

## **Community General Hospital**

Patient Account # 12345	INPATIENT REGISTRATION AND SUMMARY FORM						Medical Record # 215043		
Patient Name (Last) (First) (Middle) <b>Brown, John</b>		Attending Physician Number and Name <b>Jeff T. Moore</b>			Patient Type <b>97 Inp</b>		Hospital Services <b>S</b>	Admit Date <b>11/12/99</b>	Admit time <b>11:10</b>
Patient Address (Street) (City) (State) (Zip Code) <b>27 Cottonwood Ln Anytown USA</b>							Patient Phone # <b>123-123-4567</b>	Date of Prev. Admit	
Previous or Maiden Name		Birth Date <b>9/10/44</b>	Age <b>54</b>	Sex <b>M</b>	Marital St <b>M</b>	Religion	Comments <b>Donor No</b>		
Notify in Case of Emergency			Address		City/State		Phone	Relationship	
Patient Social Security Number <b>123-45-6789</b>	Employer Name <b>Big Company</b>			Employer City/State <b>Anytown, US</b>		Guarantor #	Guarantor Name <b>John Brown</b>		
Guarantor Address <b>Same</b>							Guarantor Social Security Number		
Payer <b>Southern Company</b>		Policy Number <b>123456789</b>			Insured's Name <b>John Brown</b>		Group Name		
Financial Class	Admitted By <b>AD12</b>			Patient Weight			Discharge Date <b>11/13/99</b>	Disch. Time <b>11:30</b>	
Provisional Diagnosis <b>Right Ing Hernia</b>									
Principal Diagnosis, Secondary Diagnosis and Complications									
<b>550.91</b> <b>214.4</b>									
<b>53.03</b> <b>63.3</b>									
<b>11-12</b> <b>Moore</b> <b>49520</b>									
Principal Procedures and Secondary Procedures									
<b>11-12</b> <b>Moore</b> <b>49520</b>									
Consultations									
<b>11-12</b> <b>Moore</b> <b>49520</b>									
Disposition of Case <input checked="" type="checkbox"/> Home		<input type="checkbox"/> Swing Bed	<input type="checkbox"/> Supervised Living	<input type="checkbox"/> Home Health	<input type="checkbox"/> Nursing Home		Coder <i>kp</i>	Date	
<input type="checkbox"/> Expired		<input type="checkbox"/> Autopsy	<input type="checkbox"/> AMA						

I certify that the narrative description of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

---

**Attending Physician**

Date

**Community General Hospital**  
**Anytown, USA**

**CONSENT TO TREATMENT  
AND  
CONDITIONS OF ADMISSION**

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

Adm Date: 11/12/1999 DOB: 09/10/44

- 1. Consent for Medical and Hospital Care.** The undersigned consents to the following:
  - a. All treatment and procedures to be performed during this hospitalization or on an outpatient basis (including emergency treatment or services). The treatment and procedures may include, but are not limited to, laboratory tests, x-ray examination, medical or surgical treatment or procedures, anesthesia, or hospital services rendered under the general and special instructions of the patient's physician.
  - b. Testing for HIV antibody (AIDS) and/or Hepatitis should the healthcare worker have an accidental exposure to the patient's blood or other body fluids.
  - c. The disposal of any body parts or tissues removed during hospitalization according to Hospital policy.
  - d. Transfer and transportation to another facility for further care as instructed by the patient's physician.
  - e. I consent to have allergies and code status listed on the front of my chart to ensure my safety as a patient.
- 2. General Risks.** The undersigned understands that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. No guarantees can or have been made regarding the results of examination, procedures, or treatment.
- 3. Healthcare Providers/Relationships.** The undersigned understands:
  - a. That all physicians furnishing services to the patient including the radiologists, pathologists, anesthesiologists, emergency room physicians, and the patient's attending and consulting physicians, are independent contractors and are not employees or agents of the Hospital.
  - b. That among those who may care for the patient at this Hospital are medical, nursing, and other healthcare students who, unless requested otherwise, may be present during or administer care as a part of their training.
- 4. Release of Information.** The undersigned authorizes the Hospital to release the following information:
  - a. In order to determine liability for payment or to obtain payment the Hospital may disclose all or portions of the patient's medical record to any person or entity or their agents who may be liable for all, or a portion of, the Hospital's charges. The Hospital's authority shall include but not be limited to release of the patient's diagnosis, surgical procedure, plan of care, and benefits by telephone at the time of admission or during or after the patient's hospitalization, and the entities to whom the information may be released shall include but not be limited to insurance companies, health maintenance organizations, worker's compensation carriers, government or other payors, or their agents such as utilization review, rehabilitation, or auditing agencies.
  - b. Clinical information to physicians and facilities for the purpose of continued health care.
- 5. Personal Valuables.** I acknowledge and understand I am responsible for my personal valuables (including money, jewelry, dentures, hearing aids, eyeglasses, etc.) while a patient at the Hospital. I also acknowledge I have been informed the Hospital maintains a safe for safekeeping of my personal valuables. I release the Hospital from any liability for loss by theft or negligence of mine or any hospital employee of my personal valuables unless it is placed in the Hospital safe.
- 6. Guarantee of Account.** The undersigned agrees, whether as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually obligates himself/herself to pay the account of the Hospital in accordance with the rates and policies of the Hospital.
- 7. Assignment of Insurance Benefits.** The undersigned authorizes, whether as agent or as patient, direct payment to the Hospital of any insurance benefits, settlements, or awards otherwise payable to or on behalf of the patient for this hospitalization or these outpatient services (including emergency services if rendered) at a rate not to exceed the Hospital's charges. The undersigned understands that he/she is financially responsible for charges not covered by this assignment except to the extent the Hospital may have otherwise contracted with patient's payor.
- 8. Notice of Privacy Practices.** The law requires that we maintain the privacy of your Protected Health Information and that we provide you with a notice of our legal duties and privacy policies with respect to protected health information. By signing below, you are acknowledging that you have received a copy of our Notice of Privacy Practices.

