|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Temple College Vocational Nursing Program**  **VNSG 1460 Clinical LVN Training II**  **(Highlight All Abnormal Findings)**  **Name:** Click or tap here to enter text.  **Date of Assessment:** Click or tap here to enter text.  **Clinical Instructor:** Click or tap here to enter text. | | | | | |
| **Demographics** | | | | | |
| **Patient’s initials** | |  | **Age** | |  |
| **Code Status** | |  | **Gender** | |  |
| **Allergies** | |  | | | |
| **Isolation** | No  Yes:  contact  extended contact  droplet  airborne  neutropenic | | | | |
| **Date of Admission** | |  | | | |
| **Admitting Diagnosis** | |  | | | |
| **Reason for admission (client’s own words)** | | | |  | |
| **Medical History** | |  | | | |
| **Surgical History** | |  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Psychosocial/ Communication** | | | |
| **Marital Status** |  | **Significant Others** |  |
| **Highest level of education** |  | **Occupation** |  |
| **Primary Language** |  | **Does the client/family understand English?**  No  Yes | |
| ***Is the client able to:*** |  | | |
| Read | No  Yes | Evidence: | |
| Write | No  Yes | Evidence: | |
| Speak Understandably | No  Yes | Evidence: | |
| Communicate Basic Needs | No  Yes | Evidence: | |
| ***Does the client have:*** |  | | |
| Hearing impairment: | No  Yes  **If Yes**, **Hearing Aids:  Yes  No** | | |
| Vision Impairment: | No  Yes  **If Yes, Glasses Contact Lenses  None/Other** | | |

