Patient Name: George Palo   **MRN:** 000-545-000
Room: 1816   **Doctor Name:** Dr. Joan Rivers
DOB: 19XX   **Date Admitted:** 01-19-xx
Age: 90

Physician's Orders

Allergies: Penicillin

Date/Time:	
	Bedrest, BRP with assist
	Regular, low fat diet
	I & O
	Peripheral vascular assessment to RLE Q 2hours
	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
	Atenolol 50mg by mouth daily
	Hydrochlorothiazide 25 mg by mouth daily
	Galantamine 12 mg by mouth daily
	ASA 81 mg po daily
	Crestor 20 mg every evening
	Trazodone 25 mg by mouth at bedtime
	Acetaminophen 325 mg by mouth as needed for mild pain
	Hydromorphone 2-4 mg slow IVP every 3 hours needed
	Dr. Joan Rivers

Physician Progress Notes

Allergies: Penicillin, lisinopril

Date/Time:	
	Admit to med/surg consult ortho trauma surgeon
	Dr. Joan Rivers

Nursing Notes

Date/Time:	
0130	Admitted via ER at 0130. Lab collected in emergency room. Mary Smith, RN
0830	Admitted to S6. 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	

	Atenolol	50 mg	by mouth	Daily	9am	
	Hydrochlorothiazide	25 mg	by mouth	Daily	9am	
	Galantamine	12 mg	by mouth	Daily	9am	
	ASA	81 mg	by mouth	Daily	9 am	
	Acetaminophen	325 mg	by mouth	PRN mild pain		
	Crestor (Rosuvastatin Calcium)	20 mg	by mouth	every evening	21:00 pm	
	Trazodone	25 mg	By mouth	Every evening	21:00pm	
	Hydromorphone	2-4 mg	Slow IVP	PRN severe pain		

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 of Order:	Medication:	Dosage:	Route:	Frequency:	Date/Time 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	….	..			

Chart Materials
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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										

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Pulse:	110	112									
O² 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: **TURGOR**:
☐ acyanotic   ☐ <3 sec
☐ pale   ☐ > 3 sec
☐ ruddy
☐ jaundiced
☐ cyanotic

TEMP: **HAIR:**
☐ warm/dry   ☐ shiny
☐ hot   ☐ dry/flaking
☐ cool   ☐ balding
☐ cold/clammy   ☐ lesions
☐ diaphoretic   ☐ lice

RESPIRATORY: ☐ see nursing notes

RESPIRATIONS:
RATE:___28___
O_2:__2lpm_____
SPO_2:__91___%

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

BREATH SOUNDS:

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

THORAX:
☐ even expansion
☐ uneven expansion

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

NEUROLOGICAL: ☐ see nursing notes

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

RESPONDS TO:
☐ name   ☐ non-responsive
☐ stimuli

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

RIGHT:
- [ ] strong
- [ ] weak
- [ ] flaccid

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

☐ contractures	☐ contractures

ROM:

ARMS:	**LEGS:**
☐ full	☐ full
☐ weak	☐ weak
☐ flaccid	☐ flaccid
☐ contractures	☐ contractures
☐ TED hose

AMPUTATION:

☐ right	☐ BKA
☐ left	☐ AKA
☐ other

SPINE:

☐ kyphosis	☐ osteoporosis
☐ scoliosis

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:	**RADIAL:**	**PEDALIS:**
☐ regular	☐ regular	☐ regular
☐ irregular	☐ irregular	☐ irregular
☐ strong	☐ strong	☐ strong
☐ faint	☐ faint	☐ faint
☐ nonpalpable	☐ 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	☐ acyanotic
☐ cool	☐ cyanotic
☐ cold	☐ discolor

SAFETY: ☐ see nursing notes
☐ fall risk

PRECAUTIONS:

☐ side rails x_2
☐ bed down   ☐ wrist

EDEMA:

☐ none ☐ generalized (anasarca)

SITE #1:__LLE_____ SITE #2: __RLE_____

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

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

CAPILLARY REFILL:

FINGERS:
☐ brisk
☐ slow

TOES:
☐ brisk
☐ slow

HX:
☐ Pacemaker
☐ HTN
☐ CAD

☐ CHF
☐ PVD
☐ 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:**__

☐ call light   ☐ vest
☐ nightlight   ☐ restraints

DISCHARGE/TEACHING: ☐ see nursing notes

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

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

PAIN INTERVENTIONS
1- Relaxation/Imagery   2 - Distraction
3- Reposition   4-Medication

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

D – Dry & intact
S – Sutures/ staples
G – Granulation tissue
P – Pale
Y – Yellow
B- Black

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

b- bedbath   a- assist bath
p- partial bath sh- shower
g- grooming   m mouth care
f- foot care   n- nail care

none
S – Serous
P – Purlulent
S – Serosanguinous
B – Bright red blood
D – Dark old blood

CARE:
C – Cleaned with NS
G – Gauze dressing
W – Gauze wrap
A – ABD pad
M – Medication
Q – other **

LAB TEST	RESULT	NORMAL RANGE
WBC	11.8	3.6-10.8 L/ul
HGB	10.0	
HCT	30.0	
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	7.35	7.35-7.45
PCO2	38	35-45
HCO3	25	22-26
PO2	90	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