Patient Name: Millie Larsen	**MRN:** 000-555-000
Room: 816	**Doctor Name:** Dr. Eric Lund
DOB: 01/23/1926	**Date Admitted:**
Age: 84	

Physician's Orders

Allergies: NKA

Date/ Time:	
	Bedrest, BRP with assist
	Regular, low fat diet
	I & 0
	captopril 25 mg po three times a day
	metoprolol 100 mg every day
	furosemide 40 mg po twice per day
	Lipitor 50 mg once daily
	pilocarpine eye drops 2 drops each eye 4 times a day
	Fosamax 10 mg every day
	Celebrex 200 mg po once a day
	tramodol for arthritis pain prn
	Ciprofloxacin 250 mg every 12 hours
	Acetaminophen 325 mg po prn
	IV fluids D5 .45 NaCl 20 mEq KCL at 60ml/hr
	Dr. Eric Lund

Physician Progress Notes

Allergies:

Date/ Time:	

	Admit. Will see later in a.m.
	Dr. Eric Lund

Nursing Notes

Date/ Time:	
0200	Admitted to ER with daughter, stable; no bed available T. Wade RN
0900	Admit to 6E. see flow sheet T. Wade RN

Medication Administration Record

Allergies:

Home Meds

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Hours to be Given:	Dates Given:
	Captopril	25 mg	po	three times a day	0800,1200,1600	
	Metoprolol	100 mg		every day	0800	
	Furosemide	40 mg	po	twice per day	0800, 1600	
	Lipitor	50 mg		once daily	0800	
	Pilocarpine eye drops	2 drops each eye		four times a day	0800,1200,1600,2000	
	Fosamax	10 mg		every day	0800	
	Tramodol			for arthritis pain/prn		
	Ciprofloxacin	250 mg		every 12 hours	0800,2000	
	Acetaminophen	325 mg	po	prn		
	Celebrex	200 mg	po	once a	0800	

				day		

Intravenous Therapy

Date of Order:	IV Solution	Rate Ordered:	Date/Time Hung:
	IV fluids D5 .45 NaCl 20 mEq KCL	60ml/hr	

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature

Medication Administration Record

Intramuscular legend:	Subcutaneous site code:
A=RUOQ ventrogluteal	1=RUQ abdomen
B=LUOQ ventrogluteal	2=LUQ abdomen
C=R Deltoid	3=RLQ abdomen
D=L Deltoid	4=LLQ abdomen
E=R Thigh Lateral	5=RU arm
F=L Thigh Lateral	6=LU arm
	7=R leg
	8=L leg

Allergies:

PRN Medications

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Date/Time Given:	
					Date:	
					Time:	
					Site:	
					Initials:	

Insulin Administration

Date	Medication:	Dosage:	Route:	Frequency	Date/Time Given:

of Order:				:		
					Date:	
					Time:	
					Site:	
					GMR:	
					Initials:	

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature

Vital Signs Record

Date:													
Time:			0200	0600	0800	1200			...	..			
Temperature:	**C⁰**	**F⁰**											
	40	**104**											
	39.5	**103**											
	39	**102**											
	38.5	**101**											

	38	**100**	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .
	37.5	**99**	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .
	37	**98**	. . **X** .	. . . **X.**	. . . **.X**	. . **.X** .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .
	36.5	**97**	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .
	36	**96**	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .	. . . . .
BP:			156/88	160/88	148/86	146/90							
Pulse:			78	80	80	76							
O^2 Saturation:			94	94	96	95							
Weight:													
Respirations:			14	12	16	14							
GMR:													
Nurse Initials:			TB	TB	CR	CR							

Intake & Output Bedside Worksheet

INTAKE					**OUTPUT**				
ORAL	TUBE FEED	IV	IVPB	OTHER	URINE	Emesis	NG	Drains Type:	Other

Total Intake this shift:					Total Output this shift:				

(This is a worksheet to be used at the bedside to keep track of each intake or output. The totals will then be recorded on the 24 hour Fluid Balance sheet.)

Fluid Measurements:	Sample Measurements:
1 ml = 1 cc	Coffee cup = 200 cc
1 ounce = 30 cc	Clear glass = 240 cc
8 ounces = 240 cc	Milk carton = 240 cc
1 cup = 8 ounces = 240 cc	Small milk carton = 120 cc
4 cups = 32 ounces = 1 quart or liter= 1000 cc	Juice, gelatin or ice cream cup = 120 cc
	Soup bowl = 160 cc
	Popsicle half = 40 cc

Nursing Assessment Flowsheet

GENERAL APPEARANCE:
☐ male ☐ female

DOB:_____
AGE:_____
ETHNICITY:_____
OCCUPATION:_____
RELIGION:_____

☐ awake ☐ sleeping ☐ agitated
☐ cheerful ☐ lethargic ☐ anxious
☐ crying ☐ calm ☐ combative
☐ fearful

