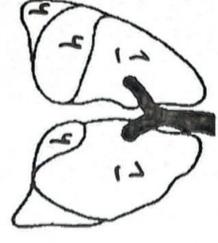
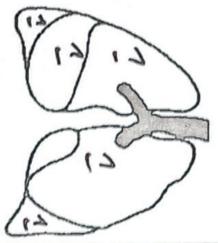


<p>PERIPHERAL VASCULAR</p> <p>3+ Bounding unable to occlude 2+ Strong able to occlude 1+ Weak palpable 0-Non palpable</p> <p>Expirities: <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Cyanotic <input type="checkbox"/> Warm</p> <p><input checked="" type="checkbox"/> Cool <input type="checkbox"/> Tender/Swelling <input type="checkbox"/> R <input type="checkbox"/> L</p> <p>Ted Hose <input type="checkbox"/> Y <input checked="" type="checkbox"/> N SCDs <input type="checkbox"/> Y <input checked="" type="checkbox"/> N</p> <p><input type="checkbox"/> Plexipulses <input type="checkbox"/> Capillary Refill: <u>3</u> Seconds</p> <p>Affected extremity pulse verified with Doppler <input type="checkbox"/> Y <input checked="" type="checkbox"/> N</p> <p>Pulses: Radial R <u>2+</u> L <u>2+</u></p> <p>Pedal R <u>2+</u> L <u>2+</u></p> <p>Post. Tib. R <u>1</u> L <u>1</u></p> <p>Comments: _____</p>	<p>NEUROLOGY/PSYCHOSOCIAL</p> <p>Family at bedside <input checked="" type="checkbox"/> Y <input type="checkbox"/> N</p> <p><input checked="" type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Comatose</p> <p><input checked="" type="checkbox"/> Sedated <input type="checkbox"/> Drowsy <input type="checkbox"/> Cough Reflex <input checked="" type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Follows Simple Commands: <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Gag <input checked="" type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Muscle Strength: (S-Strong, W-Weak, N-None)</p> <p>Grip: Rt. <u>4</u> Lt. <u>5</u> Pushes: Rt. <u>5</u> Lt. <u>5</u></p> <p>Comments: _____</p> <p>Response to Questions: <input checked="" type="checkbox"/> Readily <input type="checkbox"/> Slowly <input type="checkbox"/> None</p> <p><input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Withdrawn <input checked="" type="checkbox"/> Friendly</p> <p><input type="checkbox"/> Restless <input type="checkbox"/> Appro. for age <input type="checkbox"/> Hostile/Angry</p> <p><input type="checkbox"/> Crying <input type="checkbox"/> Anxious <input type="checkbox"/> Concerned</p> <p>Facial expressions: <input type="checkbox"/> Flat <input checked="" type="checkbox"/> Responsive <input type="checkbox"/> Grimace</p> <p><input type="checkbox"/> Seizure Precaution <input type="checkbox"/> Sedation Vacation Done for Neuro Assessment</p> <p>Comments: _____</p>	<p>CARDIOVASCULAR</p> <p>Edema: <input type="checkbox"/> Generalized <input type="checkbox"/> Dependent</p> <p>Pitting: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+</p> <p>Skin Turgor: <input checked="" type="checkbox"/> WNL <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Abnormal Heart Sounds: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N</p> <p>Murmur: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N</p> <p>PPM Site: _____ Rhythm: _____</p> <p>PACER SETTINGS</p> <p>Rate: <u>None</u> MA: A _____ V _____</p> <p>Sensitivity: _____ Mode: _____</p> <p>Transvenous @ _____ cm Site _____</p> <p>Epicardial wires: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N</p> <p>Permanent Pacemaker Site _____</p> <p><input type="checkbox"/> Left subclavian <input type="checkbox"/> Right subclavian</p> <p>INCISIONS/WOUND/DRAINS</p> <p><input checked="" type="checkbox"/> None</p> <p>#1 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#2 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#3 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#4 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>CHEST TUBES</p> <p><input checked="" type="checkbox"/> None</p> <p>#1 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R</p> <p>Suction <input type="checkbox"/> Gravity</p> <p>Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous <input type="checkbox"/> _____</p> <p>Air-leak <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Pleuravae <input type="checkbox"/> Thorascap</p> <p>Comments: _____</p> <p>#2 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R</p> <p>Suction <input type="checkbox"/> Gravity</p> <p>Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous <input type="checkbox"/> _____</p> <p>Air-leak <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Pleuravae <input type="checkbox"/> Thorascap</p> <p>Comments: _____</p> <p>#3 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R</p> <p>Suction <input type="checkbox"/> Gravity</p> <p>Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous <input type="checkbox"/> _____</p> <p>Air-leak <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Pleuravae <input type="checkbox"/> Thorascap</p> <p>Comments: _____</p>
<p>GASTROINTESTINAL</p> <p><input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinence <input checked="" type="checkbox"/> Type 2</p> <p>Stool Color: <u>black</u> Consistency: <u>type 2</u></p> <p>Abdomen: <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Distended <input type="checkbox"/> Guarding</p> <p>Bowel Sounds: <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent</p> <p>X <u>Y</u> Quadrants Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p><input type="checkbox"/> PEG <input type="checkbox"/> NGT <input type="checkbox"/> DHT R or L</p> <p>Comments: _____</p>	<p>SKELTAL</p> <p>Moves Extremities: <input checked="" type="checkbox"/> All <input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> LA <input type="checkbox"/> LL</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Stiffness <input checked="" type="checkbox"/> Tenderness <input type="checkbox"/> Weak</p> <p><input type="checkbox"/> Deformities <input type="checkbox"/> Contractures <input type="checkbox"/> Spasms <input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Amputation _____ Gait <input type="checkbox"/> Steady <input checked="" type="checkbox"/> Unsteady</p> <p>Comments: _____</p>	<p>INCISIONS/WOUND/DRAINS</p> <p><input checked="" type="checkbox"/> None</p> <p>#1 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#2 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#3 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#4 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p>
<p>GENTOURINARY</p> <p>Urine: <input checked="" type="checkbox"/> Clear <input type="checkbox"/> Sediment <input type="checkbox"/> Cloudy <input checked="" type="checkbox"/> Yellow</p> <p><input type="checkbox"/> Amber <input type="checkbox"/> Bloody <input type="checkbox"/> Voids _____</p> <p><input type="checkbox"/> Foley Size _____ Fr. Insertion Date _____</p> <p><input type="checkbox"/> Urostomy <input type="checkbox"/> BRP <input type="checkbox"/> Urinal/Bedpan <input type="checkbox"/> BSC <input type="checkbox"/> Incontinent</p> <p>Comments: _____</p>	<p>EYES, EARS, NOSE, THROAT</p> <p>Sclera: <input checked="" type="checkbox"/> White <input type="checkbox"/> Yellow <input type="checkbox"/> Red</p> <p>Scleral Edema: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Sore Throat: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N</p> <p>Nasal Drainage: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N</p> <p>Comments: _____</p>	<p>INCISIONS/WOUND/DRAINS</p> <p><input checked="" type="checkbox"/> None</p> <p>#1 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#2 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#3 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#4 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p>