Patient's Name: (please print) John Brown

Patient, Parent, Guardian, Agent: X John Brown Date: 11-10-99 Time: 3:22

Witness: LWS Date: \_\_\_\_\_ Time: \_\_\_\_\_

If other than patient, indicate relationship: \_\_\_\_\_

**Guarantee of Account by Person other than Patient:** I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Guarantee of Account and Assignment of Insurance Benefits above.

Financially Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

## DRUG THERAPY SUMMARY REPORT

PAGE 1 OF

Name: John Brown

Account No: 12345

Attending Physician: Jeff T. Moore, M.D.

Consulting Physician

Adm Date: 11/12/1999

DOB: 09/10/44

ALLERGIES *NKA*DIAG: *fever of long duration*

## ACTIVE ORDERS

## ----- MEDICATIONS -----

HOME MED INSTRUC

FTAB 500MG, CEPHALEXIN HCL MONOHYDRATE

500MG=1TAB  
ORAL Y*SC*

TAKE EVERY TWELVE HOURS

TAKE ON EMPTY STOMACH-1HR AC OR 2HR PC

\*\*\*\*\* COMMENTS \_\_\_\_\_

RTAB 10MG, HYDROCODONE 10/APAP 500

10MG=1TAB  
ORAL Y*SC*

TAKE EVERY FOUR HOURS AS NEEDED

\*\*\*\*\* COMMENTS \_\_\_\_\_

MEROL 75MG AMP, MEPERIDINE HCL

75MG=1.5ML  
INTRAMUSCULAR Y*SC*

TAKE EVERY THREE HOURS AS NEEDED

\*\*\*\*\* COMMENTS \_\_\_\_\_

STARIL, HYDROXYZINE HCL

50MG=1ML  
INTRAMUSCULAR Y*SC*TAKE EVERY THREE HOURS AS NEEDED FOR  
PAINGIVE WITH DEMEROL  
NOT TO BE GIVEN IV

\*\*\*\*\* COMMENTS \_\_\_\_\_

## ADDITIONAL DISCHARGE MEDS

INSTRU

*Sony Campbell*  
SIGNATURE OF DISCHARGE INSTRUCTO

CHECK ONE

- REFUSED CARDS
- VERBAL INSTRUCTIONS GIVEN
- VERBAL INSTRUCTIONS REFUSED

**Community General Hospital  
Anytown, USA**

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

**DISCHARGE SUMMARY**

Adm Date: 11/12/1999      DOB: 09/10/44

Page 1 of 1

**ADMITTING DIAGNOSIS:**

1. Recurrent right inguinal hernia.

**DISCHARGE DIAGNOSIS:**

1. Same.

**PROCEDURES PERFORMED:**

1. Repair of recurrent right inguinal hernia.

**HISTORY AND INDICATIONS FOR ADMISSION:** Mr. Brown is a 54-year-old white male who presented with pain to Dr. Jeff Moore. He had a hernia repair, on the right, in the past, and this was recurrent. He was scheduled for surgery.

**HOSPITAL COURSE:** The patient was admitted on 11/12/1999 and underwent surgery, and did fine. He was transferred to the floor.

On 11/13/99 he is alert, awake, afebrile, taking a regular diet. Having bowel movements, and passing his urine normally. His incision is clean and dry. He is discharged home in satisfactory condition with Lortab PRN for pain. He is to follow up with his primary care physician, Dr. Moore, on Monday.

D: 11/13/1999

T: 11/16/1999

wms

Tom W. Smith, M.D.

cc: Jeff T. Moore, M.D.



**HISTORY AND PHYSICAL**

Adm Date: 11/12/1999      DOB: 09/10/44

Page 1 of 2

**REASON FOR ADMISSION:** This is a 54 year old male, admitted here for repair of right inguinal hernia.

**HISTORY OF PRESENT ILLNESS:** The patient has had his hernia repaired in the past, elsewhere. Over the past number of months, he has seen this hernia come back and recur, and become larger. It causes discomfort. He is admitted for repair of a right inguinal hernia.

**PAST MEDICAL HISTORY:** Denies.

**MEDICATIONS:** None.

**PAST SURGICAL HISTORY:** Hernia surgery on the right in the past. The patient also has had a left inguinal hernia repair in the past.

**EXAMINATION**

**VITAL SIGNS:** Blood pressure 140/90.

**GENERAL:** Well developed, well-nourished male in no immediate distress.

**HEENT:** Essentially negative.

**NECK:** No masses.

**CHEST:** Clear to auscultation and percussion.

**HEART:** Normal sinus rhythm.

**ABDOMEN:** On plane. Well-healed left inguinal hernia repair noted. On the right there is a large right inguinal hernia.

**GENITALIA:** Normal male.

**RECTAL:** Negative. Prostate 1+.

**EXTREMITIES:** Symmetric.

**IMPRESSION:**

1. Right inguinal hernia recurrent.



Community General Hospital  
Anytown, USA

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**HISTORY AND PHYSICAL**

Adm Date: 11/12/1999      DOB: 09/10/44

Page 2 of 2

PLAN: Repair right inguinal hernia. The patient understands that the hernia can come back, may develop a neuroma, he could develop numbness. The mesh may get infected and have to be removed. I have made no guarantees written or implied. I have explained all of this to him today.

D: 11/10/1999

T: 11/10/1999

lsw

Jeff T. Moore, M.D.



