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CLIENT ASSESSMENT

Client Name:	Nurse (print):
Diagnosis	Signature:
Allergies:	Title:
	Date:
	Shift:

Neurological	Cardiovascular	Genitourinary	Ventilator (write in)
Consciousness	Heart Sounds	Urination	Mode:
☐ Alert ☐ Lethargic ☐ Somnolent	☐ Regular ☐ Irregular	☐ Voiding Catheter ☐ Anuric	Vent Rate:
Orientation	☐ Murmur ☐ Rub	Urine	Spontaneous Rate:
☐ Oriented ☐ Disoriented	Pulses	☐ Clear ☐ Cloudy ☐ Sediment	Tidal Volume:
Responsiveness	☐ Regular ☐ Irregular	Bladder	PEEP/ CPAP:
☐ Verbal ☐ Tactile ☐ Deep ☐ Unresponsive	☐ Equal ☐ Unequal	☐ Distended ☐ Non-distended	I:E Ratio:
Pupillary Response	Radial ☐ Absent ☐ Present	**Notes**	FIO2:
☐ Reactive ☐ Nonreactive	Pedal ☐ Absent ☐ Present		Flow/LMP:
Left/Right	**Notes**		Sensitivity:
☐ Equal ☐ Unequal			Pressure Limit:
Size: Left Right:			High Pressure Alarm:
Speech		**Pulmonary**	Low Pressure Alarm:
☐ Clear ☐ Stuffed ☐ Aphasic		Breath Sounds	PIP:
Extremities	**Peripheral Vascular**	☐ Equal ☐ Non-equal	Heating Chamber:
☐ Movement ☐ Numbness ☐ Sensory ☐ Deficit	Capillary Refill	☐ Clear ☐ Congested ☐ Wheezes ☐ Rales	Temperature:
Strength Left: Right:	☐ Brisk (< 3 sec) ☐ Slow	Respirations	Water Level:
Notes	Edema	☐ Even ☐ Non-even	SaO2:
	☐ None ☐ Dependent ☐ Pitting	Cough	Trach Size
	Notes	☐ Absent ☐ Productive ☐ Non-productive	Suction:
		Sputum	**Notes**
		Color	
Skin/Integument		☐ Clear ☐ Yellow ☐ Bloody	
Integrity		Character	
☐ Intact ☐ Reddened ☐ Broken	**Musculoskeletal**	☐ Thin ☐ Thick	
Temperature	Extremity Strength	Oxygen	**IV's**
☐ Hot ☐ Warm ☐ Cool ☐ Cold	☐ Normal ☐ Decreased ☐ Absent	☐ None ☐ Nasal Canula ☐ Ventilator	Size:
Character	Atrophy: ☐ Left ☐ Right	☐ Liters per min_____	Location:
☐ Clammy ☐ Moist ☐ Dry	Contractures: ☐ Left ☐ Right ☐ Upper ☐ Lower	**Notes**	☐ Normal ☐ Reddened ☐ Edema
Color	Joint Swelling		Type
☐ Pink ☐ Pale ☐ Cyanotic ☐ Mottled ☐ Flushed	☐ None ☐ If present, where?		☐ Peripheral ☐ PIC ☐ Port-A-Cath ☐ Hickman
Notes	Deformity:		Date Inserted:
	Notes	**Gastrointestinal**	Dressing Change:
		Abdomen	**Notes**
		☐ Flat ☐ Distended	
	Staff Activity	☐ Tender ☐ Non-tender	
Psychosocial	Assistance	Bowel Sounds	
Emotional status/Client	☐ Minimal ☐ Moderate ☐ Maximum	☐ Active ☐ Hyperactive ☐ Hypoactive	
☐ Cheerful ☐ Depressed ☐ Anxious	Duties	Diet	**Medications**
Family/Support Person	☐ Feeding ☐ Dressing ☐ Bathing	☐ NPO ☐ Tube Feed ☐ Soft ☐ Regular ☐ Diabetic	
☐ Cheerful ☐ Depressed ☐ Anxious	☐ Transfer ☐ Ambulation ☐ Turn	Stoma	
Notes	Ambulation	☐ G-Tube ☐ Colostomy ☐ Ileostomy ☐ Normal ☐ Reddened ☐ Edema	
	☐ Alone ☐ With Assistance ☐ Bedridden	**Notes**	
	Notes		
Bedside Testing			
☐ Blood Sugar			
☐ Ketones			

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CONTROLLED SUBSTANCE INVENTORY

Date	Shift	Initial Count	Amount/Time Administered	Shift Count	Nurses Signature On Coming	Nurses Signature Off Going

