

Name:

Pager:

Date:

Rm: Nurse: Name: Age: ♂ ♀ HD: POD:	O/N Consults	T	I PO	PE 	<input type="checkbox"/> Note	<input type="checkbox"/>
		HR	IV			
		SBP	B			
		DBP	O U			
		RR	NG			
		SpO ₂	PR			
		Wt	N			

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