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Patient Name: Ertha Williams
Room: 1816
DOB: 1941
Age: 69

MRN: 000-545-000
Doctor Name: Dr. Joan Rivers
Date Admitted: 10-30-xx

Physician's Orders

Allergies: Penicillin

Date/ Time:	
	Bedrest, BRP with assist
	Regular, low fat diet
	I & O
	Neurological assessment Q 4 hours
	Oxygen: maintain SaO2 at or above 90%. Nasal cannula @ 2 liters
	Labs: CBC, biomedical profile, BNP, (brain natriuretic peptide), urine analysis
	IV: Lactated ringers @ 50 ml/hour
	Pantoprazole 40 mg by mouth daily
	Enoxaparin 40mg Sub cut daily
	Amlodipine 10mg by mouth daily (Home Medication)
	Hydrochlorothiazide 25 mg by mouth daily (Home Medication)
	Escitalopram 20 mg by mouth daily (Home Medication)
	ASA 81 mg po daily
	Crestor 20 mg every evening (Home Medication)
	Quetiapine 25mg by mouth bid
	Dr. Joan Rivers

Physician Progress Notes

Allergies: Penicillin

Date/ Time:	
	Admit. With increased confusion, new onset of patient being combative. Geriatric Specialty to see in am.
	Dr. Joan Rivers

Nursing Notes

Date/ Time:	
0130	Admitted via ER at 0130. Lab collected in emergency room. Mary Smith, RN
0830	Admitted to S10. See MD orders and flow sheet. Mark Hayes, RN

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature
MS	Mary Smith, RN		
MH	Mark Hayes, RN		

Medication Administration Record

Allergies: Penicillin

Scheduled & Routine Drugs

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Hours to be Given:	Dates Given:
	Pantoprazole	40 mg	by mouth	Daily	9am	
	Enoxaparin	40 mg	Sub cut	Daily	9am	
	Amlodipine	10 mg	by mouth	Daily	9am	
	Hydrochlorothiazi	25 mg	by	Daily	9am	

	de		mouth			
	Escitalopram	20 mg	by mouth	Daily	9am	
	ASA	81 mg	by mouth	Daily	9 am	
	Quetiapine	25 mg	by mouth	bid	9 am 21:00 pm	
	Crestor (Rosuvastatin Calcium)	20 mg	by mouth	every evening	21:00 pm	

Intravenous Therapy

Date of Order:	IV Solution	Rate Ordered:	Date/Time Hung:
	Lactated ringers	50 ml/hr	

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature

Medication Administration Record

Intramuscular legend:	Subcutaneous site code:
A=RUOQ ventrogluteal	1=RUQ abdomen
B=LUOQ ventrogluteal	2=LUQ abdomen
C=R Deltoid	3=RLQ abdomen
D=L Deltoid	4=LLQ abdomen
E=R Thigh Lateral	5=RU arm
F=L Thigh Lateral	6=LU arm
	7=R leg
	8=L leg

Allergies: Penicillin

PRN Medications

Date	Medication:	Dosage:	Route:	Frequency	Date/Time

of Order:				:	Given:	
				as needed for acute onset of shortness of breath	Date:	
					Time:	
					Site:	
					Initials:	

Insulin Administration

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Date/Time Given:	
					Date:	
					Time:	
					Site:	
					GMR:	
					Initials:	

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature

Vital Signs Record

Date:												
Time:			0200	0600	0800	1200	1600	2000	...	. .		
Temperature:	**C⁰**	**F⁰**	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .
	40	**104**										
	39.5	**103**	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .

	39	**102**											
	38.5	**101**											
	38	**100**											
	37.5	**99**											
	37	**98**	X	X									
	36.5	**97**											
		BP:	160/92	135/88									
		Pulse:	110	112									
		O^2 Saturation:	82%	88%									
		Weight:											
		Respirations:	30	26									
		GMR:											
		Nurse Initials:	MR	MH									

Intake & Output Bedside Worksheet

INTAKE **OUTPUT**

ORAL	TUBE FEED	IV	IVPB	OTHER	URINE	Emesis	NG	Drains Type:	Other
Total Intake this shift:					Total Output this shift:				

(This is a worksheet to be used at the bedside to keep track of each intake or output. The totals will then be recorded on the 24 hour Fluid Balance sheet.)

