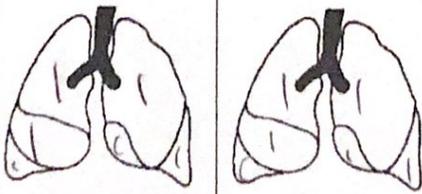


PERIPHERAL VASCULAR	NEUROLOGY/PSYCHOSOCIAL	CARDIOVASCULAR
3+ Bounding unable to occlude 2+ Strong able to occlude 1+ Weak palpable 0-Non palpable Extremities: <input type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Cyanotic <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool Calf Tenderness/Swelling <input type="checkbox"/> R <input type="checkbox"/> L Ted Hose <input type="checkbox"/> Y <input type="checkbox"/> N SCDs <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Plexipulses Capillary Refill: <u>23</u> Seconds Affected extremity pulse verified with Doppler <input type="checkbox"/> Y <input type="checkbox"/> N Pulses: Radial R <u>2+</u> L <u>2+</u> Pedal R <u>2+</u> L <u>2+</u> Post. Tib. R _____ L _____ Comments: _____	Family at bedside <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Alert <input checked="" type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Comatose <input type="checkbox"/> Sedated <input checked="" type="checkbox"/> Drowsy Cough Reflex <input type="checkbox"/> Y <input type="checkbox"/> N Follows Simple Commands: <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Gag <input type="checkbox"/> Y <input type="checkbox"/> N Muscle Strength: (S-Strong, W-Weak, N=None) Grips: Rt. <u>5</u> Lt. <u>5</u> Pushes: Rt. <u>5</u> Lt. <u>5</u> Comments: _____ Response to Questions: <input checked="" type="checkbox"/> Readily <input type="checkbox"/> Slowly <input type="checkbox"/> None <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Withdrawn <input type="checkbox"/> Friendly <input type="checkbox"/> Restless <input type="checkbox"/> Appr. for age <input type="checkbox"/> Hostile/Angry <input type="checkbox"/> Crying <input type="checkbox"/> Anxious <input type="checkbox"/> Concerned Facial expressions: <input type="checkbox"/> Flat <input type="checkbox"/> Responsive <input type="checkbox"/> Grimace <input type="checkbox"/> Seizure Precaution <input type="checkbox"/> Sedation Vacation Done for Neuro Assessment Comments: _____	Edema: <input type="checkbox"/> Generalized <input type="checkbox"/> Dependent Pitting: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ Skin Turgor WNL <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Heart Sounds <input type="checkbox"/> Y <input type="checkbox"/> N Murmur <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> PPM Site: _____ Rhythm: _____
GASTROINTESTINAL	SKELETAL	PACER SETTINGS
<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent Stool Color _____ Consistency _____ 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 <u>4</u> Quadrants Appetite: <input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> PEG <input type="checkbox"/> NGT <input type="checkbox"/> DHT R or L Comments: _____	Moves Extremities: <input checked="" type="checkbox"/> All <input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Stiffness <input type="checkbox"/> Tenderness <input type="checkbox"/> Weak <input type="checkbox"/> Deformities <input type="checkbox"/> Contractures <input type="checkbox"/> Spasms <input type="checkbox"/> Paralysis <input type="checkbox"/> Amputation _____ Gait <input checked="" type="checkbox"/> Steady <input type="checkbox"/> Unsteady Comments: _____	<input checked="" type="checkbox"/> None Rate _____ MA: A _____ V _____ Sensitivity _____ Mode _____ Transvenous @ _____ cm Site _____ <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 type="checkbox"/> Sediment <input type="checkbox"/> Cloudy <input type="checkbox"/> Yellow <input type="checkbox"/> Amber <input type="checkbox"/> Bloody <input type="checkbox"/> Voids <input type="checkbox"/> Foley Size _____ Fr Insertion Date _____ <input type="checkbox"/> Urostomy <input type="checkbox"/> BRP <input type="checkbox"/> Urinal/Bedpan <input type="checkbox"/> BSC <input type="checkbox"/> Incontinent Comments: _____	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 type="checkbox"/> N Comments: _____	<input type="checkbox"/> None #1 Location: _____ <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 _____ #2 Location: _____ <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 _____ #3 Location: _____ <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 _____ #4 Location: _____ <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 _____
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: _____ <input checked="" type="checkbox"/> Subclavian <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> PICC <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Peripheral <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Peripheral <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Arterial Line <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Femoral <input type="checkbox"/> Radial <input type="checkbox"/> PA @ _____ cm <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ Hemodialysis Access Location _____ <input type="checkbox"/> Graft <input type="checkbox"/> AV Fistula <input type="checkbox"/> Thrill <input type="checkbox"/> Bruit	Respirations: <input checked="" type="checkbox"/> No Distress <input type="checkbox"/> SOB <input type="checkbox"/> Labored <input type="checkbox"/> Accessory Muscles <input type="checkbox"/> Shallow <input type="checkbox"/> Apnea <input type="checkbox"/> Tachypnea <input checked="" type="checkbox"/> RA O2: _____ <input 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 # _____ ETT @ _____ cm # _____ Shiley Trach BVM at bedside <input type="checkbox"/> Y <input type="checkbox"/> N Obturator at bedside <input type="checkbox"/> Y <input type="checkbox"/> N Cough: <input type="checkbox"/> Productive <input type="checkbox"/> Non Productive <input checked="" type="checkbox"/> None Secretations: Color _____ Consistency _____ Amt. <input type="checkbox"/> Copious <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal Comments: _____	<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 _____ Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments _____ #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 _____ Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments _____ #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 _____ Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments _____
SKIN ASSESSMENT	LUNGS: 1. Clear (Normal) 2. Crackles 3. Wheezes 4. Diminished 5. Absent 6. Rub	
<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: _____ Skin Color normal for patient <input checked="" type="checkbox"/> <input 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 _____ <input type="checkbox"/> If Braden Scale \leq 18 initiate Skin Care Protocol Comments: _____		