# Community General Hospital

## Anytown, USA

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

Adm Date: 11/12/1999      DOB: 09/10/44

## **PHYSICIAN PROGRESS NOTES**

## **Community General Hospital Anytown, USA**

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

Adm Date: 11/12/1999      DOB: 09/10/44

## **OPERATIVE PROGRESS NOTE**

**Community General Hospital  
Anytown, USA**

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

Adm Date: 11/12/1999      DOB: 09/10/44

## **PHYSICIAN PROGRESS NOTES**

**Community General Hospital**  
**Anytown, USA**

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

Adm Date: 11/12/1999    DOB: 09/10/44

\*\*\*\*\* GENERAL CHEMISTRY \*\*\*\*\*

		NORMAL	UNITS
ATE:	11/10/99		
IME:	1620		
A	138	135-143	MIC/L
	3.8	3.5-5.0	MIC/L
L	106	93-109	MIC/L
O2	29	22-29	MIC/L
GAP	4L	7-16	
LU	100	70-105	MIC/OL
UN	10	8-20	MIC/OL
REAT	0.9	0.9-1.3	MIC/OL
UN/CREAT RATIO	11.1	8-16	
A	9.2	9.0-10.6	MIC/OL
BILI	0.9	0.2-1.2	MIC/OL
P	6.7	6.0-8.3	g/ML
LB	3.9	3.2-5.0	g/ML
LOB	2.6	2.6-3.3	g/ML
/G RATIO	1.4	0.9-1.6	
LP	73	20-100	FLU/L
ST	24	10-42	FLU/L

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Consulting Physician

Adm Date: 11/12/1999    DOB: 09/10/44

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\*\*\*\*\* HEMATOLOGY \*\*\*\*\*

ATE:	11/10/99	NORMAL	UNITS
IME:	1620		
BC	9.6	4.8-10.8	1000/uL
BC	5.32	4.7-6.1	1000/uL
GB	17.4	14.0-18.0	g/L
CT	49.3	42-52	%
CV	92.6	80.0-94.0	F
CH	32.7H	27.0-31.0	F
CHC	35.3	33.0-37.0	g/L
SW	13.1	11.5-14.5	%
LT	136	130-400	1000/uL
PV	7.6	7.4-10.4	F
LYMP	28.6	20.5-31.1	%
MON	9.8	1.7-16.0	%
GRAN	52.3	42.2-73.2	%
EOS	9.1	0.0-10.0	%
BASO	0.2	0.0-3.0	%
BS. LYMP	2.8	1.2-3.4	1000/uL
BS. MONO	0.9H	0.11-0.59	1000/uL
BS. GRAN	5.0	1.4-6.5	1000/uL
EOS	0.9H	0.0-0.7	1000/uL
BS. BASO	0.0	0.0-0.2	1000/uL
IFF TYPE:	AUTOMATED		

\*\*\*\*\* COAGULATION \*\*\*\*\*

ATE:	11/10/99	NORMAL	UNITS
IME:	1620		
NR	1.12	9.8-12.6	SECONDS
T	11.9	21.5-36.7	SECONDS
TT	27.2		

Community General Hospital  
Anytown, USA

Name: John Brown  
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Consulting Physician

Adm Date: 11/12/1999 DOB: 09/10/44

\*\*\*\*\* URINALYSIS \*\*\*\*\*

DATE: 11/10/99  
TIME: 1537 NORMAN UNITS

APR	YELLOW	
CLA	CLEAR	
SG	1.020	1.005 - 1.030
PH	6.0	5.0 - 7.0
PRO	NEGATIVE	NEG
GLU	NEGATIVE	NEG
UET	NEGATIVE	NEG
NIL	NEGATIVE	NEG
BLO	NEGATIVE	NEG
HT	NEGATIVE	NEG
JLE	NEGATIVE	NEG
JRO	1.0	0.2-1.0 EU

\*\*\*\*\* TUMOR MARKERS \*\*\*\*\*

11/10/99  
1620 PSA 1.360 EO-43 NG/ML

Brown, John

10-NOV-1999 16:17:28

55years  
Male Caucasian  
Room: TBA

Vent. rate 79 bpm  
PR interval 174 ms  
QRS duration 88 ms  
QT/QTc 360/413 ms  
P-R-T axes 44 20 79