Fluid Measurements:	Sample Measurements:
1 ml = 1 cc	Coffee cup = 200 cc
1 ounce = 30 cc	Clear glass = 240 cc
8 ounces = 240 cc	Milk carton = 240 cc
1 cup = 8 ounces = 240 cc	Small milk carton = 120 cc
4 cups = 32 ounces = 1 quart or liter= 1000 cc	Juice, gelatin or ice cream cup = 120 cc
	Soup bowl = 160 cc
	Popsicle half = 40 cc

Nursing Assessment Flowsheet

GENERAL APPEARANCE:
``☐ male ☐ female

DOB:_____
AGE:_____
ETHNICITY:_____
OCCUPATION:_____
RELIGION:_____

☐ awake ☐ sleeping ☐ agitated
☐ cheerful ☐ lethargic ☐ anxious
☐ crying ☐ calm ☐ combative
☐ fearful

SKIN: ☐ see wound care sheet ☐ see nursing notes

BRADEN SCALE SCORE: ☐ risk skin breakdown

COLOR:
☐ acyanotic
☐ pale
☐ ruddy
☐ jaundiced
☐ cyanotic

TURGOR:
☐ <3 sec
☐ > 3 sec

TEMP:
☐ warm/dry
☐ hot
☐ cool
☐ cold/clammy
☐ diaphoretic

HAIR:
☐ shiny
☐ dry/flaking
☐ balding
☐ lesions
☐ lice

NEUROLOGICAL: ☐ see nursing notes

ORIENTATION:
☐ person ☐ disoriented
☐ place ☐ confused
☐ time ☐ impaired memory

RESPONDS TO:
☐ name ☐ non-responsive
☐ stimuli

RESPIRATORY: ☐ see nursing notes

RESPIRATIONS:
RATE:__28__
O_2:__2lpm_____
SPO_2:__91____%

☐ regular ☐ labored
☐ even ☐ uses accessory muscles
☐ irregular ☐ cough

BREATH SOUNDS:

LEFT:
☐ clear
☐ crackles
☐ wheezes
☐ decreased
☐ absent

RIGHT:
☐ clear
☐ crackles
☐ wheezes
☐ decreased
☐ absent

THORAX:
☐ even expansion
☐ uneven expansion

SMOKING:
☐ cigarettes pk/day _____
☐ cigars
☐ marijuana
☐ cocaine

GASTROINTESTINAL/NUTRITION: ☐ see nursing notes

APPEARANCE:
☐ flat ☐ soft
☐ round ☐ gravid
☐ obese

BOWEL SOUNDS:
☐ active ☐ hyperactive
☐ hypoactive ☐ absent

SPEECH:
- ☐ clear
- ☐ garbled
- ☐ slurred
- ☐ aphasic
- ☐ inappropriate
- ☐ cannot follow conversation

FACE:
- ☐ symmetrical
- ☐ drooping
- ☐ drooling

EYES:
- ☐ PERRLA
- ☐ unequal
- ☐ drooping lid

SIGHT:
- ☐ no correction
- ☐ glasses
- ☐ contacts
- ☐ blind

HEARING:
- ☐ WNL
- ☐ HOH
- ☐ hearing aid

HX:
- ☐ seizures
- ☐ CVA
- ☐ brain injury
- ☐ spinal injury
- ☐ other

PALPATION:
- ☐ non-tender
- ☐ tender (location)_____
- ☐ mass (location) _____

LAST BM:_yesterday_____

- ☐ incontinent
- ☐ stoma- _____
- ☐ constipation
- ☐ diarrhea
- ☐ mucous
- ☐ blood

DIET:___Regular_____

- ☐ impaired swallowing
- ☐ choking
- ☐ NG tube
  color drainage:_____
- ☐ feeding tube
- ☐ tube feeding
  type: _____ rate:_____