|  |  |  |
| --- | --- | --- |
| **Participates in activities outside of the room?** | No  Yes  **If Yes, What activities?**  Click or tap here to enter text. | |
| **Alcohol Consumption** | No  Yes  **If Yes, # Of drinks per week?**  Click or tap here to enter text. | |
| **Smoking** | No  Yes  **If Yes,  Current  History**  **If Yes, # Packs/per day?**  Click or tap here to enter text.  **If Yes, # of years of smoking?**  Click or tap here to enter text. | |
| **Secondhand Smoke** | **Exposure to secondhand smoke?**  No  Yes | |
| **Visits from family & friends** | No  Yes  **If Yes, who visits?**  Click or tap here to enter text.  **If Yes, how often?**  Click or tap here to enter text. | |
| **Religious Preference** | **Preference Type:**  Click or tap here to enter text. | |
| **Religious Activities** | No  Yes | |
| **Visits from clergy** | No  Yes | |
| **Presence of Religious Articles** | No  Yes  **If Yes, Describe Religious Articles**  Click or tap here to enter text. | |
| **Physical Safety** | | |
| **Impaired memory or judgment** | No  Yes  **If Yes, Describe**  Click or tap here to enter text. | |
| **History of wandering** | No  Yes  **If Yes, Describe**  Click or tap here to enter text. | |
| **History of falls** | No  Yes  **If Yes, Describe** Click or tap here to enter text. | |
| **Fall Risk Assessment**   * *A checkmark on any* ***starred item*** *indicates a risk for falls.* * *A combination of four or more of the* ***unstarred items*** *indicates a risk for falls.* * *Any checked items indicate an* ***abnormal finding*** | **General Information:**  Age over 70  History of falls \*  Confusion at times  Confusion most of the time\*  Impaired memory or judgment  Unable to follow directions\*  Needs assistance with the elimination  Visual impairment  Feels Physically Weak\*  **Medications:**  Receiving central nervous system suppressants (narcotic, sedative, tranquilizer, hypnotic, antidepressant, psychotropic, anticonvulsant)  Receiving medication that causes orthostatic hypotension antihypertensive, diuretic) \*  Medication that may cause diarrhea (cathartic)  Medication that may alter blood glucose levels (insulin, hypoglycemic)  **Gait and Balance:**  Poor balance when standing\*  Balance problems when walking\*  Swaying, lurching, or slapping gait\*  Unstable when making turns\*  Needs assistive device (walker, cane, holds on to furniture) \*  **Interpretation: Risk for Falls No Risk** | |
| **Safety Precautions** | None Bed alarm Chair Alarm  Bed in lowest position  Non-skid wear  Call light in reach  Siderails up:  None X2 X3 X4  Other:  Click or tap here to enter text. | |
| **Activities of Daily Living** | | |
| **Nutrition** | | |
| **Feeding** | Independent  Assist  Total | A or T Comments:  Click or tap here to enter text. |
| **Does the client have enteral feedings?**  No  Yes  **If Yes, what is the type of enteral formula?**  Click or tap here to enter text.   * **If Yes, is the client using a pump?**   No  Yes, **If Yes, what is the rate of the pump?**  Click or tap here to enter text. | |
|  | **Does the client have a feeding tube?**  No  Yes | |
|  | **Does the client have a gastrostomy tube?**  No  Yes | |
| **Diet Type** | Regular Other, **If Other describe:**  Click or tap here to enter text. | |
| **NPO?**  No  Yes  **If Yes, what is the reason for NPO?**  Click or tap here to enter text.  **If Yes, what is the length of time for NPO?**  Click or tap here to enter text. | |
| **Fluid Restriction?**  No  Yes, **If Yes, what is the Daily Amount of fluid intake?**  Click or tap here to enter text. | |
| **Appetite** | Good Fair Poor | |
| **Breakfast:**  100%  75%  50%  25%  0%  Unable to assess, off the unit  **Lunch:**  100%  75%  50%  25%  0%  Unable to assess, off the unit  **Dinner**:  100%  75%  50%  25%  0%  Unable to assess, off the unit | |
| **Hygiene** | | |
| **Oral** | Independent Assist Total | A or T Comments:  Click or tap here to enter text. |
| **Toileting** | Independent Assist Total | A or T Comments:  Click or tap here to enter text. |
| **Bathing** | Independent Assist Total | A or T Comments:  Click or tap here to enter text. |
| **Dressing** | Independent Assist Total | A or T Comments:  Click or tap here to enter text. |
| **Grooming** | Independent Assist Total | A or T Comments:  Click or tap here to enter text. |
| **Mobility** | | |
| **Ambulation** | Independent Assist Total Unable to ambulate | |
| Ambulation aid:  No  Yes  **If Yes,  Wheelchair  Walker  Cane Holds onto Furniture** | |
| Gait: Steady  Unsteady  Shuffled  Swaying  Other:  Click or tap here to enter text. | |
| **Prosthesis** | No  Yes: **If Yes, what location is the prosthesis?**  Click or tap here to enter text. | |
| **Transfers** | Independent Assist Total | A or T Comments:  Click or tap here to enter text. |
