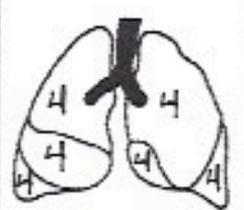
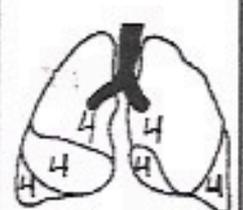


PERIPHERAL VASCULAR	NEUROLOGY/PSYCHOSOCIAL	CARDIOVASCULAR
3+ Bounding unable to occlude 2+ Strong able to occlude 1+ Weak palpable 0-Non palpable Extremities: <input type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Cyanotic <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Calf Tenderness/Swelling <input type="checkbox"/> R <input type="checkbox"/> L Ted Hse <input type="checkbox"/> Y <input checked="" type="checkbox"/> N SCDs <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Flexipulses Capillary Refill: <u>2</u> Seconds Affected extremity pulse verified with Doppler <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Pulses: Radial R <u>2+</u> L <u>2+</u> Pedal R <u>1+</u> L <u>1+</u> Post. Tib. R <u>2+</u> L <u>2+</u> Comments: <u>Capillary refill - brisk in fingers, slow in toes</u>	Family at bedside <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input checked="" type="checkbox"/> Confused <input type="checkbox"/> Comatose <input type="checkbox"/> Sedated <input type="checkbox"/> Drowsy <input type="checkbox"/> Cough Reflex <input type="checkbox"/> Y <input type="checkbox"/> N Follows Simple Commands: <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Gag <input type="checkbox"/> Y <input type="checkbox"/> N Muscle Strength: (S-Strong, W-Weak, N-None) Grips: Rt. <u>W</u> Lt. <u>N</u> Pushes: Rt. <u>W</u> Lt. <u>W</u> Comments: <u>Pt is awake, r/y, fearful, agitate</u> Response to Questions: <input type="checkbox"/> Readily <input type="checkbox"/> Slowly <input type="checkbox"/> None <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Withdrawn <input type="checkbox"/> Friendly <input type="checkbox"/> Restless <input type="checkbox"/> Appro. for age <input type="checkbox"/> Hostile/Angry <input checked="" type="checkbox"/> Crying <input checked="" type="checkbox"/> Anxious <input type="checkbox"/> Concerned Facial expressions: <input type="checkbox"/> Flat <input checked="" type="checkbox"/> Responsive <input type="checkbox"/> Grimace <input type="checkbox"/> Seizure Precaution <input type="checkbox"/> Sedation Vacation Done for Neuro Assessment Comments: <u>Fall risk, disoriented, impaired memory</u>	Edema: <input checked="" type="checkbox"/> Generalized <input type="checkbox"/> Dependent Pitting: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 Skin Turgor WNL <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Abnormal Heart Sounds <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Murmur <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PPM Site: <u>N/A</u> Rhythm: <u>N/A</u>
GASTROINTESTINAL	SKELLETAL	PACER SETTINGS
<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent Stool Color: <u>N/A</u> Consistency: <u>NA</u> Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Distended <input type="checkbox"/> Guarding Bowel Sounds: <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent X-Quadrants Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> PEG <input type="checkbox"/> NGT <input type="checkbox"/> DIT R or L Comments: <u>DiA not assess BM</u>	<input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Stiffness <input type="checkbox"/> Tenderness <input checked="" type="checkbox"/> Weak <input type="checkbox"/> Deformities <input type="checkbox"/> Contractures <input type="checkbox"/> Spasms <input type="checkbox"/> Paralysis <input type="checkbox"/> Amputation <input type="checkbox"/> Gait <input type="checkbox"/> Steady <input checked="" type="checkbox"/> Unsteady Comments: <u>walks with walker</u>	<input checked="" type="checkbox"/> None Rate: <u>MA</u> A: <u> </u> V: <u> </u> Sensitivity: <u> </u> Mode: <u> </u> Transvenous @ <u> </u> cm Site: <u> </u> <input type="checkbox"/> Epicardial wires <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Permanent Pacemaker Site <input type="checkbox"/> Left subclavicular <input type="checkbox"/> Right subclavicular
GENITOURINARY	EYES, EARS, NOSE, THROAT	INCISIONS/WOUNDS/DRAINS
Urine: <input type="checkbox"/> Clear <input checked="" type="checkbox"/> Sediment <input checked="" type="checkbox"/> Cloudy <input type="checkbox"/> Yellow <input type="checkbox"/> Amber <input checked="" type="checkbox"/> Bloody <input checked="" type="checkbox"/> Voids <input type="checkbox"/> Foley Size: <u>N/A</u> Fr Insertion Date: <u>N/A</u> <input type="checkbox"/> Urostomy <input type="checkbox"/> BRP <input type="checkbox"/> Urinal/Bedpan <input type="checkbox"/> BSC <input type="checkbox"/> Incontinent Comments: <u>Urine: red/wine</u>	Sclera: <input checked="" type="checkbox"/> White <input type="checkbox"/> Yellow <input type="checkbox"/> Red Scleral Edema: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Sore Throat: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Nasal Drainage: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Comments: <u>N/A</u> <u>PERIL</u>	<input checked="" type="checkbox"/> None #1 Location: <u> </u> <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings <input type="checkbox"/> Comments: <u> </u> #2 Location: <u> </u> <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings <input type="checkbox"/> Comments: <u> </u> #3 Location: <u> </u> <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings <input type="checkbox"/> Comments: <u> </u> #4 Location: <u> </u> <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings <input type="checkbox"/> Comments: <u> </u>