HISTORY AND PHYSICAL

GENERAL INFORMATION

Today's Date:_____ Start of Care:_____ Unit:_____ Chart:_____

Patient's Name:_____ Admitting DX:_____

Address:_____ Date of Birth:_____ Sex: ❑ M ❑ F

City and State: _____ Zip:_____ Phone #:_____

Directions:_____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated **ALLERGIES**:_____

Race: ❑ Caucasian ❑ Black ❑ Hispanic ❑ Other

Hospital:_____ Admitted:_____ Discharged:_____

Physician_____ Office #:_____

Lab Preferred: ❑ MD's Office ❑ Other:_____

Primary Payer:_____ Number:_____

Secondary Payer:_____ Number:_____

ADMISSION ORDERS:_____

_____

_____

Outside of Home Emergency Contact: Name:_____ Number:_____

Caregiver:_____

❑ Foley Catheter: Size:_____ ❑ Feeding Tube: Size Type:_____

VITAL SIGNS

B/P:___ /____ ❑ Sitting ☐ Standing ❑ Lying **PULSE**_____ ❑ Radial ❑ Apical **RESPIRATIONS**_____

TEMPERATURE_____ ❑ Oral ❑ Axillary ☐Rectal **HEIGHT**_____ Feet/Inches ❑ Actual ❑Estimated

WEIGHT_____ Pounds ❑ Actual ❑ Estimated

PROSTHESIS

❑ Dentures ❑Removable ❑ Bridge ❑ Crown ❑Braces

❑Glasses ❑ Contact Lenses ❑ Lens Implant(s) _____

❑Hearing Aid ❑Pacemaker

Artificial Limb(s): ❑ Right ❑ Left ❑ Upper ❑ Lower _____

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HISTORY AND PHYSICAL

PATIENT NAME:_____

HISTORY

MEDICAL HISTORY:_____

_____

_____

SURGICAL HISTORY:_____

_____

_____

PRIOR HISTORY:_____

_____

Comments on History:_____

_____

_____

MUSCULOSKELETAL

INSPECT & PALPATE EXTREMITIES

❑ Skin Smooth / Temp Warm ❑ Edema ❑ Pitting +1 +2 +3 +4 ❑ Non-pitting

GAIT and MOVEMENT

❑ Coordinated ❑ Uses Assistive Person ❑Uses Assistive Device

JOINTS BILATERAL

❑ Pain ❑ ROK ❑ WNL ❑Edema ❑Crepitation ❑Heat

INTEGUMENT

COLOR

❑ Normal ❑ Pale ❑Cyanotic

❑ Jaundiced

MOISTURE

❑ Dry ❑Clammy

CAPILLLARY REFILL TIME

Almost Immediate ❑ Y ❑ N

TEMPERATURE

❑ Warm ❑ Cool ❑Hot

SKING TURGOR

❑ Return Quickly to Place ❑Tenting

CONTOUR OF NAIL

❑ Convex ❑Other

PRESSURE RELIEVING DEVICES

❑ Egg Crate ❑Air Mattress

PROTECTORS

❑Heel ❑Elbow

SKIN INTACT ❑ Yes ❑ No (*if skin is not intact use Wound Care Flow Sheet*)

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HISTORY AND PHYSICAL

FAMILY HISTORY

	YES	NO	DMR
Diabetes	_____	_____	_____
Tuberculosis	_____	_____	_____
Heart Disease	_____	_____	_____
CVA	_____	_____	_____
Hypertension	_____	_____	
Cancer	_____	_____	
COPD	_____	_____	
Mental Illness	_____	_____	

CARDIOVASCULAR

Heart Rhythm & Rate: ❑ Regular ❑ Slightly Irregular ❑ Very Irregular Chest Pain: ❑ Yes ❑ No Distended Neck Veins ❑ Yes ❑ No

Peripheral Pulses: ❑ Strong ❑ Weak ❑ Not Present ❑ Other:_____

NEUROLOGICAL

❑ Alert ❑ Oriented ❑ Forgetful ❑ Confused ❑ Agitated ❑ Comatose ❑ Depressed ❑ Paralysis ❑ Tremors ❑ Seizures

❑ Headaches ❑ Numbness ❑ Tingling ❑ Lethargic Memory Loss: ❑ Short Term ❑Long Term

❑ Hallucinations ❑ Delusions Disoriented: ❑ Time ❑ Place ❑ Person Attention Span:_____ Affect:_____

