

Patient Name: Millie Larsen
Room: 616
DOB: 01/23/1926
Age: 84

MRN: 000-555-000
Doctor Name: Dr. Eric Lund
Date Admitted:

PATIENT CHART

Chart for Millie Larsen

Physician's Orders

Allergies: NKA

Date/Time:	
Day 1, 0900	Bedrest, BRP with assist
	Regular, low fat diet
I & O	
	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
	tramadol 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

Nursing Notes

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Date/Time:	
0900	Pt Alert and oriented. Denies pain. Pt up and ambulating on own with minimal assist. Will continue to monitor. T. Williams RN

Medication Administration Record

Allergies: NKDA

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Hours to be Given:	Dates Given:
Day 1	Captopril	25 mg	po	three times a day	0800-TW 1200-TW, 1600-TW	Day 1
	Metoprolol	100 mg		every day	0800-TW	Day 1
	Furosemide	40 mg	po	twice per day	0800-TW, 1600-TW	Day 1
	Lipitor	50 mg		once daily	0800-TW	Day 1
	Pilocarpine eye drops	2 drops each eye		four times a day	0800-TW 1200-TW, 1600-TW 2000-SH	Day 1
	Fosamax	10 mg		every day	0800-TW	Day 1
	Tramadol			for arthritis pain/prn		
	Ciprofloxacin	250 mg		every 12 hours	0800-TW, 2000-SH	Day 1
	Acetaminophen	325 mg	po	prn		
	Celebrex	200 mg	po	once a day	0800-TW	Day 1

Intravenous Therapy

Date of Order:	IV Solution	Rate Ordered:	Date/Time Hung:
Day 3	IV fluids D5 .45 NaCl 20 mEq KCL	60ml/hr	Day 1, 1200-TW 0400-SH

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature
TW	Terrence Williams, RN	SH	Scott Hansen, RN, BSN

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

Vital Signs Record

Date:	Day 3					
Time:	0800	1200	1600	2000	0000	0400
Temperature:	37.2	37.3	37.2	37.1	37.0	37.1
BP:	130/68	126/70	12880	132/6 8	128/7 6	126/7 4
Pulse:	80	76	78	72	74	68
O² Saturation:	94	96	96	94	94	94
Weight:						
Respirations:	12	14	14	14	10	12
GMR:						
Nurse Initials:	TW	TW	TW	SH	SH	SH

Intake & Output Bedside Worksheet

0900-2100 INTAKE					OUTPUT				
ORAL	TUBE FEED	IV	IVPB	OTHER	URINE	Emesis	NG	Drains Type:	Other
240		720			500				
360					750				
120					750				
240									
Total Intake this shift: 1650					Total Output this shift: 2000				

2100-0900	INTAKE	OUTPUT							
ORAL	TUBE FEED	IV	IVPB	OTHER	URINE	Emesis	NG	Drains Type:	Other

240		720			200			
480					400			
Total Intake this shift: 1440					Total Output this shift: 1250			

Nursing Assessment Flowsheet

GENERAL APPEARANCE: <input type="checkbox"/> male <input checked="" type="checkbox"/> female <input checked="" type="checkbox"/> awake <input type="checkbox"/> sleeping <input type="checkbox"/> agitated <input type="checkbox"/> cheerful <input type="checkbox"/> lethargic <input type="checkbox"/> anxious <input type="checkbox"/> crying <input checked="" type="checkbox"/> calm <input type="checkbox"/> combative <input type="checkbox"/> fearful			RESPIRATORY: <input type="checkbox"/> see nursing notes RESPIRATIONS: RATE: 14 O ₂ : RA SPO ₂ : 94% <input checked="" type="checkbox"/> regular <input type="checkbox"/> labored <input checked="" type="checkbox"/> even <input type="checkbox"/> uses accessory muscles <input type="checkbox"/> irregular <input type="checkbox"/> cough		
SKIN: <input type="checkbox"/> see wound care sheet <input type="checkbox"/> see nursing notes BRADEN SCALE SCORE: <input type="checkbox"/> risk skin breakdown			BREATH SOUNDS: LEFT: <input checked="" type="checkbox"/> clear <input type="checkbox"/> crackles <input type="checkbox"/> wheezes <input type="checkbox"/> decreased <input type="checkbox"/> absent RIGHT: <input checked="" type="checkbox"/> clear <input type="checkbox"/> crackles <input type="checkbox"/> wheezes <input type="checkbox"/> decreased <input type="checkbox"/> absent		
COLOR: <input checked="" type="checkbox"/> acyanotic <input type="checkbox"/> pale <input type="checkbox"/> ruddy <input type="checkbox"/> jaundiced <input type="checkbox"/> cyanotic			TURGOR: <input checked="" type="checkbox"/> <3 sec <input type="checkbox"/> > 3 sec		
TEMP: <input checked="" type="checkbox"/> warm/dry <input type="checkbox"/> hot <input type="checkbox"/> cool			HAIR: <input checked="" type="checkbox"/> shiny <input type="checkbox"/> dry/flaking <input type="checkbox"/> balding		
			SMOKING: <input type="checkbox"/> cigarettes pk/day _____ <input type="checkbox"/> cigars <input type="checkbox"/> marijuana		