Normal sinus rhythm  
Nonspecific T wave abnormality  
Abnormal ECG

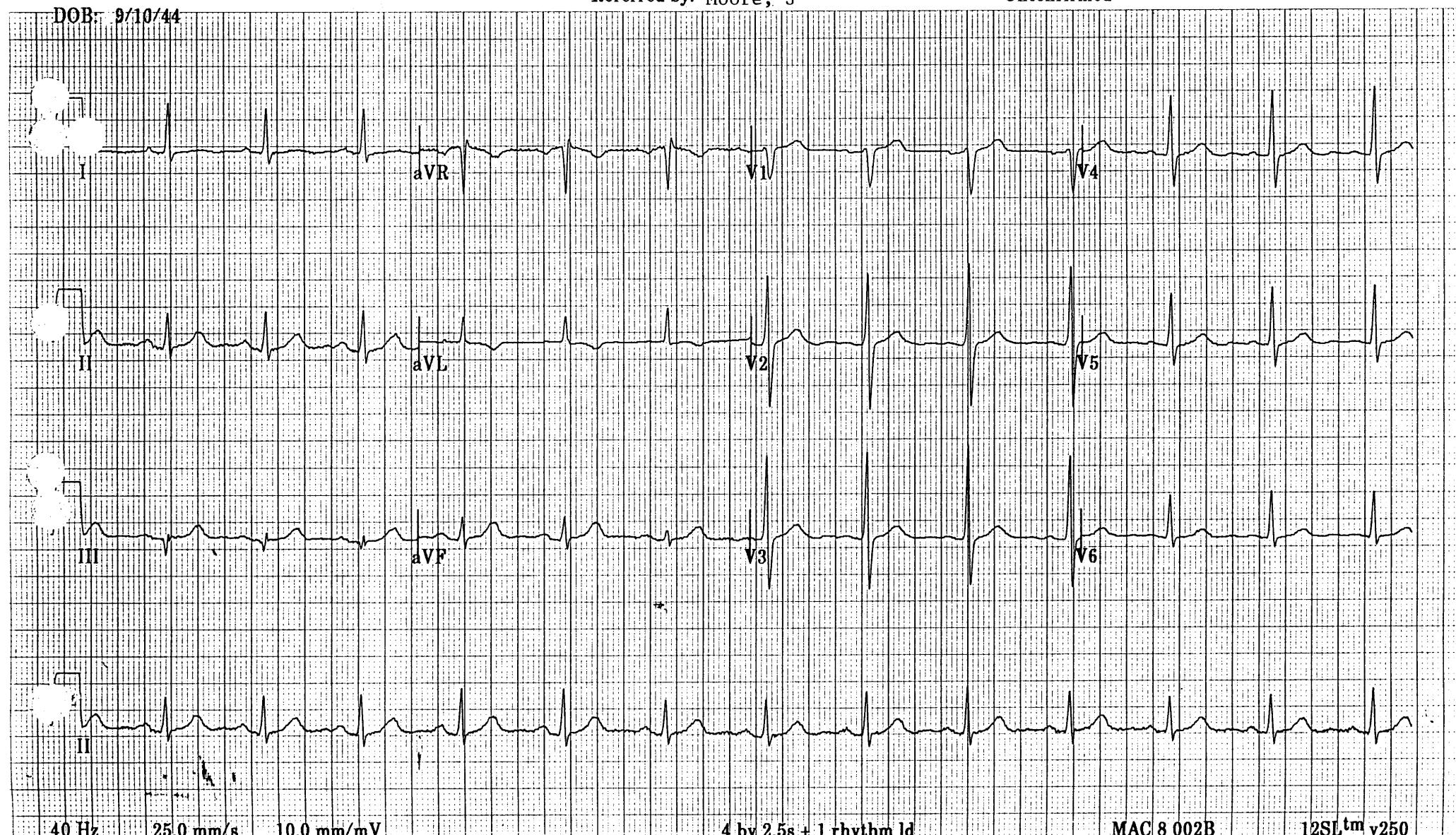
Technician: TB

Meds: SURG 11/12/99

DOB: 9/10/44

Referred by: Moore, J

Unconfirmed



Community General Hospital  
Anytown, USA

**RADIOLOGY REPORT**

Name: John Brown      DOB: 09/10/44  
Ordering Physician: Jeff T. Moore, M.D.  
Exam date: 11/10/1999  
Radiology Number: 506024  
Account Number: 12345  
Outpatient: TA to be admitted

Page 1 of 1

**EXAMINATION DESCRIPTION:** Chest PA & Lateral

CHEST: the heart is normal in size and configuration. The lung fields are clear bilaterally. The hilar and mediastinal structures appear normal. The thorax is not remarkable.

**IMPRESSION:** Normal chest.

**HISTORY:** pre-op. Inguinal hernia. Denies chest complaints/SOB.

D: 11/10/1999

T: 11/10/1999

mls

*Chuck Hamlin*

Chuck Hamlin, M.D.  
Radiologist

Community General Hospital  
Anytown, USA

**RADIOLOGY REPORT**

Name: John Brown DOB: 09/10/44  
Ordering Physician: Jeff T. Moore, M.D.  
Exam date: 11/12/1999  
Radiology Number: 506024  
Account Number: 12345  
Inpatient: NS/Room/Bed: 2W/ 238/ B

Page 1 of 1

EXAM: Abdomen KUB portable 1 vw

HISTORY: Postoperative. Inguinal hernia.

Postoperative KUB: Surgical clips project at the right inguinal region. No unexpected radiopaque foreign bodies are present.

D: 11/12/1999  
T: 11/12/1999  
tb

*Chuck Hamlin*

Chuck Hamlin, M.D.  
Radiologist

Community General Hospital  
Anytown, USA

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

Adm Date: 11/12/1999 DOB: 09/10/44

## Surgery Consent Form

1. I hereby authorize Dr. Moore and whomever he may designate to perform upon \_\_\_\_\_ the following procedure: Repair Right inguinal hernia and insert mesh.

I further authorize him/her to do whatever is medically necessary or appropriate to accomplish this procedure.

2. The nature, purpose and possible alternative methods of treatment, the risks involved, and the possibilities of complications have been fully explained to me by my surgeon/physician/anesthetist. I acknowledge that no guarantee or assurance has been made me as to the results that may be obtained.
3. I request and consent to the administration of such anesthetics as may be considered necessary or advisable by the physicians responsible for this service.
4. I consent to the disposal of any tissues or parts by proper authorities of Lookout Memorial Hospital.
5. I consent to the administration of blood and blood products as deemed medically necessary. (If refuses, cross out #5 narrative and patient must initial).
6. I consent to the taking of any photographs deemed necessary by my surgeon/physician.
7. Education materials, handouts: I have received patient education concerning the above procedure and have been allowed to ask questions.

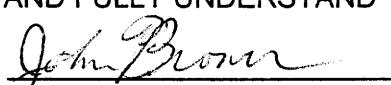
"Cross Out" blank lines if nothing is added to #8 and #9.

8. Right hernia can come back, may develop numbness, neurona, mesh may have to be removed

9. \_\_\_\_\_

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT.

  
Physician Signature

  
Patient/Guardian Signature

Relationship to Patient

  
Witness' Signature

11/10/99  
Date/Time

Witness' Printed Name

## **ANESTHESIA RECORD**

NPO Status

Post-Op Notes

Name: John Brown

Account No: 12345

Attending Physician: Jeff T. Moore, M.D.

#### **Consulting Physician**

Adm Date: 11/12/1999      DOB: 09/10/44

Operation (B) Inguinal Hernia Repair Date: 1/12/99  
Surgeon(s): \_\_\_\_\_

**Surgeon(s):**

Anesthetist: \_\_\_\_\_ Anesthesia: Liz McDonnell CRNA

Anesthetist: \_\_\_\_\_ Anesthesia: Liz McDonnell CRNA

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

Adm Date: 11/12/1999      DOB: 09/10/44

## **PAR RECORD**

Time	0850	0855	0900	0905	0920
B/P	114/ 78	116/ 72	98/ 80	114/ 79	125/ 72
Pulse	75	77	75	73	76
Resp.	18	18	18	18	18
Temp	97 <sup>2</sup>	—	—	—	97 <sup>4</sup>
O <sub>2</sub> SAT.	96%	94%	94%	94%	96%

<b>AIRWAY</b>	<b>none</b>	<b>DRESSING</b>
out @ _____	Dry & intact	
<b>OXYGEN</b>	<b>none</b>	
Route	Flow	CAST
Heated Aero <sup>o</sup>		
NC		—
Mack		—
Other		IMMOBILIZER —