MUSCULOSKELETAL: ☐ see nursing notes

GAIT:
- ☐ steady
- ☐ unsteady
- ☐ non-ambulatory

ACTIVITY:
- ☐ up ad lib
- ☐ walker
- ☐ cane
- ☐ crutches
- ☐ wheelchair

ASSIST:
- ☐ x1
- ☐ x2
- ☐ lift
- ☐ bed bound

HAND GRIPS:
AMPUTATION: ☐ left ☐ right
LOCATION:_____

LEFT:
- ☐ strong
- ☐ weak
- ☐ flaccid
- ☐ contractures

RIGHT:
- ☐ strong
- ☐ weak
- ☐ flaccid
- ☐ contractures

GENITOURINARY: ☐ see nursing notes

- ☐ voids
- ☐ catheter
- ☐ stoma

APPEARANCE OF URINE:
- ☐ clear
- ☐ light yellow
- ☐ amber
- ☐ brown
- ☐ cloudy
- ☐ sediment
- ☐ red/wine
- ☐ clots

BLADDER:
- ☐ soft
- ☐ firm/distended
- ☐ incontinent

FEMALES: LMP: _____

- ☐ WNL
- ☐ dysmenorrheal

BIRTH CONTROL:
- ☐ yes
- ☐ no
- ☐ BSE monthly
- ☐ menopause
- ☐ taking estrogen

ROM:

ARMS:
- ☐ full
- ☐ weak
- ☐ flaccid
- ☐ contractures

LEGS:
- ☐ full
- ☐ weak
- ☐ flaccid
- ☐ contractures
- ☐ TED hose

AMPUTATION:
- ☐ right
- ☐ left
- ☐ BKA
- ☐ AKA
- ☐ other

SPINE:
- ☐ kyphosis
- ☐ scoliosis
- ☐ osteoporosis

OTHER:
- ☐ CAST LOCATION:_____
- ☐ TRACTION:_____

SEXUALITY:
- ☐ sexually active
- ☐ safe sex

MED HX:
- ☐ urinary retention
- ☐ BPH
- ☐ Frequent UTI

CARDIOVASCULAR: ☐ see nursing notes

HEART SOUNDS:
- ☐ normal S_1-S_2
- ☐ abnormal S_3-S_4
- ☐ murmur

PULSE:

APICAL:
- ☐ regular
- ☐ irregular
- ☐ strong
- ☐ faint

RADIAL:
- ☐ regular
- ☐ irregular
- ☐ strong
- ☐ faint
- ☐ nonpalpable

PEDALIS:
- ☐ regular
- ☐ irregular
- ☐ strong
- ☐ faint
- ☐ nonpalpable

PAIN ASSESSMENT: ☐ see nursing notes ☐ see MAR

PRECIPITATING:_____

QUALITY:_____

REGION:_____all over

SEVERITY (0-10/10):

NOW: _5___ AT WORST: 10____ AT BEST: _3_____

TIMING:_____

EXTREMITY COLOR & TEMP:
- ☐ warm
- ☐ cool
- ☐ cold
- ☐ acyanotic
- ☐ cyanotic
- ☐ discolor

EDEMA:

SAFETY: ☐ see nursing notes ☐ fall risk

PRECAUTIONS:
- ☐ side rails x_2
- ☐ bed down
- ☐ call light
- ☐ wrist
- ☐ vest

☐ none ☐ generalized (anasarca)

SITE #1:_____ SITE #2: _____

pitting	pitting
☐ 1+	☐ 1+
☐ 2+	☐ 2+
☐ 3+	☐ 3+
☐ 4+	☐ 4+
☐ non-pitting	☐ non-pitting

CAPILLARY REFILL:

FINGERS:	**TOES:**
☐ brisk	☐ brisk
☐ slow	☐ slow

HX:

☐ Pacemaker	☐ CHF
☐ HTN	☐ PVD
☐ CAD	☐ Other: _____

FLUID BALANCE: ☐ see nursing notes

INTAKE:

☐ PO ☐ IV

SOLUTION: _ Lactated ringers @ 50 ml/hour

SITE LOCATION: Right hand

☐ clean	☐ swelling	☐ pain
☐ patent	☐ cool	☐ tubing change
☐ redness	☐ hot	☐ dressing change

MUCOUS MEMBRANES:

☐ moist	☐ sticky	☐ dry
☐ pink	☐ coated	

TODAY'S WT:63 kg **YESTERDAY'S WT:**__

☐ nightlight ☐ restraints

DISCHARGE/TEACHING: ☐ see nursing notes

NEEDS:___case management for placement/home health, finical,o2 needs?