<input type="checkbox"/> cold/clammy <input type="checkbox"/> diaphoretic	<input type="checkbox"/> lesions <input type="checkbox"/> lice	<input type="checkbox"/> cocaine
NEUROLOGICAL: <input type="checkbox"/> see nursing notes		
ORIENTATION: <input checked="" type="checkbox"/> person <input type="checkbox"/> disoriented <input checked="" type="checkbox"/> place <input type="checkbox"/> confused <input checked="" type="checkbox"/> time <input type="checkbox"/> impaired memory		
RESPONDS TO: <input checked="" type="checkbox"/> name <input type="checkbox"/> non-responsive <input type="checkbox"/> stimuli		
SPEECH: <input checked="" type="checkbox"/> clear <input type="checkbox"/> aphasic <input type="checkbox"/> garbled <input type="checkbox"/> inappropriate <input type="checkbox"/> slurred <input type="checkbox"/> cannot follow conversation		
FACE: <input checked="" type="checkbox"/> symmetrical <input type="checkbox"/> drooling <input type="checkbox"/> drooping		
EYES: <input checked="" type="checkbox"/> PERRLA SIGHT: <input type="checkbox"/> unequal <input type="checkbox"/> no correction <input type="checkbox"/> drooping lid <input checked="" type="checkbox"/> glasses <input type="checkbox"/> contacts <input type="checkbox"/> blind <input type="checkbox"/> hearing aid		
HEARING: <input type="checkbox"/> WNL <input type="checkbox"/> impaired swallowing <input checked="" type="checkbox"/> HOH <input type="checkbox"/> choking <input type="checkbox"/> NG tube		
HX: <input type="checkbox"/> seizures <input type="checkbox"/> spinal injury <input type="checkbox"/> CVA <input type="checkbox"/> other <input type="checkbox"/> brain injury		
GASTROINTESTINAL/NUTRITION: <input type="checkbox"/> see nursing notes		
APPEARANCE: <input type="checkbox"/> flat <input checked="" type="checkbox"/> soft <input checked="" type="checkbox"/> round <input type="checkbox"/> gravid <input type="checkbox"/> obese		
BOWEL SOUNDS: <input checked="" type="checkbox"/> active <input type="checkbox"/> hyperactive <input type="checkbox"/> hypoactive <input type="checkbox"/> absent		
PALPATION: <input checked="" type="checkbox"/> non-tender <input type="checkbox"/> mass (location) _____ <input type="checkbox"/> tender (location) _____		
LAST BM yesterday <input type="checkbox"/> incontinent <input type="checkbox"/> diarrhea <input type="checkbox"/> stoma- _____ <input type="checkbox"/> mucous <input type="checkbox"/> constipation <input type="checkbox"/> blood		
DIET: normal <input type="checkbox"/> impaired swallowing <input type="checkbox"/> choking <input type="checkbox"/> NG tube color drainage: _____ <input type="checkbox"/> feeding tube <input type="checkbox"/> tube feeding type: _____ rate: _____		