<p>ARTERIAL AND VENOUS SITES</p> <p>A-Without Redness or Swelling B-Redness C-Swelling D-Dressing</p> <p><input type="checkbox"/> Jugular <input type="checkbox"/> R <input type="checkbox"/> L Start: _____</p> <p><input type="checkbox"/> Subclavian <input type="checkbox"/> R <input type="checkbox"/> L Start: _____</p> <p><input type="checkbox"/> PICC <input type="checkbox"/> R <input type="checkbox"/> L Start: _____</p> <p><input checked="" type="checkbox"/> Peripheral <input checked="" type="checkbox"/> R <input checked="" type="checkbox"/> L Start: <u>2/19</u></p> <p><input type="checkbox"/> Peripheral <input type="checkbox"/> R <input type="checkbox"/> L Start: _____</p> <p><input type="checkbox"/> Arterial Line <input type="checkbox"/> R <input type="checkbox"/> L Start: _____</p> <p><input type="checkbox"/> Femoral <input type="checkbox"/> Radial</p> <p><input type="checkbox"/> PA @ _____ cm <input type="checkbox"/> R <input type="checkbox"/> L Start: _____</p> <p>Hemodialysis Access Location _____</p> <p><input type="checkbox"/> Graft <input type="checkbox"/> AV Fistula <input type="checkbox"/> Thrill <input type="checkbox"/> Bruit</p>	<p>PULMONARY</p> <p>Respirations: <input checked="" type="checkbox"/> No Distress <input type="checkbox"/> SOB <input type="checkbox"/> Labored</p> <p><input type="checkbox"/> Accessory Muscles <input type="checkbox"/> Shallow <input type="checkbox"/> Apnea <input type="checkbox"/> Tachypnea</p> <p><input checked="" type="checkbox"/> RA O2: _____ <input type="checkbox"/> NC <input type="checkbox"/> Veni Mask <input type="checkbox"/> Trach Collar</p> <p><input type="checkbox"/> Non rebrather <input type="checkbox"/> T-Piece <input type="checkbox"/> Ventilator: <input type="checkbox"/> BIPAP/CPAP</p> <p># _____ ETT @ _____ cm # _____ Shiley Trach</p> <p>BVM at bedside <input type="checkbox"/> Y <input checked="" type="checkbox"/> N</p> <p>Obturator at bedside <input type="checkbox"/> Y <input checked="" type="checkbox"/> N</p> <p>Cough: <input type="checkbox"/> Productive <input type="checkbox"/> Non Productive <input type="checkbox"/> None</p> <p>Secretions: Color _____ Consistency _____</p> <p>Amt. <input type="checkbox"/> Copious <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal</p> <p>Comments: _____</p>	<p>INCISIONS/WOUND/DRAINS</p> <p><input checked="" type="checkbox"/> None</p> <p>#1 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#2 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#3 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#4 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p>
<p>SKIN ASSESSMENT</p> <p><input checked="" type="checkbox"/> Skin Intact</p> <p>Skin assessment codes:</p> <p>1. Abrasions 2. Decubitis 3. Bruises 4. Incision</p> <p>5. Redness 6. Edema 7. Rash 8. Lacerations</p> <p>9. Petechiae 10. Hematoma 11. Blister 12. Stoma</p> <p>13. Sutures 14. Staples 15. Other _____</p> <p>Skin Color normal for patient <input checked="" type="checkbox"/></p> <p><input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Shiny <input type="checkbox"/> Clammy <input type="checkbox"/> Cool</p> <p><input type="checkbox"/> Diaphoretic</p> <p>Braden Scale Score <u>20</u></p> <p><input type="checkbox"/> If Braden Scale \leq 18 initiate Skin Care Protocol</p> <p>Comments: _____</p>	 	<p>INCISIONS/WOUND/DRAINS</p> <p><input checked="" type="checkbox"/> None</p> <p>#1 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#2 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#3 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p> <p>#4 Location: _____</p> <p>Sutures: <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p>Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p>Open to Air <input type="checkbox"/> Dressings _____</p> <p>Comments: _____</p>

Initial Assessment See Narrative for Additional Information Signature: MyShires Date: 2/23/24 Time: 0800

No Changes to initial assessment See Narrative for _____ Signature: _____ Date: _____ Time: _____

No Changes to previous assessment See Narrative for _____ Signature: _____ Date: _____ Time: _____