HEAD AND NECK

❑ Normocephalic ❑ Face Symmetric_____ ❑ Hearing Loss_____

EYEBALLS
❑ Firm ❑ Soft

CONJUNCTIVA
❑ Moist ❑ Dry

SCLERA
❑ White ❑ Moist

PUPILS
❑ Round ❑ Equal
❑ React to Light
❑ Sluggish

CORNEAL LIGHT REFLEX
❑ Equal ❑ Not Equal

CORNEA
❑ Transplant ❑ Normal

PERIORBITAL EDEMA
❑ Yes ❑ No

LYMPH NODE
❑ Within Normal Limits ❑ Other_____

TOUNGUE
❑ Dry ❑ Moist ❑ Pink ❑ Teeth

LIPS
❑ Dry ❑ Moist ❑ Lesions ❑ Ulcers ❑ Cracks

GUMS
❑ Pink ❑ Pale ❑ Bleeding ❑ Ulcers

OTHER:_____

RESPIRATORY

❑ Regular ❑ Shallow ❑ Irregular ❑ Dyspnea ❑ Orthopnea ❑ Cough ❑ Production ❑ Oxygen ❑ Nasal Cannula

❑ Audible Breath Sounds

URINARY

❑ Dysuria ❑ Frequency ❑ Burning ❑ Nocturia ❑ Hematuria ❑ Retention ❑ Incontinent ❑ Pampers ❑ Catheter: ___Texas ___Foley

Character of Urine:_____

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HISTORY AND PHYSICAL

HOUSING AND FAMILY DYNAMICS

LIVING QUARTERS: ❑ Single Dwelling ❑ Apartment ❑ Duplex ❑ Other:_____

CONDITIONS OF DWELLING: ❑ Adequate ❑ Poor ❑ Inadequate Comments:_____

FAMILY DYNAMICS:_____

_____

_____

RELIGIOUS PREFERENCE:_____

_____

MISCELLANEOUS

SLEEP PATTERN

❑ Well ❑ Fair ❑ Poor ❑ Insomnia

EMOTIONAL SUPPORT

❑ Patient ❑ Significant ❑Other

SPEECH

❑ Normal ❑ Slurred

Hardness ❑ R ❑ L

SAFETY

❑ Side Rails ❑ Restraints ❑ Uses Assistive Devices ❑ Other:_____

ADDITIONAL ASSESSMENT DATA

_____

_____

_____

_____

_____

_____

_____

_____

SUBJECTIVE

_____

_____

_____

_____

PHYSICIAN APPOINTMENTS:_____ **PHYSICIAN CONTACTS**:_____

_____

_____

_____

NEW ORDERS:

_____

_____

_____

_____

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HISTORY AND PHYSICAL

GASTROINTESTINAL

ABDOMEN: ❑ Flat ❑ Rotund ❑ Distended ❑ Rigid ❑ Rebound Tenderness ❑Soft ❑ Masses

❑ Nausea ❑ Vomiting ❑ Difficulty Swallowing ❑ Diarrhea ❑ Constipation ❑ Incontinent ❑ Tarry Stools ❑ Change in Bowel Habits

BOWEL SOUNDS: ❑ Present ❑ Absent Quadrant: _____

APPETITE
❑ Good ❑ Fair ❑ Poor ❑ Unchanged

NUTRITIONAL STATUS
❑ Good ❑ Fair ❑ Poor

HYDRATION
❑ Good ❑ Fair ❑ Poor

Task	Wholly Independent	Uses Assistive Devices	Help of Another	Assistive Device & Help	Wholly Dependent	Undetermined
Eating						
Transferring						
Dressing						
Bathing						
Toileting						
Ambulation						
Finances						
Cleaning/Laundry						
Shopping						

SELF-CARE AGENCY (Ability to Perform ADL's)

INSTRUCTIONS RENDERED TO : ❑ Patient ❑ Significant Other

INTERVENTIONS

❑ A1 Skilled Observation/Assessment
❑ A2 Foley Catheter Insertion
❑ A3 Bladder Instillation
❑ A4 Open Wound Care/Dressing
❑ A5 Decubitus Care-State 3, 4, 5
❑ A6 Venipuncture
❑ A7 Restorative Nursing
❑ A8 Post Cataract Care
❑ A9 Bowel/Bladder Training
❑ A10 Chest Physiotherapy (includes postural drainage)
❑ A11 Adm. Of Vitamin B-12
❑ A12 Adm. Insulin
❑ A13 Adm. Other IM/Subq.
❑ A14 Adm. IV's
❑ A15 Teach Ostomy or Ileo Conduit Care
❑ A16 Teach Nasogastric Feeding
❑ A17 Reinsertion Nasogastric Feeding Tube
❑ A18 Teach Gastrostomy Feeding
❑ A19 Teach Parenteral Nutrition
❑ A20 Teach Care of Tracheostomy
❑ A21 Adm. Care of Tracheostomy
❑ A22 Teach Inhalation
❑ A23 Adm. Inhalation RX
❑ A24 Teach Adm. of Injection
❑ A25 Teach Diabetic Care
❑ A26 Disimpaction/F.U. edema
❑ A27 Other (specify under orders)
❑ A28 Wound Care/Dressing-Closed Incision/Suture Line
❑ A29 Decubitus Care-Stage 1, 2, 3
❑ A30 Teaching Care of Any Indwelling Catheter (V/S, Response to Meds, etc.)