MUSCULOSKELETAL: <input type="checkbox"/> see nursing notes		GENITOURINARY: <input type="checkbox"/> see nursing notes		
GAIT: <input type="checkbox"/> steady <input checked="" type="checkbox"/> unsteady <input type="checkbox"/> non-ambulatory		<input checked="" type="checkbox"/> voids <input type="checkbox"/> catheter <input type="checkbox"/> stoma		
ACTIVITY:	ASSIST:	APPEARANCE OF URINE:		
<input type="checkbox"/> up ad lib <input type="checkbox"/> walker <input type="checkbox"/> cane <input type="checkbox"/> crutches <input type="checkbox"/> wheelchair	<input checked="" type="checkbox"/> x1 <input type="checkbox"/> x2 <input type="checkbox"/> lift <input type="checkbox"/> bed bound	<input type="checkbox"/> clear <input type="checkbox"/> light yellow <input checked="" type="checkbox"/> amber <input type="checkbox"/> brown	<input checked="" type="checkbox"/> cloudy <input type="checkbox"/> sediment <input type="checkbox"/> red/wine <input type="checkbox"/> clots	
HAND GRIPS:				
AMPUTATION: <input type="checkbox"/> left <input type="checkbox"/> right	BLADDER: <input checked="" type="checkbox"/> soft <input type="checkbox"/> firm/distended <input checked="" type="checkbox"/> incontinent			
LOCATION: _____				
LEFT: <input type="checkbox"/> strong <input checked="" type="checkbox"/> weak <input type="checkbox"/> flaccid <input type="checkbox"/> contractures	RIGHT: <input type="checkbox"/> strong <input checked="" type="checkbox"/> weak <input type="checkbox"/> flaccid <input type="checkbox"/> contractures	FEMALES: LMP: " in the 70's sometime" <input checked="" type="checkbox"/> WNL <input type="checkbox"/> dysmenorrheal		
ROM: ARMS: <input checked="" type="checkbox"/> full <input type="checkbox"/> weak <input type="checkbox"/> flaccid <input type="checkbox"/> contractures	LEGS: <input checked="" type="checkbox"/> full <input type="checkbox"/> weak <input type="checkbox"/> flaccid <input type="checkbox"/> contractures <input type="checkbox"/> TED hose	BIRTH CONTROL: <input type="checkbox"/> yes <input type="checkbox"/> no		
AMPUTATION: <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> BKA <input type="checkbox"/> AKA <input type="checkbox"/> other	SEXUALITY: <input type="checkbox"/> sexually active <input type="checkbox"/> safe sex		
SPINE: <input type="checkbox"/> kyphosis <input type="checkbox"/> scoliosis	<input type="checkbox"/> osteoporosis	MED HX: <input type="checkbox"/> urinary retention <input type="checkbox"/> BPH <input type="checkbox"/> Frequent UTI		
OTHER: <input type="checkbox"/> CAST LOCATION: _____ <input type="checkbox"/> TRACTION: _____				

CARDIOVASCULAR: <input type="checkbox"/> see nursing notes	PAIN ASSESSMENT: <input type="checkbox"/> see nursing notes <input type="checkbox"/> see MAR		
HEART SOUNDS: <input checked="" type="checkbox"/> normal S ₁ -S ₂ <input type="checkbox"/> abnormal S ₃ -S ₄ <input type="checkbox"/> murmur	PRECIPITATING: walking, general movement		
PULSE:	QUALITY: _ dull, aching		
APICAL: <input checked="" type="checkbox"/> regular <input type="checkbox"/> irregular <input type="checkbox"/> strong <input type="checkbox"/> faint	RADIAL: <input checked="" type="checkbox"/> regular <input type="checkbox"/> irregular <input type="checkbox"/> strong <input type="checkbox"/> faint <input type="checkbox"/> nonpalpable	PEDALIS: <input checked="" type="checkbox"/> regular <input type="checkbox"/> irregular <input type="checkbox"/> strong <input type="checkbox"/> faint <input type="checkbox"/> nonpalpable	REGION: bilateral knees
			SEVERITY (0-10/10): 3 NOW: 3 AT WORST: 6 AT BEST: 1
EXTREMITY COLOR & TEMP:	TIMING: _____		
<input checked="" type="checkbox"/> warm <input type="checkbox"/> cool <input type="checkbox"/> cold	<input checked="" type="checkbox"/> acyanotic <input type="checkbox"/> cyanotic <input type="checkbox"/> discolored		
EDEMA: <input checked="" type="checkbox"/> none <input type="checkbox"/> generalized (anasarca)	SAFETY: <input type="checkbox"/> see nursing notes <input type="checkbox"/> fall risk		
SITE #1: _____	PRECAUTIONS:		
pitting <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+	<input checked="" type="checkbox"/> side rails x 2 <input checked="" type="checkbox"/> bed down <input checked="" type="checkbox"/> call light <input checked="" type="checkbox"/> nightlight		
<input type="checkbox"/> non-pitting	<input type="checkbox"/> restraints <input type="checkbox"/> wrist <input type="checkbox"/> vest		
SITE #2: _____	DISCHARGE/TEACHING: <input type="checkbox"/> see nursing notes		
pitting <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+	NEEDS: _____ _____ _____		
CAPILLARY REFILL:	TYPE OF LEARNER:		
FINGERS: <input checked="" type="checkbox"/> brisk <input type="checkbox"/> slow	<input checked="" type="checkbox"/> visual <input type="checkbox"/> auditory <input type="checkbox"/> kinesthetic		
TOES: <input checked="" type="checkbox"/> brisk <input type="checkbox"/> slow	EDUCATIONAL LEVEL: High school		
HX: <input type="checkbox"/> Pacemaker <input checked="" type="checkbox"/> HTN <input type="checkbox"/> CAD	FAMILY PRESENT: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no		
<input type="checkbox"/> CHF <input type="checkbox"/> PVD <input type="checkbox"/> Other: _____			

