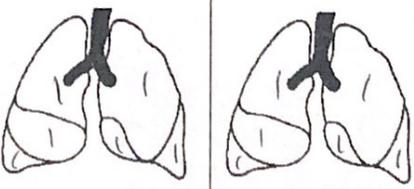


PERIPHERAL VASCULAR	NEUROLOGY/PSYCHOSOCIAL	CARDIOVASCULAR
3+-Bounding unable to occlude 2+-Strong able to occlude 1+-Weak palpable 0-Non palpable	Family at bedside <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Alert <input checked="" type="checkbox"/> Oriented <input checked="" type="checkbox"/> Confused <input type="checkbox"/> Comatose <input type="checkbox"/> Sedated <input type="checkbox"/> Drowsy Cough Reflex <input checked="" 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. _____ Lt. _____ 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: _____
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: _____ 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: _____	Response to Questions: <input type="checkbox"/> Readily <input checked="" 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 Withdrawn 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 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: _____	PACER SETTINGS
GASTROINTESTINAL	SKELETAL	<input checked="" type="checkbox"/> None Rate _____ MA: A _____ V _____ Sensitivity _____ Mode _____ Transvenous @ _____ cm Site _____ Epicardial wires <input type="checkbox"/> Y <input type="checkbox"/> N Permanent Pacemaker Site <input type="checkbox"/> Left subclavicular <input type="checkbox"/> Right subclavicular
<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input checked="" type="checkbox"/> Incontinent Stool Color <u>Brown</u> Consistency _____ Abdomen: <input type="checkbox"/> Soft <input type="checkbox"/> Firm, <input type="checkbox"/> Distended <input type="checkbox"/> Guarding Bowel Sounds: <input type="checkbox"/> Active <input checked="" type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent X <u>4</u> Quadrants Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input checked="" 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 type="checkbox"/> Steady <input type="checkbox"/> Unsteady Comments: _____	INCISIONS/WOUNDS/DRAINS
GENITOURINARY	EYES, EARS, NOSE, THROAT	#1 Location: <u>Bedsores Cervical</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 checked="" type="checkbox"/> Dressings <u>patch</u> <input type="checkbox"/> Comments <u>Bedsores</u>
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 type="checkbox"/> N Sore Throat: <input type="checkbox"/> Y <input type="checkbox"/> N Nasal Drainage: <input type="checkbox"/> Y <input type="checkbox"/> N 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 _____
ARTERIAL AND VEIN SITES	PULMONARY	#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 _____
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 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 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 type="checkbox"/> RA O2: <u>3L</u> <input checked="" type="checkbox"/> NC <input type="checkbox"/> Venti 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 checked="" type="checkbox"/> Productive <input type="checkbox"/> Non Productive <input type="checkbox"/> None Secretions: Color _____ Consistency _____ Amt. <input type="checkbox"/> Copious <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal 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 _____
SKIN ASSESSMENT	LUNGS: 1. Clear (Normal) 2. Crackles 3. Wheezes 4. Diminished 5. Absent 6. Rub	CHEST TUBES
<input type="checkbox"/> Skin Intact Skin assessment codes: 1. Abrasions 2. Decubitus 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: _____		<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 _____
<input checked="" type="checkbox"/> Initial Assessment <input type="checkbox"/> See Narrative for Additional information Signature <u>[Signature]</u> Date: <u>01-19-21</u> Time: <u>1500</u> <input type="checkbox"/> No Changes to initial assessment <input type="checkbox"/> See Narrative for _____s Signature _____ Date: _____ Time: _____ <input type="checkbox"/> No Changes to previous assessment <input type="checkbox"/> See Narrative for _____s Signature _____ Date: _____ Time: _____		

COVENANT SCHOOL OF NURSING STUDENT DOCUMENTATION

DAILY ASSESSMENT

Student Name: Aileen Sihanouraj

Date: 01-24-21

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)

1500, volume overload and acute renal failure.
Speaks Spanish

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

alert and oriented x 2 confused sometimes, hand
grasp strong and equal bilaterally, responds
slowly to questions

Comfort level: Pain rates at _____ (0-10 scale) Location: _____

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

Agitated and annoyed affect, interacts
appropriately with wife

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

Sclera clear and white, productive
cough, has trouble hearing instructions

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

Breath sounds clear to auscultation.
NC 3L O₂, respirations 16

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

HR 62, radial pulses 2+ bilaterally, pedal
pulses 2+ bilaterally

Student Name: _____

Date: _____

IM1 Patient Physical Assessment Narrative

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

palpation) Abd Hypoactive bowel sounds x4 quadrants, poor appetite, no tenderness to palpation, incontinent, brown stool

_____ Last BM 01-20-21

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

bleeding, discharge) yellow urine, incontinent

_____ **Urine output** (last 24 hrs) _____ **LMP** (if applicable) _____

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

Moves all extremities but needs assistance, gait not assessed

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

skin color appropriate for race, warm

Wounds/Dressings

pt has a bedsore on (R) gluteal that is covered with a patch

Other