| **Ability to Reposition Self** | Independent Assist Total | A or T Comments:  Click or tap here to enter text. |
| **ADL Comments:** | * *Summarize* ***abnormal*** *findings* * *If* ***no abnormal*** *findings: Document “None”* * Click or tap here to enter text. | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Physical Assessment** | | | | | | | | | | | | | | | | | | |
| **Vital Signs** | | | | | | | | | | | | | | | | | | |
| ***Vital Signs*** | **Date: \_\_\_\_\_\_\_\_\_\_\_**  **Time**: \_\_\_\_\_\_\_\_\_\_\_ | | | | | **Date: \_\_\_\_\_\_\_\_\_\_\_**  **Time**: \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | **Normal Ranges** | | | | | |
| Temperature | °F | | | | | °F | | | | | | | °F | | | | | |
| Blood Pressure | mmHg | | | | | mmHg | | | | | | | mmHg | | | | | |
| Respirations | Breaths /minute | | | | | Breaths /minute | | | | | | | Breaths /minute | | | | | |
| Heart Rate | Beats /minute | | | | | Beats /minute | | | | | | | Beats /minute | | | | | |
| SpO2 | % | | | | | % | | | | | | | % | | | | | |
| **Height/Weight/BMI** | | | | | | | | | | | | | | | | | | |
| **Height** | Click or tap here to enter text.  cm  inches | | | | | | | | | | | | | | | | | |
| **Current Weight** | Click or tap here to enter text.  kg  lbs. | | | | | | | | | | | | | | | | | |
| **Ideal Weight** | Click or tap here to enter text.  kg  lbs. | | | | | | | | | | | | | | | | | |
| **Current BMI** | Click or tap here to enter text. | | | | | | | | | | | | | | | | | |
| **Normal BMI Range** | Normal Range is  Click or tap here to enter text.  to  Click or tap here to enter text.  kg  lbs. | | | | | | | | | | | | | | | | | |
| ***General*** | | | | | | | | | | | | | | | | | | |
| **General Appearance** | Well Nourished  Emaciated  Clean  Soiled | | | | | | | | | | | | | | | | | |
| **Affect** | Appropriate  Flat | | | | | | | | | | | | | | | | | |
| **Posture:** | Erect Slouched Other: **If Other, describe:**  Click or tap here to enter text. | | | | | | | | | | | | | | | | | |
| **Level of Consciousness** | Awake  Alert  Lethargic  Obtunded  Unarousable | | | | | | | | | | | | | | | | | |
| **Orientation** | Person  Place  Time  Situation  Oriented  Confused | | | | | | | | | | | | | | | | | |
| **Pain** | No  Yes  **If Yes, Pain Scale Out of 10:**  Click or tap here to enter text. | | | | | | | | | | | | | | | | | |
| **If Yes, Pain Location:**  Click or tap here to enter text. | | | | | | | | | | | | | | | | | |
| **If Yes, Pain is Acute Chronic** | | | | | | | | | | | | | | | | | |
| **If Yes,**  **Subjective findings:** | | | | | Click or tap here to enter text. | | | | | | | | | | | | |
| **If Yes,**  **Objective findings:** | | | | | Click or tap here to enter text. | | | | | | | | | | | | |
| **Skin** | Color | | | | Appropriate for ethnicity  Pale  Yellow  Red | | | | | | | | | | | | | |
| Temperature | | | | Warm  Hot  Cool  Cold | | | | | | | | | | | | | |
| Moisture | | | | Dry  Moist  Scaly | | | | | | | | | | | | | |
| Abnormalities | | | | No  Yes  **If Yes,  Weeping  Bruising  Scar  Open Wound If Yes, Location(s):**  Click or tap here to enter text. | | | | | | | | | | | | | |
| Turgor | | | | Less than 3 seconds  Greater than 3 seconds | | | | | | | | | | | | | |
| **Braden Skin Assessment**  ***Reference: (Williams)*** | ***Client’s Score:***  Click or tap here to enter text. | | | | 19 - 23 = no risk  15 - 18 = at risk  13 - 14 = moderate risk  10 - 12 = high risk  6 - 9 = severe risk | | | | | | | | | | | | | |
| **General Comments:** | * *Summarize* ***abnormal*** *findings* * *If* ***no abnormal*** *findings: Document “None* * Click or tap here to enter text. | | | | | | | | | | | | | | | | | |
| ***Head and Neck*** | | | | | | | | | | | | | | | | | | |
| **Head Symmetry** | Symmetrical  Asymmetrical | | | | | | | | | | | | | | | | | |
| **Sclera** | White  Red  Yellow | | | | | | | | | | | | | | | | | |
| **Conjunctiva** | Pink  Pale  Red | | | | | | | | | | | | | | | | | |
| Moist  Dry  Drainage | | | | | | | | | | | | | | | | | |
| **Pupils** | Equal  Unequal  Round  Accommodating | | | | | | | | | | | | | | | | | |
| Reactive to light  Non-reactive to light | | | | | | | | | | | | | | | | | |
| Brisk  Sluggish | | | | | | | | | | | | | | | | | |
| Size in mm | **Before Light** | | | | |  | | **During Light** | |  | | | **After Light** | |  | | |
| **Ears** | Symmetrical  Asymmetrical | | | | | | | | | | | | | | | | | |
| Redness  Drainage | | | | | | | | | | | | | | | | | |
| **Nose** | Symmetrical  Asymmetrical | | | | | | | | | | | | | | | | | |
| **Dentition** | All present  Missing teeth  Caries | | | | | | | | | | | | | | | | | |
| Ability to Chew:  No  Yes | | | | | | | | | | | | | | | | | |
| Dentures:  No  Yes | | | | | | | | | | | | | | | | | |
| **Oral mucosa** | Pink  Pale  Red | | | | | | | | | | | | | | | | | |
| Moist  Dry  Drainage | | | | | | | | | | | | | | | | | |
