

GENERAL INFORMATION:				VITAL SIGNS:				NEUROLOGICAL:			
Patient Initials: _____				Time: _____				<input type="checkbox"/> Awake/Alert/Oriented to person, place, time			
Physician: _____				BP: _____				<input type="checkbox"/> Confused <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive			
TPCN: _____ Aide: _____				P: _____				<input type="checkbox"/> PERRL <input type="checkbox"/> Pupils Unequal <input type="checkbox"/> Dysphagia			
Code status: _____ Telemetry# _____				T: _____				Grips R ___ L ___ Pushes R ___ L ___			
Admit Dx: _____				R: _____				S - Strong, W - Weak, N - None			
Allergies: _____				SaO2%: _____				Comments: _____			
<input type="checkbox"/> Isolation (Type): _____				PAIN ASSESSMENT:				ORAL:			
O2 @ _____ liters per min _____ %				Time: _____				<input type="checkbox"/> Membranes <input type="checkbox"/> pink <input type="checkbox"/> moist <input type="checkbox"/> intact <input type="checkbox"/> dry			
Diet: _____ <input type="checkbox"/> Needs asst. w/meals				Scale/Observation: _____				<input type="checkbox"/> Ulcerations <input type="checkbox"/> Discoloration Color: _____			
<input type="checkbox"/> Glasses <input type="checkbox"/> Hearing aids X _____				Location: _____				<input type="checkbox"/> Dentures/Dental Device Type: _____			
Notes: _____				Intervention: _____				Able to care for own teeth <input type="checkbox"/> Yes <input type="checkbox"/> No			
				Reassess score: _____				Comments: _____			
				CAPILLARY BLOOD GLUCOSE				IVs			
INTAKE AND OUTPUT:				Time: _____				<input type="checkbox"/> No IV <input type="checkbox"/> Peripheral IV <input type="checkbox"/> CVAD			
Intake / time: _____				Result: _____				<input type="checkbox"/> Red <input type="checkbox"/> Dressing intact/no redness			
Output / time: _____				GENERAL APPEARANCE:				Location: _____ Next Δ Date: _____			
CARDIOVASCULAR:				<input type="checkbox"/> Neat, Clean / Normal Development				GASTROINTESTINAL:			
Rhythm <input type="checkbox"/> Regular <input type="checkbox"/> Irregular				<input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <input type="checkbox"/> Delayed Dev Age				Abdomen: <input type="checkbox"/> Flat <input type="checkbox"/> Soft <input type="checkbox"/> Nontender			
Pulses: Radial L _____ R _____				Comments: _____				<input type="checkbox"/> Distended <input type="checkbox"/> Firm <input type="checkbox"/> Tender <input type="checkbox"/> _____			
Pulses: Pedal L _____ R _____				RESPIRATORY:				Bowel Sounds: <input type="checkbox"/> Active X 4 quads <input type="checkbox"/> Hypo			
0 absent 1+ weak 2+ normal 3+ strong 4+ bounding				<input type="checkbox"/> Breath sounds clear bilaterally				<input type="checkbox"/> Hyper <input type="checkbox"/> Absent <input type="checkbox"/> Nausea/vomiting			
<input type="checkbox"/> Edema _____ Location _____				<input type="checkbox"/> Wheezes: Loc: _____ Inspir/Expir				<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bleeding			
<input type="checkbox"/> Edema _____ Location _____				<input type="checkbox"/> Diminished: Loc: _____ Inspir/Expir				Comments: _____			
1+ rapid recovery 2+ 10-15 sec 3+ 15-30 sec 4+ > 30 sec				<input type="checkbox"/> Crackles: Loc: _____ Inspir/Expir				ELIMINATION:			
Capillary refill _____ seconds				<input type="checkbox"/> Absent: Loc: _____ Inspir/Expir				<input type="checkbox"/> Continent <input type="checkbox"/> Catheter Δ Date: _____			
MUSCULOSKELETAL:				Cough: <input type="checkbox"/> Yes <input type="checkbox"/> No Productive <input type="checkbox"/> Yes <input type="checkbox"/> No				Incontinent <input type="checkbox"/> Bowel <input type="checkbox"/> Bladder			
<input type="checkbox"/> Moves all extremities				Secretions: Color _____				Urine appearance: _____			
<input type="checkbox"/> Joint stiffness <input type="checkbox"/> Contracted <input type="checkbox"/> Weakness				Consistency: _____ <input type="checkbox"/> Suction				Comments: _____			
<input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors				Comments: _____				SKIN:			
Calf tenderness <input type="checkbox"/> None <input type="checkbox"/> R <input type="checkbox"/> L				MOBILITY:				<input type="checkbox"/> Warm <input type="checkbox"/> Dry <input type="checkbox"/> Color normal for race			
Equipment <input type="checkbox"/> TEDs <input type="checkbox"/> SCDs <input type="checkbox"/> PlexiPulse				<input type="checkbox"/> Independent <input type="checkbox"/> Amb with asst X _____				<input type="checkbox"/> Diaphoretic <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundice <input type="checkbox"/> Pale			
<input type="checkbox"/> Walker <input type="checkbox"/> W/C <input type="checkbox"/> Barton <input type="checkbox"/> Immobilizer				<input type="checkbox"/> Transfers alone <input type="checkbox"/> Trans with asst X _____				<input type="checkbox"/> Cyanotic <input type="checkbox"/> Cool <input type="checkbox"/> Specialty bed			
<input type="checkbox"/> Polar Care <input type="checkbox"/> Traction <input type="checkbox"/> Cast/Sling				<input type="checkbox"/> Assistive device: _____				<input type="checkbox"/> Turgor < 5 sec <input type="checkbox"/> Turgor > 5 sec			
Comments: _____				<input type="checkbox"/> Bedridden <input type="checkbox"/> Paralysis <input type="checkbox"/> Para <input type="checkbox"/> Quad				<input type="checkbox"/> Wounds/Dressings/Breakdown			
				<input type="checkbox"/> Hemiplegia <input type="checkbox"/> Right <input type="checkbox"/> Left				Describe: _____			
				<input type="checkbox"/> Restraints Type: _____							
ADDITIONAL NOTES:								BRADEN SCALE/SKIN RISK:			
								<input type="checkbox"/> No risk <input type="checkbox"/> Low risk (15 or 16)			

<input type="checkbox"/> Mod risk (13 or 14) <input type="checkbox"/> High risk (12 or less)
<input type="checkbox"/> Skin Care Protocol (18 or less)

