Do not fill out the required sections below if it does not apply to your patient. For example, drains: No drain present; you would leave sections blank.

Patient Information:
Name (**YOUR** name), patient's sex assigned at birth, gender identity, age, **provider** (Bernard Robinson, MD), code status, and **comments** (Clinical Instructor and Unit you are on).

Provider:
Chief Complaint & History of Present Illness:
Admission Problems:

- Chief Complaint, Primary Concern - Admission Diagnosis, Other Problems/Diagnosis

History:

- Past Medical History
- Past Surgical History

Allergies & Home Medications:

- Add allergens

Notes:

- Enter a free-form text note (not required but welcome to add any notes)

Flowsheets:
Vital Signs: NO Measurements

- Enter Vital Signs

Assessment:

- Head, Face, Anterior Fontanel, Neck
- Eyes, Ears, Nose, Throat
- Neurological Group (**NO** Deep Tendon Reflexes)
- **NO**: Glasgow Coma Scale
- Respiratory
- Cardiac
- Peripheral Vascular
- Integumentary
- Braden Scale
- Musculoskeletal

- Morse Fall Scale
- Gastrointestinal
- Genitourinary
- Pain Assessment

Intake and Output:

- Oral Intake
- IV Intake
- Unmeasured Output:
    - Stool: **Last BM, Color, Amount, Continent/Incontinent**
    - Urine**: Color, Amount, Order, Continent/Incontinent**

Interventions:

- **IVs/Lines**
- Urinary Catheters
- Gastric Tubes
- Drains

Wounds/Incisions/Ostomies:

Orders: Add New Orders, Order Type *Entered by Provider*

- ENTER at least **THREE** Medications Orders
    - Dose, Route, Frequency
- Admin Instructions/Comments: Underline Titles and # 1-4 patient teachings
    - Drug Class, Therapeutic Reason, Adverse Reactions
- Student Notes: Need FOUR patients teaching relevant to your patient

Example: “Underline”
New Order: Lisinopril 25mg po daily

Admin Instructions/Comments:
Drug Class: Ace-Inhibitor
Therapeutic Reason: Hypertension
Adverse Reactions: Hypotension, Dizziness, Angioedema, etc.

Student Notes: “Relevant to your patient”
Patient Teaching
1. Caution when ambulation- drop in BP
2. Take with meals- GI upset

3. Watch for cough- ACE cough report to provider
4. Patient is pregnant, Avoid while pregnant.

SBAR: Add giver (YOU) and receiver (Instructor)

S:

- Age, gender
- Reason for admission
- Current status (stable, improving, deteriorating)
- Any immediate concerns

B:

- Hosptial day #, allergies, and diagnosis
- Relevant medical history
- Relevant Lab values
- Procedures or treatments during this shift
- Code status

A:

- Current assessment updates: improvement and/or declines
- Vital signs with values
- Pain level and management
- Mental status
- Mobility and fall risk
- Skin condition (e.g., wounds, pressure injuries)
- I&O status (IV status, oral fluids, urine, bowel movements)

R:

- What needs follow-up on the next shift?
- Labs or tests pending
- Meds due or recommend
- Patient education needs
- Discharge planning
- Any concerns to monitor