ARTERIAL AND VENOUS SITES	PULMONARY	CHEST TUBES
A Without Redness or Swelling B-Redness C: Swelling D Dressing <input type="checkbox"/> Jugular <input type="checkbox"/> R <input type="checkbox"/> L Start: <u> </u> <input type="checkbox"/> Subclavian <input type="checkbox"/> R <input type="checkbox"/> L Start: <u> </u> <input type="checkbox"/> PICC <input type="checkbox"/> R <input type="checkbox"/> L Start: <u> </u> <input checked="" type="checkbox"/> Peripheral <input checked="" type="checkbox"/> R <input checked="" type="checkbox"/> L <u>hand</u> Start: <u>unknown</u> <input type="checkbox"/> Peripheral <input type="checkbox"/> R <input type="checkbox"/> L Start: <u> </u> <input type="checkbox"/> Arterial Line <input type="checkbox"/> R <input type="checkbox"/> L Start: <u> </u> <input type="checkbox"/> Femoral <input type="checkbox"/> Radial <input type="checkbox"/> PA @ <u> </u> cm <input type="checkbox"/> R <input type="checkbox"/> L Start: <u> </u> Hemodialysis Access Location: <u> </u> <input type="checkbox"/> Graft <input type="checkbox"/> AV Fistula <input type="checkbox"/> Thrill <input type="checkbox"/> Bruit	Respirations: <input type="checkbox"/> No Distress <input type="checkbox"/> SOB <input checked="" type="checkbox"/> Labored <input type="checkbox"/> Accessory Muscles <input type="checkbox"/> Shallow <input type="checkbox"/> Apnea <input type="checkbox"/> Tachypnea <input type="checkbox"/> RA O2: <u>2L</u> <input checked="" type="checkbox"/> NC <input type="checkbox"/> Vent Mask <input type="checkbox"/> Trach Collar <input type="checkbox"/> Non rebreather <input type="checkbox"/> T-Piece <input type="checkbox"/> Ventilator <input type="checkbox"/> BiPAP/CPAP <input checked="" type="checkbox"/> N/A ETT @ <u>N/A</u> cm # <u>N/A</u> Shiley Trach <input type="checkbox"/> BVM at bedside <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Obturator at bedside <input type="checkbox"/> Y <input type="checkbox"/> N Cough: <input type="checkbox"/> Productive <input type="checkbox"/> Non Productive <input type="checkbox"/> None Secretions: Color: <u>N/A</u> Consistency: <u>N/A</u> <input type="checkbox"/> Amt. <input type="checkbox"/> Copious <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal Comments: <u>N/A</u>	<input checked="" type="checkbox"/> None #1 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Suction <input type="checkbox"/> Gravity Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous <input type="checkbox"/> <u> </u> <input type="checkbox"/> Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments: <u> </u> #2 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Suction <input type="checkbox"/> Gravity Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous <input type="checkbox"/> <u> </u> <input type="checkbox"/> Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments: <u> </u> #3 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Suction <input type="checkbox"/> Gravity Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous <input type="checkbox"/> <u> </u> <input type="checkbox"/> Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments: <u> </u>
SKIN ASSESSMENT	LUNGS: 1. Clear (Normal) 2. Crackles 3. Wheezes 4. Diminished 5. Absent 6. Rub <div style="display: flex; justify-content: space-around;">   </div> <p style="text-align: center;">Inspiratory Expiratory</p>	
<input type="checkbox"/> Skin Intact Skin assessment codes: 1. Abrasions 2. Decubitis 3. Bruises 4. Incision 5. Redness 6. Edema 7. Rash 8. Lacerations 9. Petechiae 10. Hematoma 11. Blister 12. Stoma 13. Sutures 14. Staples 15. Other: <u> </u> Skin Color normal for patient <input type="checkbox"/> <input checked="" type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Jaundice <input type="checkbox"/> Shiny <input type="checkbox"/> Clammy <input type="checkbox"/> Cool <input type="checkbox"/> Diaphoretic Braden Scale Score: <u>N/A</u> <input type="checkbox"/> If Braden Scale \leq 18 initiate Skin Care Protocol Comments: <u>N/A</u>	<input type="checkbox"/> Initial Assessment <input type="checkbox"/> See Narrative for Additional information Signature: <u>[Signature]</u> Date: <u>12/16/2020</u> Time: <u>0800</u> <input type="checkbox"/> No Changes to initial assessment <input type="checkbox"/> See Narrative for <input type="checkbox"/> Signature Date: <u> </u> Time: <u> </u> <input type="checkbox"/> No Changes to previous assessment <input type="checkbox"/> See Narrative for <input type="checkbox"/> Signature Date: <u> </u> Time: <u> </u>	