

### Diagnostic Worksheet

Mark high / low values with (↑ or ↓)	Covenant Normal Values <small>*Diagnostic values vary from laboratory to laboratory.</small>	Admit day	Most Recent	AD MR	Mark high / low values with (↑ or ↓)	Covenant Normal Values <small>*Diagnostic values vary from laboratory to laboratory.</small>	Admit day	Most Recent	AD MR
<b>CBC</b>									
WBC	3.6-10.8 k/uL	4.8	5.0	L		N/A	11010	Ø	<del>AD MR</del>
HGB	14-18 g/dL	1.9	9.4	L		N/A	N	Ø	<del>AD MR</del>
HCT	42% - 52%	25.5	29.0	L		N/A	500	Ø	<del>AD MR</del>
RBC	4.7-6.1 m/uL	2.10	3.23	L		N/A	N	Ø	<del>AD MR</del>
PLT	150 - 400 K/uL	402	419	H		N/A	N	Ø	<del>AD MR</del>
<b>CMP</b>									
Glucose	70-110 mg/dL	213	358	H		N/A	N	Ø	<del>AD MR</del>
Sodium	134 - 145 mmol/L	130	130			N/A	N	Ø	<del>AD MR</del>
Potassium	3.5 - 5.3 mmol/L	4.8	4.0			N/A	N	Ø	<del>AD MR</del>
BUN	9-21 mg/dL	22	12	H		N/A	N	Ø	<del>AD MR</del>
Creatinine	0.8-1.5 mg/dL	1.00	0.86			N/A	N	Ø	<del>AD MR</del>
Chloride	98 - 108 mmol/L	109	108			N/A	N	Ø	<del>AD MR</del>
Calcium	8.4 - 11.0 mg/dL	8.7	7.7	L		N/A	N	Ø	<del>AD MR</del>
Mg++	1.6 - 2.3 mg/dL	Ø	Ø			N/A	N	Ø	<del>AD MR</del>
Total Protein	5.5 - 7.8 g/dL	6.2	Ø	L		N/A	N	Ø	<del>AD MR</del>
Albumin	3.4 - 5 g/dL	0.8	Ø			N/A	N	Ø	<del>AD MR</del>
Total Bilirubin	0.1 - 1.3	0.3	Ø			N/A	N	Ø	<del>AD MR</del>
AST (SGOT)	5 - 45 u/L	11	Ø			N/A	N	Ø	<del>AD MR</del>
ALT (SGPT)	7-72 u/L	14	Ø			N/A	N	Ø	<del>AD MR</del>
Alk Phos (ALP)	38 - 126 u/L	100	Ø			N/A	N	Ø	<del>AD MR</del>
<b>Lipid Panel</b>									
Cholesterol	200mg/dL	Ø	Ø			N/A	N	Ø	<del>AD MR</del>
TRIG	0-150 mb/dL	Ø	Ø			N/A	N	Ø	<del>AD MR</del>
HDL	>60mg/dL	Ø	Ø			N/A	N	Ø	<del>AD MR</del>
LDL	0-100 mg/dL	Ø	Ø			N/A	N	Ø	<del>AD MR</del>
<b>Common</b>									
GFR	Refer to lab specific data	55	760	L		N/A	N	Ø	<del>AD MR</del>
TSH	0.35 - 5.5 U/L	Ø	Ø			N/A	N	Ø	<del>AD MR</del>
Digoxin	0.8 - 2 ng/dL	Ø	Ø			N/A	N	Ø	<del>AD MR</del>
PT	10.0 - 12.9 secs	Ø	Ø			N/A	N	Ø	<del>AD MR</del>
INR	Therapeutic 2 - 3	Ø	Ø			N/A	N	Ø	<del>AD MR</del>
PTT	25.3 - 36.9 secs	Ø	Ø			N/A	N	Ø	<del>AD MR</del>
BNP	5 - 100 pg/dL	Ø	Ø			N/A	N	Ø	<del>AD MR</del>
CKMB	0 - 5 ng/dL	Ø	Ø			N/A	N	Ø	<del>AD MR</del>
Troponin	neg = < 0.07 ng/mL	Ø	Ø			N/A	N	Ø	<del>AD MR</del>
<b>Other Labs</b>									
Date	Culture	Site	Result						
	Blood								
	Urine								
	Wound								
	Wound								
<b>Other Diagnostic / Procedures</b>									
Examples: CT/Xray/MRI/Paracentesis									
Date	Type	Result							
3/23	ANNUAL LOW FXT LEFT W/LENTICIT	MOD SEVERE ATHEROSCLEROTIC							
3/22	HEAD W/OUT CONTRAST	NB ABNORMALITIES							
3/21	FLUOROSCOPY	LEFT TOTAL HIP PROSTHESIS							
<b>Point of Care Glucose Results</b>									
Date	Time	Result	Date	Time	Result				
3/29	1111	308	3/21	2145	447				
3/28	2009	103	3/22	0710	310				
3/25	1042	291	3/23	0722	312				

Student Name: Zandrea Farris

Date: 3/29/22

### 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)

Time: 0820

Ad Dx: left hip dislocation

General Appearance: Clean and well kept

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

LOC: Alert oriented x4

pupil sz: 3 mm

Sensation: Sharp and dull intact

Strength: Strong bilaterally

Coordination:

Speech: clear and understandable

Comfort level: Pain rates at 5 (0-10 scale) Location: Headache

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

Outward: calm relaxed quiet and respectful

Interaction: Acts respectful and calm with hospital staff

**EENT** (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing) EENT-symmetrical no drainage

Mouth: dry

Swallowing: no difficulty

Dentition: teeth intact denture

Nodes: non palpable

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

Chest configuration: equal

depth: PT takes deep breath on demand

Breath sounds: clear unlabored

pattern: Equal unlabored

Rate: 18

Rhythm: Equal

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

S1: Audible

pattern: regular

S2: Audible

Apical: 90

Radial: 90

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Patient Physical Assessment Narrative

**Gastrointestinal** (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) Did not observe patient stated no bowel movement while here.

Appearance of abdomen: Flat non tender on palpation

Bowel sounds: Active x4 Last BM NO BM on visit.

**Genitourinary-Reproductive** (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) Patient states frequency, urgency, and incontinence  
Patient states lots of urine, I did not observe. Patient denies odor  
or discharge. Student nurse did not observe any odor or discharge.  
Input and output not documented

Urine output (last 24 hrs) 0ML LMP (if applicable) NA

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

Alignment: Symmetrical

Posture: Upright

Mobility: Independent

Gait: Bed rest total assist

Movement: Strong in all extremities

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

Skin: Appropriate for race

Temp: Warm to touch

Texture: Smooth + dry

Turgor: Elastic

**Wounds/Dressings**

IV: Drive and intact with dressing

DICC: Drive and intact with dressing

Left hip: Dressing intact dry; did not observe

Other

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