SKIN: ☐ see wound care sheet ☐ see nursing notes

BRADEN SCALE SCORE: ☐ risk skin breakdown

COLOR:
☐ acyanotic
☐ pale
☐ ruddy
☐ jaundiced
☐ cyanotic

TURGOR:
☐ <3 sec
☐ > 3 sec

TEMP:
☐ warm/dry
☐ hot
☐ cool
☐ cold/clammy
☐ diaphoretic

HAIR:
☐ shiny
☐ dry/flaking
☐ balding
☐ lesions
☐ lice

NEUROLOGICAL: ☐ see nursing notes

ORIENTATION:
☐ person ☐ disoriented
☐ place ☐ confused
☐ time ☐ impaired memory

RESPONDS TO:
☐ name ☐ non-responsive
☐ stimuli

RESPIRATORY: ☐ see nursing notes

RESPIRATIONS:
RATE:_____
O_2:_____
SPO_2:_____%

☐ regular ☐ labored
☐ even ☐ uses accessory muscles
☐ irregular ☐ cough

BREATH SOUNDS:

LEFT:	RIGHT:
☐ clear	☐ clear
☐ crackles	☐ crackles
☐ wheezes	☐ wheezes
☐ decreased	☐ decreased
☐ absent	☐ absent

THORAX:
☐ even expansion
☐ uneven expansion

SMOKING:
☐ cigarettes pk/day _____
☐ cigars
☐ marijuana
☐ cocaine

GASTROINTESTINAL/NUTRITION: ☐ see nursing notes

APPEARANCE:
☐ flat ☐ soft
☐ round ☐ gravid
☐ obese

BOWEL SOUNDS:
☐ active ☐ hyperactive
☐ hypoactive ☐ absent

SPEECH:
- ☐ clear
- ☐ garbled
- ☐ slurred
- ☐ aphasic
- ☐ inappropriate
- ☐ cannot follow conversation

FACE:
- ☐ symmetrical
- ☐ drooping
- ☐ drooling

EYES:
- ☐ PERRLA
- ☐ unequal
- ☐ drooping lid

SIGHT:
- ☐ no correction
- ☐ glasses
- ☐ contacts
- ☐ blind

HEARING:
- ☐ WNL
- ☐ HOH
- ☐ hearing aid

HX:
- ☐ seizures
- ☐ CVA
- ☐ brain injury
- ☐ spinal injury
- ☐ other

PALPATION:
- ☐ non-tender
- ☐ mass (location) _____
- ☐ tender (location)_____

LAST BM: Pt cannot recall –maybe last night

- ☐ incontinent
- ☐ stoma- _____
- ☐ constipation
- ☐ diarrhea
- ☐ mucous
- ☐ blood

DIET:_____

- ☐ impaired swallowing
- ☐ choking
- ☐ NG tube
  color drainage:_____
- ☐ feeding tube
- ☐ tube feeding
  type: _____ rate:_____

MUSCULOSKELETAL: ☐ see nursing notes

GAIT:
- ☐ steady
- ☐ unsteady
- ☐ non-ambulatory

ACTIVITY:
- ☐ up ad lib
- ☐ walker
- ☐ cane
- ☐ crutches
- ☐ wheelchair

ASSIST:
- ☐ x1
- ☐ x2
- ☐ lift
- ☐ bed bound

HAND GRIPS:
AMPUTATION: ☐ left ☐ right
LOCATION:_____

LEFT:
- ☐ strong
- ☐ weak

RIGHT:
- ☐ strong
- ☐ weak

GENITOURINARY: ☐ see nursing notes

- ☐ voids
- ☐ catheter
- ☐ stoma

APPEARANCE OF URINE:
- ☐ clear
- ☐ light yellow
- ☐ amber
- ☐ brown
- ☐ cloudy
- ☐ sediment
- ☐ red/wine
- ☐ clots

BLADDER:
- ☐ soft
- ☐ firm/distended
- ☐ incontinent

FEMALES: LMP: _____

- ☐ WNL
- ☐ dysmenorrheal

☐ flaccid
☐ contractures

☐ flaccid
☐ contractures

ROM:

ARMS:
☐ full
☐ weak
☐ flaccid
☐ contractures

LEGS:
☐ full
☐ weak
☐ flaccid
☐ contractures
☐ TED hose

AMPUTATION:
☐ right
☐ left

☐ BKA
☐ AKA
☐ other

SPINE:
☐ kyphosis
☐ scoliosis

☐ osteoporosis

OTHER:
☐ CAST LOCATION:_____
☐ TRACTION:_____

BIRTH CONTROL:
☐ yes
☐ no

☐ BSE monthly
☐ menopause
☐ taking estrogen

SEXUALITY:
☐ sexually active ☐ safe sex

MED HX:
☐ urinary retention
☐ BPH
☐ Frequent UTI

CARDIOVASCULAR: ☐ see nursing notes

HEART SOUNDS:
☐ normal S_1-S_2 ☐ abnormal S_3-S_4 ☐ murmur

PULSE:

