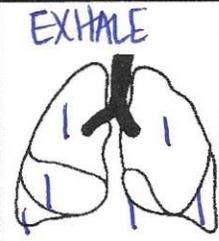


PRIMARY

73

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 type="checkbox"/> Warm <input checked="" type="checkbox"/> Cool Calf Tenderness/Swelling <input type="checkbox"/> R <input type="checkbox"/> L Ted Hose <input type="checkbox"/> Y <input checked="" type="checkbox"/> SCDs <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Plexipulses Capillary Refill: <u>53</u> Seconds Affected extremity pulse verified with Doppler <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Pulses: Radial R <u>1+</u> L <u>2+</u> Pedal R <u>1+</u> L <u>1+</u> Post. Tib. R _____ L _____ Comments: _____	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 checked="" type="checkbox"/> Drowsy Cough Reflex <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Follows Simple Commands: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Gag <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Muscle Strength: (S-Strong, W-Weak, N-None) Grips: Rt. <u>W</u> Lt. <u>W</u> Pushes: Rt. <u>W</u> Lt. <u>W</u> Comments: <u>unable to lift arms</u> Response to Questions: <input type="checkbox"/> Readily <input type="checkbox"/> Slowly <input type="checkbox"/> None <input checked="" type="checkbox"/> Calm/Relaxed <input checked="" type="checkbox"/> Quiet <input type="checkbox"/> Withdrawn <input checked="" 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 checked="" 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 checked="" type="checkbox"/> Dependent Pitting: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 1+ <input checked="" type="checkbox"/> 2+ <input type="checkbox"/> 3+ Skin Turgor WNL <input type="checkbox"/> Y <input checked="" 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: _____ Rhythm: _____
GASTROINTESTINAL	SKELETAL	PACER SETTINGS
<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent Stool Color _____ 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 type="checkbox"/> Hypo <input checked="" type="checkbox"/> Hyper <input type="checkbox"/> Absent X <u>4</u> Quadrants Appetite: <input type="checkbox"/> Good <input checked="" 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 type="checkbox"/> All <input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> LA <input checked="" type="checkbox"/> L <input type="checkbox"/> Pain <input checked="" 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 _____ Gait <input type="checkbox"/> Steady <input checked="" type="checkbox"/> Unsteady Comments: <u>bedrest</u>	<input 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 checked="" type="checkbox"/> Cloudy <input type="checkbox"/> Yellow <input type="checkbox"/> Amber <input type="checkbox"/> Bloody <input checked="" 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 checked="" type="checkbox"/> Incontinent Comments: <u>uses diaper</u>	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 checked="" type="checkbox"/> N Nasal Drainage: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Comments: <u>difficulty swallowing</u>	<input type="checkbox"/> None #1 Location: <u>C craniotomy</u> <input type="checkbox"/> Sutures <input checked="" type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____ <input checked="" 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 type="checkbox"/> Subclavian <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> BICC <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input checked="" type="checkbox"/> Peripheral <input type="checkbox"/> R <input type="checkbox"/> L Start: <u>3129</u> <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"/> 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 checked="" type="checkbox"/> N Obturator at bedside <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Cough: <input checked="" type="checkbox"/> Productive <input type="checkbox"/> Non Productive <input checked="" type="checkbox"/> None Secretions: Color _____ Consistency _____ Amt. <input type="checkbox"/> Copious <input type="checkbox"/> Moderate <input checked="" 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 <input type="checkbox"/> _____ 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 <input type="checkbox"/> _____ 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 <input type="checkbox"/> _____ 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: <u>skin tear</u> Skin Color normal for patient <input 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 <u>14</u> <input type="checkbox"/> If Braden Scale \leq 18 initiate Skin Care Protocol Comments: _____	<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>INHALE</p>  </div> <div style="text-align: center;"> <p>EXHALE</p>  </div> </div> <p style="text-align: center;"><u>S. Angeles</u></p>	
<input checked="" type="checkbox"/> Initial Assessment <input type="checkbox"/> See Narrative for Additional information Signature: <u>S. Angeles</u> Date: <u>3/30/21</u> Time: <u>0900</u> <input checked="" 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: _____		