

PERIPHERAL VASCULAR	NEUROLOGY/PSYCHOSOCIAL	CARDIOVASCULAR
3+-Bounding unable to occlude 2+-Strong able to occlude 1+-Weak palpable 0-Non palpable Extremities: <input checked="" 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 checked="" type="checkbox"/> Y <input type="checkbox"/> N SCDs <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Plexipulses Capillary Refill: _____ 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>2+</u> L <u>2+</u> Post. Tib. R <u>2+</u> L <u>2+</u> Comments: _____	Family at bedside <input type="checkbox"/> Y <input checked="" 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 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 checked="" 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 Withdrawn 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 checked="" type="checkbox"/> Friendly <input type="checkbox"/> Restless <input checked="" 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 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 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 PPM Site: _____ Rhythm: _____
GASTROINTESTINAL	SKELETAL	PACER SETTINGS
<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent Stool Color <u>Brown</u> Consistency <u>Yes</u> Abdomen: <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input checked="" 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 checked="" 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: <u>left forearm and R. are bruised and sore due to fall</u>	<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 checked="" type="checkbox"/> Clear <input type="checkbox"/> Sediment <input type="checkbox"/> Cloudy <input checked="" type="checkbox"/> Yellow <input type="checkbox"/> Amber <input type="checkbox"/> Bloody <input type="checkbox"/> Voids 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>USES URINAL w/ help</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: _____	<input checked="" 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
<input checked="" type="checkbox"/> A-Without Redness or Swelling <input type="checkbox"/> B-Redness <input type="checkbox"/> C-Swelling <input type="checkbox"/> 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 <u>Trilysis R. Subclavian</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 checked="" 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>34%</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 <input type="checkbox"/> BVM at bedside <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Obturator at bedside <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Cough: <input 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 type="checkbox"/> Minimal Comments: <u>SOB w/ exertion</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 _____ 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 checked="" type="checkbox"/> Skin Intact Skin assessment codes: <input checked="" type="checkbox"/> 1. Abrasions <input type="checkbox"/> 2. Decubitis <input checked="" type="checkbox"/> 3. Bruises <input type="checkbox"/> 4. Incision <input type="checkbox"/> 5. Redness <input checked="" type="checkbox"/> 6. Edema <input type="checkbox"/> 7. Rash <input type="checkbox"/> 8. Lacerations <input type="checkbox"/> 9. Petechiae <input type="checkbox"/> 10. Hematoma <input type="checkbox"/> 11. Blister <input type="checkbox"/> 12. Stoma <input type="checkbox"/> 13. Sutures <input type="checkbox"/> 14. Staples <input type="checkbox"/> 15. Other: _____ 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>19</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>Inspiratory</p> </div> <div style="text-align: center;"> <p>Expiratory</p> </div> </div>	

Initial Assessment See Narrative for Additional information Signature Juan Garcia SN
 No Changes to initial assessment See Narrative for _____s Signature _____
 No Changes to previous assessment See Narrative for _____s Signature _____

Date: 3/31/2021 Time: 08:00am
 Date: _____ Time: _____
 Date: _____ Time: _____

Student Name: Jacob Tarazue

Date: 4/1/2021

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)

07:13am Upon entering Pt room, pt was awake and alert. Pt was admitted on 3/18/2021 for Congestive Heart Failure Exacerbation. Pt. CT is a 82 yr. old Male. Vital Signs; Regular Heart Rate 60, BP 107/48, Respirations 14, Temp 97.4 Temporal Pt on 3 L/min Nasal Cannula Sats 93%. No family present at bedside.

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

Pt CT, Awake, Alert, and Orientated to Person, Place and date. Moves all extremities on command. Responds appropriately, light touch sensation, HGTW, strong equal bilaterally. Movements are purposeful and coordinated. Speaks English clearly w/o hesitation. Pupils are equal, round and reactive to light.

Comfort level: Pain rates at 0 (0-10 scale) Location: N/A

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

Pt interacts appropriately with staff, and family. Very pleasant, communicates well.

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

Sclera clear; White w/o damage. Ears Symmetrical, Auditory Canals w/o drainage. Hears spoken voices w/o difficulty. Nasal Septum midline, mucosa pink, oral mucosa pink, moist intact, No discharge. Neck Normal active ROM, Trachea midline, No palpable lymph Nodes

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

Equal Chest expansion w/ respirations. Trachea midline, clear normal vesicular breath sounds in all lobes on Inspiratory and Expiratory.

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

S1; S2 Heard in all 4 locations w/ Heart Rate 60. Apical pulse of 60, Radial pulse 2+ Bilaterally w/ Pedal pulses 2+, Post tib 2+.

Student Name: _____

Date: _____

IM1 Patient Physical Assessment Narrative

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) Abdomen was distended, Active bowel sounds, x 4 Quadrants. Pt. stated he had normal bowel habits with consistency of solid stool. His belly was distended due to the fluid build up.

Last BM 3/29/2021

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) Pt. Urine Normal Clear, No odor present when emptying urinal, Yellow color to it. When assessing Perineal are pt. Scrotum was a size of grapefruit due to edema. Elevated the scrotum with pillow due to swelling.

Urine output (last 24 hrs) 200 **LMP** (if applicable) N/A

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities) Normal Spinal Curvature, No edema present. Pt. is on bedrest due to the fluid and edema and SOB that occurs with exertion.

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

Color is appropriate for race, Normal, Pt. does present with some bruising and abrasions on forearms as well his forehead. Pt. stated he had fallen a while back at home. The edema is dependent along with generalized.

Wounds/Dressings

N/A

Other

Pt. is on strict I/O. Pt. as well had a R. Trialysis place in the subclavian. Will start dialysis on second shift.