ml/hr
 _____ @ _____ ml/hr
 Date to change Dressing: _____
 Site Condition: Intact Without Redness or Swelling
 Dressing changed using: Sterile Aseptic technique Transparent
 Bag Changed Tubing Changed Cap Changed
 Date to change Peripheral IV: _____ Flushed with _____
 Comment: _____

MUSCULO-SKELETAL

ROM: ROM Limited ROM Contractures _____
 Muscles: Normal Rigid Hypertonic Hypotonic Weakness
 Ambulation: Independent With Assist Immobile
 Reposition q2 hours Passive ROM Active ROM
 Assistive Equipment: _____
 Comment: _____