| **Abnormalities:**  No  Yes  **If Yes, ☐ Bruising  Scar  Open Wound** | | | | | | | | | | | | | | | | | |
| **Neck** | Symmetrical  Asymmetrical | | | | | | | | | | | | | | | | | |
| **Head and Neck Comments:** | * *Summarize* ***abnormal*** *findings* * *If* ***no abnormal*** *findings: Document “None”* * Click or tap here to enter text. | | | | | | | | | | | | | | | | | |
| ***Chest*** | | | | | | | | | | | | | | | | | | |
| **Thorax** | Symmetrical  Asymmetrical | | | | | | | | | | | | | | | | | |
| Even chest rise  Uneven chest rise | | | | | | | | | | | | | | | | | |
| **Lung Sounds** | Clear:  RUL  RML  RLL  LUL  LLL  Wheezes:  RUL  RML  RLL  LUL  LLL  Rales/Rhonchi:  RUL  RML  RLL  LUL  LLL  Diminished:  RUL  RML  RLL  LUL  LLL | | | | | | | | | | | | | | | | | |
| **Cough:**  No  Yes, **If Yes,  Non-productive  Productive:** | | | | | | | | | | | | | | | | | |
| **If productive** | | Color | | | | | Pink  Yellow  Green  Clear  White | | | | | | | | | | |
| Amount | | | | | Scant  Moderate  Copious | | | | | | | | | | |
| Consistency | | | | | Frothy  Thick  Thin | | | | | | | | | | |
| Oxygen Therapy No  Yes  **If Yes, Type of device & amount:**  Click or tap here to enter text.  **If Yes,  Continuous  PRN** | | | | | | | | | | | | | | | | | |
| **Heart Sounds** | S1, S2 present  Murmur | | | | | | | | | | | | | | | | | |
| Regular  Irregular | | | | | | | | | | | | | | | | | |
| Telemetry:  No  Yes  **If Yes, Telemetry Box Number:**  Click or tap here to enter text. | | | | | | | | | | | | | | | | | |
| **Apical Pulse Rate**:  Click or tap here to enter text. | | | | | | | | | | | | | | | | | |
| **Chest Comments:** | * *Summarize* ***abnormal*** *findings* * *If* ***no abnormal*** *findings: Document “None”* * Click or tap here to enter text. | | | | | | | | | | | | | | | | | |
| ***Abdomen*** | | | | | | | | | | | | | | | | | | | |
| **Shape** | Flat  Rounded  Distended | | | | | | | | | | | | | | | | | | |
| Soft  Firm  Tender | | | | | | | | | | | | | | | | | | |
| No devices  Medical devices, **If Medical Devices Describe**:  Click or tap here to enter text. | | | | | | | | | | | | | | | | | | |
| **Bowel** | Date of Last Bowel Movement:  Click or tap here to enter text. | | | | | | | | | | | | | | | | | | |
| Active:  RLQ  RUQ  LUQ  LLQ  Hypoactive:  RLQ  RUQ  LUQ  LLQ  Hyperactive:  RLQ  RUQ  LUQ  LLQ | | | | | | | | | | | | | | | | | | |
| Stool:  Formed  Soft  Loose  Watery | | | | | | | | | | | | | | | | | | |
| Continent  Incontinent:  **If Incontinent, Management:**  Click or tap here to enter text. | | | | | | | | | | | | | | | | | | |
| **Urinary** | Date of Last Void:  Click or tap here to enter text. | | | | | | | | | | | | | | | | | | |
| Urine:  Clear  Cloudy  Yellow  Amber  Orange  Odor | | | | | | | | | | | | | | | | | | |
| Continent  Incontinent:  **If Incontinent, Management:**  Click or tap here to enter text. | | | | | | | | | | | | | | | | | | |
| No devices  Medical devices: **If Medical Devices Describe:**  Click or tap here to enter text. | | | | | | | | | | | | | | | | | | |
| **Abdomen Comments:** | * *Summarize* ***abnormal*** *findings* * *If* ***no abnormal*** *findings: Document “None”* * Click or tap here to enter text. | | | | | | | | | | | | | | | | | | |
| ***Extremities*** | | | | | | | | | | | | | | | | | |
| **Nails** | **Hands** | | | Smooth  Thick  Convex  Clubbing  Pink | | | | | | | | | | | | | |
| Capillary Refill:  Less than 3 seconds Greater than 3 seconds | | | | | | | | | | | | | |
| **Feet** | | | Smooth  Thick  Convex  Clubbing  Pink | | | | | | | | | | | | | |
| Capillary Refill:  Less than 3 seconds Greater than 3 seconds | | | | | | | | | | | | | |
| **Pulses**  0, absent  1+, palpable, weak  2+, present  3+, increased  4+, full, bounding | **Radial:** | | | Equal  Unequal | | | | | | **Right** | |  | | **Left** | | |  |
| **Dorsalis Pedis:** | | | Equal  Unequal | | | | | | **Right** | |  | | **Left** | | |  |
| **Edema** | None  Non-pitting: Location:  Click or tap here to enter text.  Pitting: Location:  Click or tap here to enter text.  1+ Barely detectable  2+ Indentation less than 5mm  3+ Indentation 5-10mm  4+ Indentation more than 10mm | | | | | | | | | | | | | | | | |
| **Muscle Strength**  0-None-ROM  1-Partial ROM  2-Full ROM | **Hand grips** | | | Equal  Unequal | | | | | | **Right** | |  | | | **Left** | |  |
| **Feet push/pull:** | | | Equal  Unequal | | | | | | **Right** | |  | | | **Left** | |  |
| **Extremities Comments**: | * *Summarize* ***abnormal*** *findings* * *If* ***no abnormal*** *findings: Document “None”* * Click or tap here to enter text. | | | | | | | | | | | | | | | | |
| **Date:**  Click or tap here to enter text. | **Time:**  Click or tap here to enter text. | | | **Signature with Credentials:**  Click or tap here to enter text. | | | | | | | | | | | | | |