INTAKE		OUTPUT			
IV or Oral	Amount	Time	Drain Type	Character	Amount
LR-IV	50	0920	Ø	Ø	Ø
Total	50	Total	Ø	Ø	Ø

ASSESSMENT	
EKG/Heart Rhythm:	<u>NSR @ 80 bpm</u>
EKG Strip on Back:	<input checked="" type="checkbox"/> No
Lung Sound:	<u>CTA -</u>
CMS/Pulses:	<u>—</u>

urses Notes                      Warming Blanket

1 week, edema & (R)TA

POST ANESTHESIA RECOVERY SCORE	ON ARRIV.	15 MIN.	30 MIN.	45 MIN.	60 MIN.	DIS-CHG
Able to move 4 extremities voluntarily or on command = 2						
Able to move 2 extremities voluntarily or on command = 1	1	2	2			
Able to move 0 extremities voluntarily or on command = 0						
Able to deep breathe and cough freely = 2						
Spontaneous rhythmic breathing = 1	Respirations	2	2	2		
Dyspnea/Apnea = 0						
BP ± 20% of preanesthetic level = 2						
BP ± 20-50% of preanesthetic level = 1	Circulation	2	2	2		
BP ± 50% of preanesthetic level = 0						
Fully awake = 2						
Arousable on calling = 1	Consciousness	2	2	2		
Not responding = 0						
Pink = 2						
Pale, dusky, blotchy jaundiced = 1	Color	2	2	2		
Cyanotic = 0						
	TOTALS	9	10	10		

**Discharge:**

Time: 0920 am

**Home:**

Via: W/C  Ambulatory

**Accompanied by:** \_\_\_\_\_

### **Dischg Instructions:**

**Rx:** \_\_\_\_\_

Hospital Room: 828

Via: Bed  Cart

Report to: Sue Smith, RN by Linda McRae, CRNA

IV Credit: 600CC

1000-10000 m.s<sup>-1</sup>

1

Recovery Nurse 15

Recovery Nurse: Lisa M. Gibbons RN

Recovery Nurse: Lisa M. Gibbons RN

Community General Hospital  
Anytown, USA

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

Adm Date: 11/12/1999 DOB: 09/10/44

O.R. RECORD

DATE <b>11/12/99</b>	ROOM NUMBER <b>6</b>	PACU IN	PACU OUT		
<input checked="" type="checkbox"/> INPATIENT	<input type="checkbox"/> OUTPATIENT	<input type="checkbox"/> P 6 P.M. & WEEKEND	<input checked="" type="checkbox"/> A.M. ADMIT	<input type="checkbox"/> SECOND PROCEDURE	<input type="checkbox"/> EXTRA STAFF
PATIENT TRANSFERRED TO OR VIA: <input checked="" type="checkbox"/> STRETCHER <input type="checkbox"/> BED <input checked="" type="checkbox"/> SIDE RAILS UP <input type="checkbox"/> OTHER					
PATIENT IN ROOM <b>0101</b>	SURGEON AVAILABLE <b>0700</b>	SURGERY BEGAN <b>0732</b>	OUT OF ROOM		
ANES. AVAILABLE <b>0700</b>	ANESTHETIC BEGAN <b>0715</b>	SURGERY ENDED	ANES. ENDED		
				<input checked="" type="checkbox"/> ELECTIVE	ANESTHESIA TYPE <input type="checkbox"/> GENERAL <input checked="" type="checkbox"/> SPINAL / CAUDAL <input type="checkbox"/> REGIONAL BLOCK <input type="checkbox"/> ASA CLASS _____
				<input type="checkbox"/> URGENT <input type="checkbox"/> EMERGENCY	<input type="checkbox"/> MAC <input type="checkbox"/> LOCAL <input type="checkbox"/> N/A

INITIALS	NAME	INITIALS	NAME
<i>JP</i>	<i>Ila Person CR</i>	<i>JG</i>	<i>Jeanne Johnson RN</i>
<i>Dr. Lisa J Channing MD</i>			

PRE-OPERATIVE NURSING ASSESSMENT

DISPOSITION FROM: <input type="checkbox"/> PT. ROOM <input type="checkbox"/> E.D. <input type="checkbox"/> ICU/CCU <input type="checkbox"/> PACU <input checked="" type="checkbox"/> HOLD. AREA	DISPOSITION TO: <input type="checkbox"/> PT. TO BE <input type="checkbox"/> DISCHARGED TO: <input type="checkbox"/> PACU <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PACU <input checked="" type="checkbox"/> BYPASS PACU <input type="checkbox"/> DIRECTLY TO	TRANSPORTED TO OR: <input type="checkbox"/> O2 @ ____ LITER <input type="checkbox"/> EKG MONITOR <input type="checkbox"/> IV SITE CHECKED <input checked="" type="checkbox"/> IV ____ cc's <input type="checkbox"/> AMBU	TUBES / DRAINS: <input checked="" type="checkbox"/> NONE <input type="checkbox"/> FOLEY <input type="checkbox"/> NASOGASTRIC <input type="checkbox"/> SWAN-GANZ <input type="checkbox"/> ARTERIAL LINE <input type="checkbox"/> CHEST TUBE <input type="checkbox"/> OTHER	PHYSIOLOGICAL HEALTH STATUS: <input type="checkbox"/> FLUSHED <input type="checkbox"/> PALE <input type="checkbox"/> DIAPHORETIC <input type="checkbox"/> SWAN-GANZ <input type="checkbox"/> COOL <input type="checkbox"/> WARM <input type="checkbox"/> PINK <input type="checkbox"/> SKIN CONDITION CLEAR	NEUROLOGICAL STATUS: <input type="checkbox"/> UNRESPONSIVE <input checked="" type="checkbox"/> ALERT <input type="checkbox"/> CALM / RELAXED <input type="checkbox"/> ANXIOUS <input type="checkbox"/> CONFUSED <input type="checkbox"/> SEDATED
PATIENT IDENTIFIED BY ARMBAND <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	VERBAL VERIFICATION OF OPERATIVE SITE <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	NPO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> VERBAL VERIFICATION <input type="checkbox"/>	ALLERGIES <i>NKA</i>	PSYCHOSOCIAL HEALTH STAT <input type="checkbox"/> LANGUAGE BARRIER <input type="checkbox"/> PREVIOUS SURGERY	
CHART CHECK VARIANCES: <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES - REPORTED TO DR.		BLOOD ORDERED: <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> UNITS AVAILABLE		MOBILITY <i>MATExy</i>	PROSTHESIS <i>S</i>
DISABILITIES <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES	Smoker		DIABETIC <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES	GLUCOPHAGE <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES	INITIALS <i>SC</i>