Initial Assessment See Narrative for Additional information Signature: [Signature] SN Date: 01/13/21 Time: 1640
 No Changes to initial assessment See Narrative for s Signature _____ Date: _____ Time: _____
 No Changes to previous assessment See Narrative for s Signature _____ Date: _____ Time: _____

Student Name: Aileen Sihanouraj

Date: _____

Patient Physical Assessment Narrative

PHYSICAL ASSESSMENT NARRATIVE BY SYSTEMS: (Complete using assessment check list and reminders below).

GENERAL INFORMATION (Time of assessment, admit diagnosis, general appearance)

32 y/o male, fungal meningitis, HIV+,
Speaks Spanish

Neurological-sensory (LOC, sensation, strength, coordination, speech, pupil assessment)

Alert oriented x3, Hand grasp equal + strong
bilaterally, speaks Spanish

Comfort level: Pain rates at 8 **(0-10 scale) Location:** head

Psychological/Social (affect, interaction with family, friends, staff)

Friendly, interacts appropriately with family
and staff

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing)

Sclera clear and white, hears spoken
voice without difficulty

Respiratory (chest configuration, breath sounds, rate, rhythm, depth, pattern)

Respirations 14, breath sounds clear to
auscultation bilaterally. Breathing room air, O₂
94%.

Cardiovascular (heart sounds, apical and radial rate, rhythm, radial and pedal pulse, pattern)

HR 99, radial pulse 2+ bilaterally, pedal
pulses 2+ bilaterally. Nailbeds pink, capillary
refill < 3 seconds

Student Name: _____

Date: _____

IM1 Patient Physical Assessment Narrative

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to

palpation) Abd soft, active bowel sounds x4 quadrants

_____ **Last BM** _____

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal

bleeding, discharge) did not assess

_____ **Urine output** (last 24 hrs) _____

_____ **LMP** (if applicable) _____

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities)

Moves all extremities on command, gait steady

Skin (skin color, temp, texture, turgor, integrity)

Skin appropriate to race, warm

Wounds/Dressings

None

Other