**Select 2 Nursing Diagnosis:**

1. Click or tap here to enter text.

2. Click or tap here to enter text.

**Select 4 Client’s Strengths:**

1. Click or tap here to enter text.
2. Click or tap here to enter text.

3. Click or tap here to enter text.

4. Click or tap here to enter text.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **LAB & DIAGNOSTIC TESTS** | | | | |
|  | | | | |
| **Test** | Client’s Results | **Normal Values** | | Purpose for test for client |
|  | | | | |
| **Blood (Serum) Tests** | | | | |
| RBC | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Hemoglobin (Hgb) | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Hematocrit (Hct) | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| WBC | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Platelets | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| **Metabolic Panel.** | | | | |
| Glucose | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Calcium (Ca) | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Chloride (Cl) | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Magnesium (Mg) | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Phosphorus (P) | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Potassium (K) | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Sodium (Na) | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| BUN | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Serum Creatinine | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Total Protein | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Albumin | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Bilirubin | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| ALP (alkaline phosphatase) | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| ALT (alanine transaminase) | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| AST (aspartate transaminase) | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| **Lipid Panel:** | | | | |
| LDL | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | |
| HDL | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | |
| Total Cholesterol | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | |
| Triglycerides | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | |
| **Arterial Blood Gas (ABG’s)** |  |  |  | |
| pH | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| PO2 | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| PCO2 | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| HCO3 | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| O2 saturation | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Base excess | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| **Coagulation Tests** | | | | |
| PT | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| PTT | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| INR | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| **Urinalysis (UA) Tests** | | | | |
| Appearance | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Color | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Odor | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| pH | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Protein | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Specific gravity | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| LAB & DIAGNOSTIC TESTS | | | | |
| **Test** | Client’s Results | **Normal Values** | | Purpose for Test for this Client |
| Stool | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| **Chest Xray** | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| **EKG** | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| **Blood Glucose Tests** No Yes   **If Yes, How often are tests:** Click or tap here to enter text. | | | | |
| **Date** | **Time** | **Result** | | **Intervention** |
| Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
| Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication**  **(Dose/Route/Time)** | **Classification of Medication** | **Indication**  **(Specific to Patient)** | **Side Effects** | **Nursing Implications** |
| *Click or tap here to enter text.* | *Click or tap here to enter text.* | *Click or tap here to enter text.* | *Click or tap here to enter text.* | Click or tap here to enter text. |
| *Click or tap here to enter text.* | *Click or tap here to enter text.* | *Click or tap here to enter text.* | *Click or tap here to enter text.* | *Click or tap here to enter text.* |
| *Click or tap here to enter text.* | *Click or tap here to enter text.* | *Click or tap here to enter text.* | *Click or tap here to enter text.* | *Click or tap here to enter text.* |
| *Click or tap here to enter text.* | *Click or tap here to enter text.* | Click or tap here to enter text. | *Click or tap here to enter text.* | *Click or tap here to enter text.* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication**  **(dose/route/time)** | **Classification of Medication** | **Indication**  **(Specific to Patient)** | **Side Effects** | **Nursing Implications/**  **Client Education** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

***/Rev: 7/23/AX; rev. 8/1/23 AX***