APICAL:
☐ regular
☐ irregular
☐ strong
☐ faint

RADIAL:
☐ regular
☐ irregular
☐ strong
☐ faint
☐ nonpalpable

PEDALIS:
☐ regular
☐ irregular
☐ strong
☐ faint
☐ nonpalpable

EXTREMITY COLOR & TEMP:
☐ warm
☐ cool
☐ cold

☐ acyanotic
☐ cyanotic
☐ discolor

EDEMA:
☐ none ☐ generalized (anasarca)

PAIN ASSESSMENT: ☐ see nursing notes
☐ see MAR

PRECIPITATING: "walking too much"

QUALITY:_____

REGION: bil Knees

SEVERITY (0-10/10):

NOW: 0 AT WORST: 5 AT BEST: 0

TIMING: No specific time

SAFETY: ☐ see nursing notes
☐ fall risk

PRECAUTIONS:
☐ side rails x2 ☐ restraints

SITE #1:_____ SITE #2: _____

pitting
- ☐ 1+
- ☐ 2+
- ☐ 3+
- ☐ 4+
- ☐ non-pitting

pitting
- ☐ 1+
- ☐ 2+
- ☐ 3+
- ☐ 4+
- ☐ non-pitting

CAPILLARY REFILL:

FINGERS:
- ☐ brisk
- ☐ slow

TOES:
- ☐ brisk
- ☐ slow

HX:
- ☐ Pacemaker
- ☐ HTN
- ☐ CAD
- ☐ CHF
- ☐ PVD
- ☐ Other: _____

- ☐ bed down
- ☐ call light
- ☐ nightlight
- ☐ wrist
- ☐ vest

DISCHARGE/TEACHING: ☐ see nursing notes

NEEDS: Home Health,

TYPE OF LEARNER:
- ☐ visual
- ☐ auditory
- ☐ kinesthetic

EDUCATIONAL LEVEL: High School

FAMILY PRESENT:
- ☐ yes
- ☐ no

FLUID BALANCE: ☐ see nursing notes

INTAKE:
- ☐ PO
- ☐ IV

SOLUTION:D5 0.45% NaCl + 20mEq KCL
RATE:60mL/hr ml/hr

SITE LOCATION: rt forearm 20 ga

- ☐ clean
- ☐ patent
- ☐ redness
- ☐ swelling
- ☐ cool
- ☐ hot
- ☐ pain
- ☐ tubing change
- ☐ dressing change

MUCOUS MEMBRANES:
- ☐ moist
- ☐ pink
- ☐ sticky
- ☐ coated
- ☐ dry

TODAY'S WT:48 **YESTERDAY'S**

NURSE SIGNATURE: _____

TIME COMPLETED: _____

REASSESSMENT:

TIME: _____
- ☐ no change
- ☐ see nurses notes
- ☐ initials_____

TIME: _____
- ☐ no change
- ☐ see nurses notes
- ☐ initials_____

TIME: _____
- ☐ no change
- ☐ see nurses notes
- ☐ initials_____

kg	WT:_____	

Risk Assessments & Nursing Care

	Date: Braden Scale Score: Fall Risk Score:									Date: Braden Scale Score: Fall Risk Score:							
Time Hourly																	
PAIN ASSESSMENT																	
Intensity (1-10/10)																	
Pain Type (see legend)																	
Intervention (see legend)																	
PATIENT POSITION																	
PO FLUIDS (ml)																	
IV SITE/RATE CHECKED																	
PATIENT HYGIENE																	
WOUND ASSESSMENT																	
WOUND BED																	
WOUND DRAINAGE																	
WOUND CARE																	
Nurse Initials																	

Initial	Nurse Signature	Initial	Nurse Signature

LEGEND: *= see nursing notes

PAIN TYPE:
A- aching **T-** throbbing
ST- stabbing **B-** burning
SH- shooting **P-** pressure

PAIN INTERVENTIONS:
1- Relaxation/Imagery **2 -** Distraction
3- Reposition **4-**Medication

POSTIONING:
B- back
R- right
L- left
C- chair
A- ambulatory

PT. HYGIENE:
b- bedbath **a-** assist bath
p- partial bath **sh-** shower
g- grooming **m** mouth care
f- foot care **n-** nail care

LAB TEST	RESULT	NORMAL RANGE
WBC	12,000	
HGB	9.9	
HCT	32	
NA+	149	
K+	3.5	
GLUCOSE	105	
UA	Urine color: dark amber, cloudy Specific gravity: 1.050 (normal 1.005-1.035) ph 6.0 (normal 4.5-8.0) RBC - 9 (normal 0-2) WBC - 150,000 (normal 0-5)	

WOUND ASSESSMENT
**1-4** Pressure Ulcer stage
I – Incision
R – Rash
SK – skin tear
E –Echymosis
A – Abrasion

WOUND BED:
D– Dry & intact
S – Sutures/ staples
G – Granulation tissue
P – Pale
Y – Yellow
B- Black

WOUND DRAINAGE:
0 – none
S – Serous
P – Purlulent
S – Serosanguinous
B – Bright red blood
D – Dark old blood

WOUND CARE:
C – Cleaned with NS
G – Gauze dressing
W – Gauze wrap
A – ABD pad
M – Medication
O – other **