DIAGNOSIS	PLAN OF CARE		OUTCOME / EVALUATION
	POTENTIAL / ACTUAL KNOWLEDGE DEFICIT RELATED TO PLANNED SURGICAL INTERVENTION	OUTCOME: PATIENT HAS UNDERSTANDING OF SURGICAL INTERVENTION ASSESS THE PATIENT FOR LEVEL OF CONSCIOUSNESS, PSYCHO / SOCIAL STATUS AND BARRIERS TO EFFECTIVE COMMUNICATION. (See Perioperative Nursing Assessment) EXPLAIN PERIOPERATIVE ROUTINE ALLOW FOR AND ANSWER ADDITIONAL PATIENT QUESTIONS IF PATIENT EXPRESSES LACK OF UNDERSTANDING OF SURGICAL PROCEDURE (See Nursing Notes) THE SURGEON IS TO BE NOTIFIED (See Nursing Notes)	
POTENTIAL FOR ANXIETY RELATED TO SURGICAL INTERVENTION	OUTCOME: DEMONSTRATES DECREASED ANXIETY PLAN AND IMPLEMENTATION: GIVE CLEAR, CONCISE EXPLANATIONS COMMUNICATE PATIENT CONCERN'S TO OTHER HEALTH CARE MEMBERS CONVEY CARING, SUPPORTIVE ATTITUDE NOTIFY ANEST. IF OUTCOME GOAL NOT MET	PRE-OP. DEMONSTRATED ADAPTIVE COPING STRATEGIES <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ANESTHESIA NOT	
POTENTIAL / ACTUAL INJURY RELATED TO TRANSPORT TO O.R.	OUTCOME: PATIENT WILL REMAIN INJURY FREE PATIENT TRANSPORTED TO O.R. SUITE VIA: <input checked="" type="checkbox"/> ASSESS PATIENT'S MOBILITY AND RANGE OF MOTION LIMITATIONS <input type="checkbox"/> BED (SR ↑) <input type="checkbox"/> STRETCHER (SR ↑) <input type="checkbox"/> WHEELCHAIR <input checked="" type="checkbox"/> BY HIM/HERSELF & ASSISTANCE FROM RN <input type="checkbox"/> PATIENT TRANSFERRED SELF TO O.R. TABLE: <input type="checkbox"/> BY O.R. TEAM <input type="checkbox"/> REMAINED ON STRETCHER <input checked="" type="checkbox"/> SAFETY STRAP ACROSS PATIENT <input checked="" type="checkbox"/> R.N. REMAIN WITH PATIENT DURING INDUCTION	<input checked="" type="checkbox"/> REMAINED INJURY FREE PRE-OP. DURING TRANSFER & TRANSPORT TO OR & OR TABLE <i>SC</i>	
POTENTIAL LOSS OF DIGNITY RELATED TO EXCESS EXPOSURE	OUTCOME: PT. DIGNITY MAINTAINED COVER PATIENT EXCEPT FOR AREA OF SURGICAL PROCEDURE AT ALL TIMES KEEP O.R. DOOR CLOSED MINIMIZE TRAFFIC INTO O.R. SUITE	<input checked="" type="checkbox"/> PT. DIGNITY MAINTAINED PRE-INTRA-POST OPER. <i>SC</i>	

Name: John Brown  
 Account No: 12345  
 Attending Physician: Jeff T. Moore, M.D.  
 Consulting Physician