FLUID BALANCE: <input type="checkbox"/> see nursing notes		NURSE SIGNATURE: Terrence Williams, RN	
INTAKE: <input checked="" type="checkbox"/> PO <input type="checkbox"/> IV		TIME COMPLETED: 0800	
SOLUTION: D5 .45 RATE: 60 ml/hr		REASSESSMENT:	
SITE LOCATION: L FA		TIME: 1200	
<input checked="" type="checkbox"/> clean <input type="checkbox"/> swelling <input type="checkbox"/> pain <input checked="" type="checkbox"/> patent <input type="checkbox"/> cool <input type="checkbox"/> tubing change <input type="checkbox"/> redness <input type="checkbox"/> hot <input type="checkbox"/> dressing change		<input checked="" type="checkbox"/> no change <input type="checkbox"/> see nurses notes Initials TW	
MUCOUS MEMBRANES:		TIME: 1600	
<input checked="" type="checkbox"/> moist <input type="checkbox"/> sticky <input type="checkbox"/> dry <input checked="" type="checkbox"/> pink <input type="checkbox"/> coated		<input checked="" type="checkbox"/> no change <input type="checkbox"/> see nurses notes Initials TW	
TODAY'S WT: 48 kg YESTERDAY'S WT: _____		TIME: 2000	
		<input checked="" type="checkbox"/> no change <input type="checkbox"/> see nurses notes Initials SH	

Risk Assessments & Nursing Care

	Date: Day 1 0900-2100 Braden Scale Score: 20 Morse Fall Risk Score: 70							Date: Braden Scale Score: 20 Morse Fall Risk Score: 70							
	Time	08	10	12	14	16	18		20	22	00	02	04	06	
PAIN ASSESSMENT									1	1	1	1	1	1	
Intensity (1-10/10)		2	1	2	1	1	2								
Pain Type (see legend)		A	A	A	A	A	A		A	A	A	A	A	A	
Intervention (see legend)		3	3	3	3	3	3		3	3	3	3	3	3	
PATIENT POSITION		B	B	C	A	A	B		B	B	R	L	A	B	
PO FLUIDS (ml)	See I & O								See I & O						
IV SITE/RATE CHECKED		Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	
PATIENT HYGIENE		Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	
WOUND ASSESSMENT	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a	n/a	n/a	n/a	n/a	
WOUND BED	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a	n/a	n/a	n/a	n/a	

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WOUND DRAINAGE		n/a	n/a	n/a	n/a	n/a	n/a			n/a	n/a	n/a	n/a	n/a	n/a		
WOUND CARE		n/a	n/a	n/a	n/a	n/a	n/a			n/a	n/a	n/a	n/a	n/a	n/a		
Nurse Initials		TW	TW	TW	TW	TW	TW			SH	SH	SH	SH	SH	SH		

Initial	Nurse Signature	Initial	Nurse Signature
TW	Terrence Williams, RN	SH	Scott Hansen, RN, BSN

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	POSITIONING: 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
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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 **
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