



Republic of the Philippines
City of Cebu
CEBU CITY MEDICAL CENTER
A PHIC ACCREDITED HEALTH CARE PROVIDER
N. Bacalso Avenue corner Panganiban Street, Cebu City, Philippines 6000



MEDICATION SHEET

Name of Patient: _____ Area & Bed No.: _____ Case No.: _____

Allergies: _____

Medication					

NURSE'S NAME AND SIGNATURE

NURSE'S NAME & SIG.	6-2	NURSE'S NAME & SIG.	2-10	NURSE'S NAME & SIG.	10-6



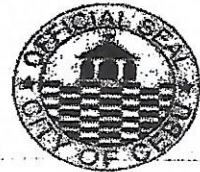
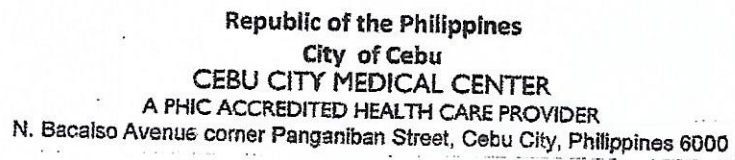
Republic of the Philippines
City of Cebu
CEBU CITY MEDICAL CENTER
A PHIC ACCREDITED HEALTH CARE PROVIDER
N. Bacalso Avenue corner Panganiban Street, Cebu City, Philippines 6000



KARDEX

Name of Patient: _____ Age: _____ Sex: _____ Status: _____
Date of Birth: _____ Religion: _____ Nationality: _____
Date of Admission: _____ Time of Admission: _____ Case No.: _____ MSS Classification: _____
Physician: _____ Impression/Diagnosis: _____

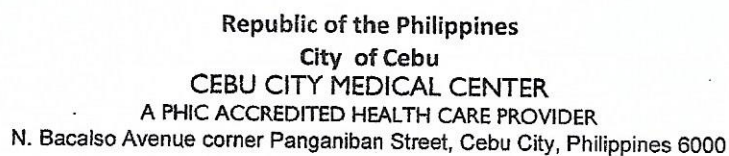
TREATMENT		ATTACHMENTS		IVF/ INFUSIONS			
V/S: _____ I & O: _____ NVS: _____ POSITION: _____ _____ _____ _____	<input type="checkbox"/> O2: _____ L/MIN <input type="checkbox"/> NGT _____ <input type="checkbox"/> OGT _____ <input type="checkbox"/> FBC _____ <input type="checkbox"/> CTT _____ <input type="checkbox"/> ETT SIZE: _____ LEVEL: _____ <input type="checkbox"/> TRACHEOSTOMY ATTACHED TO: <input type="checkbox"/> PPV _____ L/MIN <input type="checkbox"/> MECHANICAL VENTILATOR MODE: _____ FIO2: _____ BUR: _____ PFR: _____ TV: _____ PEEP: _____ <input type="checkbox"/> CARDIAC MONITOR <input type="checkbox"/> PULSE OXIMETER OTHERS:	DATE	BOTTLE NO.	IVF	RATE		
		DATE	BOTTLE NO.	INFUSION	RATE		
		DATE	LABORATORY/DIAGNOSTIC	DATE	LABORATORY/DIAGNOSTIC		
REFERRALS							
DEPARTMENT: _____ RE: _____							
PROCEDURES/OPERATIONS		DATE CONTRACTIONS STARTED					
		IV ACCESS: _____ IV TUBING: _____ NGT: _____ FBC: _____ ETT: _____ OTHERS: _____ _____ _____					
		DIET, RESTRICTIONS AND ALLERGIES					
		DIET: _____ ALLERGIES: _____ LOF: _____ AM: _____ PM: _____ NOC: _____					



NURSES PROGRESS NOTES

Name of Patient: _____ Area & Bed No.: _____ Case No.: _____

[illegible]



DOCTOR'S ORDER

Name of Patient: _____ Area & Bed No.: _____ Case No.: _____

[illegible]



Republic of the Philippines
City of Cebu
CEBU CITY MEDICAL CENTER
A PHIC ACCREDITED HEALTH CARE PROVIDER
N. Bacalso Avenue corner Panganiban Street, Cebu City, Philippines 6000



TPR SHEET

Name of Patient: _____ Area & Bed No.: _____ Case No.: _____

DATE		AM			PM			AM			PM			AM			PM			AM			PM		
PR	TE	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8			
RR	MP °C																								
200	43																								
180	42																								
170	41																								
160	40																								
150	39																								
140	38																								
130	37																								
120	36																								
110	35																								
100	34																								
90	32																								
80	30																								
70																									
60																									
50																									
40																									
30																									
20																									
10																									
0																									
		URINE			STOOL			URINE			STOOL			URINE			STOOL			URINE			STOOL		
	6-2																								
	2-10																								
	10-6																								
		BLOOD PRESSURE			BLOOD PRESSURE			BLOOD PRESSURE			BLOOD PRESSURE			BLOOD PRESSURE											
	6-2																								
	2-10																								
	10-6																								
		WEIGHT:			HEIGHT:			HC:			AG:						MUAC:								