Adm Date: 11/12/1999 DOB: 09/10/44

		PLAN OF CARE		OUTCOME / EVALUATION			
DIAGNOSIS	PLAN OF CARE						
	OUTCOME: PATIENT WILL REMAIN INJURY FREE (Cont.)			NO EVIDENCE OF IMPAIRED SKIN INTEGRITY RELATED TO POSITIONING POST OPER.			
POTENTIAL / ACTUAL INJURY RELATED TO POSITIONING	OR TABLES <input type="checkbox"/> NEURO <input checked="" type="checkbox"/> STANDARD _____ <input type="checkbox"/> CYSTO <input type="checkbox"/> FRACTURE _____ <input type="checkbox"/> EYE STRETCHER <input type="checkbox"/> OTHER _____			folded Rotted sheet ↓ pelvic foam Pad ↓ heel's ↓ both arm			
	POSITIONING CHECKED BY PHYSICIAN / ANESTHESIA <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO POSITION: <input checked="" type="checkbox"/> SUPINE <input type="checkbox"/> JACKKNIFE <input type="checkbox"/> LT. LATERAL <input type="checkbox"/> RT. LATERAL <input type="checkbox"/> PRONE <input type="checkbox"/> TRENDelenburg <input type="checkbox"/> LITHOTOMY <input type="checkbox"/> LOW <input type="checkbox"/> HIGH <input type="checkbox"/> OTHER: _____			head			
POTENTIAL / ACTUAL IMPAIRED SKIN INTEGRITY	OUTCOME: NO IMPAIRED SKIN INTEGRITY <input type="checkbox"/> SHAVE <input type="checkbox"/> NO SHAVE <input checked="" type="checkbox"/> DONE-PREP <input type="checkbox"/> REMOVE HAIR AROUND INCISION SITE <input type="checkbox"/> RAZOR <input type="checkbox"/> ELECTRIC CLIPPER      DONE BY: _____			<input checked="" type="checkbox"/> THE PATIENT'S SKIN INTEGRITY IS MAINTAINED <input checked="" type="checkbox"/> THE PATIENT IS FREE OF FURTHER SKIN BREAKDOWN (See Nursing Assmt) POST-OPR.			
	PREP SOLUTION: <input type="checkbox"/> POVIDONE SOLUTION <input type="checkbox"/> PHISOHEX <input type="checkbox"/> ALCOHOL <input type="checkbox"/> OTHER: <u>Duraprep X2</u> <input type="checkbox"/> POVIDONE SCRUB <input type="checkbox"/> HIBIENS			INITIALS: <u>JC</u>			
POTENTIAL / ACTUAL INJURY RELATED TO USE OF CHEMICALS	OUTCOME: NO INJURY RESULTING FROM THE USE OF CHEMICALS ALLERGIES NOTED. (See Perioperative Nursing Assessment) ASSESS SKIN CONDITION (See Perioperative Nursing Assessment) PREVENT POOLING OF SOLUTIONS KEEP OR BED DRY AND WRINKLE FREE FOLLOWING SKIN PREP			OTHER CHEMICAL AGENTS USED OTHER THAN PREP SOLUTION: (A) AGENT: _____ (B) AGENT: _____ (C) AGENT: _____ (A) METH. OF APP.: _____ (B) METH. OF APP.: _____ (C) METH. OF APP.: _____			
				<input checked="" type="checkbox"/> THE OPERATIVE SITE SHOWS MINIMAL OF NO TISSUE REACTION FROM SKIN PREPARATION PROCEDURES <input checked="" type="checkbox"/> NO ALLERGIC OR OTHER UNTOWARD REACTIONS TO THE USE OF OTHER CHEMICAL AGENTS POST-OPR.			
PRE-OPERATIVE DIAGNOSIS: <u>(R) ing hernia - recurrent</u> POST-OPERATIVE DIAGNOSIS: <u>None</u> SURGICAL PROCEDURE: <u>(R) inginal hernia repair w/ Bard mesh</u>							
SURGEON: <u>Jeff Mann</u> SURGICAL ASSISTANT: <u>Jay Smith</u> CIRCULATOR: <u>Lisa Schreiner RN</u> <u>T. Martin RN</u> <u>0815</u> SCRUB: <u>Sara Pearson CTS</u> <u>Sharon Wright</u>							
LASER TECH / NURSE: ANESTHESIOLOGIST / CRNA: <u>Dr. Wright / Cheryl Smith CRNA</u> VISITOR:							
POTENTIAL FOR / ACTUAL INFECTION	<b>IMPLANTS</b> (Place sticker or write here)  Manu: <b>Bard</b> Mesh PerFix®Plug, Devic: Extra Large, Monofilament Knitted Polypropylene Size: Extra Large Plug REF 01172 LOT 32DKM1		OUTCOME: AVOIDANCE OF PATIENT INFECTION MAINTAIN ASEPTIC TECHNIQUE VERIFY PARAMETERS HAVE BEEN MET <input type="checkbox"/> FLASH <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/> STERIS		<input checked="" type="checkbox"/> THE PATIENT IS FREE FROM SIGNS / SYMPTOMS OF WOUND INFECTION		
			WOUND CLASSIFICATION: <input checked="" type="checkbox"/> CLEAN <input type="checkbox"/> CLEAN-CONTAMINATED <small>CONTAMINATED</small> <input type="checkbox"/> DIRTY		<input checked="" type="checkbox"/> INFECTION CONTROL MEASURES IMPLEMENTED PRE-INTRA-POST OPER.		
PLACE IMPLANT STICKERS ON BACK OF WHITE COI IMPLANT INFORMATION ABOVE O.R. PROGRESS NOTES.						URINE OUTPUT: _____ OTHER DRAINAGE: _____	
POTENTIAL FOR / ACTUAL CHANGE IN PT. BODY TEMP.      OUTCOME: THE NURSE WILL ASSESS PATIENTS NEED FOR DEVICES TO CONTROL & MONITOR PATIENTS TEMP. Temp Pre/Op <u>98.5</u> <input type="checkbox"/> THERMAL BOOTS <input type="checkbox"/> RM TEMP ADJUSTED TO: <u>98</u> <input checked="" type="checkbox"/> THERMAL BLANKET <input type="checkbox"/> K-THERMIA      ID # _____ <input type="checkbox"/> WARM SHEETS <input type="checkbox"/> WARM TOUCH      ID# _____						PT AT OR RETURNING TO NORMAL THERM: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO      POST-OP TEMP <u>98</u> INITIALS: <u>JC</u>	

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X-RAYS IN O.R.	<input type="checkbox"/>	N/A	FLURO IN O.R.	<input checked="" type="checkbox"/>	N/A
SPECIMEN TO LAB:	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	
DESCRIBE:	<i>Hysteria SAC</i>				
CULTURE TO LAB:	<input type="checkbox"/>	YES	<input checked="" type="checkbox"/>	NO	
DESCRIBE:					