_____

TYPE OF LEARNER:

☐ visual
☐ auditory
☐ kinesthetic

EDUCATIONAL LEVEL: _____

FAMILY PRESENT:

☐ yes
☐ no

NURSE SIGNATURE: ___ Mark Hayes, RN _____

TIME COMPLETED: ___just now_____

REASSESSMENT:

TIME: _____

☐ no change ☐ see nurses notes ☐ initials_____

TIME: _____

☐ no change ☐ see nurses notes ☐ initials_____

TIME: _____

☐ no change ☐ see nurses notes ☐ initials_____

Risk Assessments & Nursing Care

	Date: Braden Scale Score: Fall Risk Score:									Date: Braden Scale Score: Fall Risk Score:							
Time Hourly																	
PAIN ASSESSMENT																	
Intensity (1-10/10)																	
Pain Type (see legend)																	
Intervention (see legend)																	
PATIENT POSITION																	
PO FLUIDS (ml)																	
IV SITE/RATE CHECKED																	
PATIENT HYGIENE																	
WOUND ASSESSMENT																	
WOUND BED																	
WOUND DRAINAGE																	
WOUND CARE																	
Nurse Initials																	

Initial	Nurse Signature	Initial	Nurse Signature

LEGEND: *= see nursing notes

PAIN TYPE:
A- aching **T-** throbbing
ST- stabbing **B-** burning
SH- shooting **P-** pressure

PAIN INTERVENTIONS:
1- Relaxation/Imagery **2 -** Distraction

POSTIONING:
B- back
R- right
L- left
C- chair
A- ambulatory

PT. HYGIENE:
b- bedbath **a-** assist bath
p- partial bath **sh-** shower
g- grooming **m** mouth care
f- foot care **n-** nail care

LAB TEST	RESULT	NORMAL RANGE
WBC	**11.8**	3.6-10.8 L/uL
HGB	10.0	Female 12-16 g/dL
HCT	30.0	Female 37-47%
CHEMISTRIES		
NA+	137	136-145mEq/L
K+	4.0	3.5-5.0 mmol/L
GLUCOSE	109	70-110mg/dL critical - <50 or >400 mg/dL
MAGNESIUM	2.1	70-110mg/dL critical - <50 or >400 mg/dL
BNP	250	< 100
ABG'S		
PH	7.34*	7.35-7.45
PCO2	50*	35-45
HCO3	27	22-26
PO2	88	90-100
Urinalysis (UA)		
Appearance	Cloudy	clear
Color	Dark Yellow	amber yellow
Odor		aromatic
PH	7.0	4.6-8.0
Protein		0-80mg/dL
Specific Gravity	1.010	1.005-1.030
Leukocyte Esterase	positive	negative
Nitrites	positive	negative
Ketones	positive	None
Bilirubin	none	None
Urobilinogen	0.01	0.01-1 Ehrlich unit/mL
Crystals	positive	None
Cast	positive	None
Glucose	positive	None
WBC	Too numerous to count	0-4 per low-power field
Red Blood Cells	Too numerous to count	<2
Bacteria	Too numerous to count	negative

WOUND ASSESSMENT
 # 1-4 Pressure Ulc
I – Incision
R – Rash
SK – skin tear
E –Echymosis
A – Abrasion

WOUND BED:
G – Granulation tissue
P – Pale
Y – Yellow
B- Black

WOUND DRAINAGE:
P – Purulent
S – Serosanguinous
B – Bright red blood
D – Dark old blood

WOUND CARE:
ned with NS
ze dressing
W – Gauze wrap
A – ABD pad
M – Medication
O – other **