INSTRUCTION

Adequate Hydration
Prevention Constipation
Dressing Changes
Decubitus Care
Catheter Care
Irrigation
Medication: Time, Dose, Route
Emergency Measures
Safety Precautions
Adequate Nutrition

LEVEL OF COMPREHENSION REGARDING INSTRUCTION RENDERED ❑ Good (70-100%) ❑ Fair (35-70%) ❑ Poor (0-35%)

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HISTORY AND PHYSICAL

METHOD OF INSTRUCTION

❑ Written instructions left in the home (see attached)

❑ Verbal instructions rendered

PROJECTION OF NEED FOR FUTURE INSTRUCTION

❑ Much teaching and reinforcement regarding patient's care

❑ Moderate teaching and reinforcement regarding patient's care

❑ Minimal teaching and reinforcement regarding patient's care

ADDITIONAL INTERVENTIONS

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MEDICATION ADMINISTRATION RECORD

Entries Must Be Printed

Name:	Diagnosis:
Age:	
Doctor:	Allergies (Record in Red): ____ ____

		Medications, Dosage, Frequency of Administration	Dates Given								
			Hour								

Nurse Initials_________ Nurse Signature____

Nurse Initials_________ Nurse Signature____

Nurse Initials_________ Nurse Signature____

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NARCOTIC RECORD

Patient Name:	Attending Physician:
Drug & Dosage:	
Rx Number of bottle:	
Amount Received:	
Date Received:	
Received and counted by:	

Date	Time	Dosage	Adm. By: (Full Signature of Nurse)	Remaining

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NURSES PROGRESS NOTES

Patient Name:_____ Shift:_____

NOTES SHOULD BE SIGNED BY PERSON WRITING THEM.

DATE	TIME	NOTES

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NURSING CARE FLOW SHEET

Patient Name_____Date:_____

Hospital Day:_____Post-operative Day_____

	HOUR	F	12A	4A	8A	12P	8P	12A	4A	8A	12P	8P	12A	4A	8A	12P	8P
TEMPERATURE		105	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮
		104	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮
		103	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮
		102	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮
		101	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮
		100	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮
		99	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮
		98	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮
		97	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮
		96	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮
		Pulse															
		Respiration															
	Blood Pressure	Systolic/ Diastolic															

	Shift	11-7	7-3	3-11	**Total**	11-7	7-3	3-11	**Total**	11-7	7-3	3-11	**Total**
INTAKE	Oral												
	Tube Feeding												
	Blood												
	IV												
	IV Meds												
	Other												
	Total Intake												
OUTPUT	Urine												
	Gastric												
	Emesis												
	Stools												
	Drainage												
	Other												
	Total Output												

SIGNATURE 11-7			
SIGNATURE 7-3			
SIGNATURE 3-11			

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PHYSICIANS' ORDERS

Patient Name:_____

Nurses: Date, Time & Sign Each Order Written.

DATE	TIME	ORDER

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Record of Medication Destruction or Release

Patient Name: _____ Date:_____

Medication & Strength	Quantity	Rx Number	Pharmacy	Reason for Release or Destruction

Select the action: ❑ **Medication Release** ❑ **Medication Destruction**

Nurse's Signature & Title:_____

Nurse's Signature & Title:_____

Family Member Signature & Relationship:_____

Date Released & Time_____ **To Whom**_____

Date Destroyed & Time:_____

Method of Destruction:_____

MEDICATIONS RELEASED OR DESTROYED MUST BE DONE BY TWO (2) NURSES.

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TREATMENT RECORD

Entries Must Be Printed

Name:	Diagnosis:
Age:	
Doctor:	Allergies (Record in Red): ____ ____

Procedure for Treatment			Dates Given								
			Hour								

Nurse Initials_________ Nurse Signature____

Nurse Initials_________ Nurse Signature____

Nurse Initials_________ Nurse Signature____