POTENTIAL / ACTUAL INJURY RELATED TO PHYSICAL HAZARDS	PLAN OF CARE		OUTCOME / EVALUATION	
	OUTCOME: PATIENT WILL REMAIN INJURY FREE	□ TOURNIQUET CALIBRATION CHECKED PRIOR TO USE	✓ SUPPLIES/EQUIPMENT AVAILABLE FOR PATIENT IN PROPER WORKING ORDER	
	<input checked="" type="checkbox"/> SUPPLIES AND EQUIPMENT ARE AVAILABLE AND IN GOOD REPAIR	TOURNIQUET ID # _____	□ PT. TISSUE PERFUSION CONSISTENT WITH OR IMPROVED FROM PRE-OP BASELINE	
	TOURNIQUET USED: SKIN INTEGRITY OF EXTREMITY CHECKED & CUFF APPLIED BY _____			
	□ RT. ARM/LEG mmHg TIMES: _____ - _____ ↓ _____ - _____ ↓ _____ (TOTAL)			
	□ LT. ARM/LEG mmHg TIMES: _____ - _____ ↓ _____ - _____ ↓ _____ (TOTAL)			
POTENTIAL / ACTUAL INJURY RELATED TO ELECTRICAL EQUIPMENT	OUTCOME: PATIENT WILL REMAIN INJURY FREE	SETTINGS: CUT 35 COAG 35	□ PT. FREE FROM SIGNS/SYMPOMS RELATED TO ELECTRICAL INJURY	
	<input checked="" type="checkbox"/> ESU # 5093	SETTINGS: COAG		
	□ BIPOLAR ID # _____	EKG ELECTRODES = ○ SAFETY STRAP =  ESU PAD = <input type="checkbox"/> Tourniquet = +		
	TEMP CONTROL BLANKET (OUTLINE PLACEMENT)			
	PULSE OX SITE = LT RT under	BP CUFF = *		
	SPECIAL EQUIPMENT:	GEN SURG CART # _____		
	CO2 INSUFLATOR ID # _____	GYN CART # _____		
	MICROSCOPE ID # _____	EXTRA TV MONITOR _____		
	SMOKE EVACUATOR ID # _____	SUCTION D/C MACHINE _____		
	LIGHT SOURCE ID # _____	CUSA ID # _____		
	SCD ID # 5792	CELL SAVER ID # _____		
	ARTHROSCOPY CART # _____	OTHER: _____		
	□ LASER CO2 # _____	□ YAG LASER # _____	□ LASER SAFETY LIST COMPLETED	
POTENTIAL / ACTUAL INJURY RELATED TO RETAINED FOREIGN OBJECT	OUTCOME: NO FOREIGN OBJECT WILL BE RETAINED	□ ALL PATIENT CARE ITEMS CONFINED AND CONTAINED	INSTRUMENT COUNT	1st COUNT: (PRE-OP.)
	<input checked="" type="checkbox"/> ALL SHARPS/Sponges COUNTED	<input type="checkbox"/> N/A	INITIALS:	Correct <input type="checkbox"/> Incorrect
	IF COUNTS ARE INCORRECT: <input type="checkbox"/> PHYSICIAN NOTIFIED <input type="checkbox"/> X-RAY TAKEN IN OR <input type="checkbox"/> X-RAY TAKEN IN PACU		CAVITY: (INTRA-OP.)	INITIALS:
	<input type="checkbox"/> X-RAY NOT TAKEN <input type="checkbox"/> X-RAY RESULTS: _____		2nd COUNT: (INTRA-OP.)	INITIALS:
	BY ORDER DR. READ BY: _____		Final COUNT: (INTRA-OP.)	INITIALS:
	DISCHARGE FROM OR: <input checked="" type="checkbox"/> PRESSURE AREAS CHECKED <input type="checkbox"/> PATIENT DRESSING DRY AND CLEAN		□ PT. FREE FROM SIGNS/SYMPOMS OF INJURY RELATED TO TRANSFER/TRANSPORT.	
	<input type="checkbox"/> TUBES AND DRAINS SECURED <input type="checkbox"/> IMMOBILIZER		INITIALS:	
POTENTIAL / ACTUAL INJURY DURING TRANSFER FROM OR	OUTCOME: PATIENT WILL BE TRANSFERRED WITHOUT INJURY	PLAN AND IMPLEMENTATION:		
	TRANSFERRED TO: <input checked="" type="checkbox"/> PACU <input type="checkbox"/> OP <input type="checkbox"/> ROOM VIA: <input type="checkbox"/> BED <input checked="" type="checkbox"/> SLIDERAILS ↑ <input checked="" type="checkbox"/> STRETCHER		Drains/Packing:	
	<input type="checkbox"/> ICU <input type="checkbox"/> ER <input type="checkbox"/> HOLDING <input type="checkbox"/> RESTRAINTS <input type="checkbox"/> OTHER: _____		Secured As Prescribed	
	ACCOMPANIED BY: <input type="checkbox"/> PAA <input type="checkbox"/> SURGEON <input checked="" type="checkbox"/> CRNA <input checked="" type="checkbox"/> NURSE <input type="checkbox"/> ANESTHESIOLOGIST			
	LEVEL OF CONSCIOUSNESS: <input checked="" type="checkbox"/> AWAKE / SEDATED <input type="checkbox"/> UNRESPONSIVE <input type="checkbox"/> RESPONSIVE TO STIMULI			
	OTHER: <input checked="" type="checkbox"/> CONDITION STABLE <input type="checkbox"/> EKG MONITOR <input type="checkbox"/> SKIN CONDITION, UNCHANGED			
	<input type="checkbox"/> OTHER OBSERVATIONS: _____			
	DISCHARGE FROM OR: <input checked="" type="checkbox"/> PRESSURE AREAS CHECKED <input type="checkbox"/> PATIENT DRESSING DRY AND CLEAN			
	<input type="checkbox"/> TUBES AND DRAINS SECURED <input type="checkbox"/> IMMOBILIZER			
MEDICATIONS:	TIME	ROUTE	ADMINISTERED BY	
Unpsi Ursyn 3 Iams. Cefazolin 1 gm in 250cc N/S as irrigant & to soak Davol plug prior to implantation Maccaine 0.25% 1 cc used	11/12/99 11/12/99 top	IV top	anesthesia Dr. Moore Dr. Moore	
NURSE'S NOTES				
SCD hose kept inflated on arrival & D/C prior to D/C to PACU.				
REPORT TO NURSE: <input checked="" type="checkbox"/> PACU <input type="checkbox"/> OPNU <input type="checkbox"/> FLOOR RN OR NURSE GIVING REPORT: 				
PRIMARY CIRCULATING NURSE SIGNATURE: 				
□ PT. CARE CONSISTENT w/ PERI-OPERATIVE PLAN OF CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO EXPLAIN: Warm sheets kept in OR & in PACU				

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**OR HOLDING AREA  
 NURSING NOTES**

ADDRESSOGRAPH OR PT. STICKER

Date: <u>11/12/99</u>	Time In: <u>0700</u>	Time Out: <u>0700</u>
Transported by: <u>John Small</u>	<input type="checkbox"/> O2 @ _____ L	
Accompanied by: <input checked="" type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> None		
Transported via: <input type="checkbox"/> Stretcher <input type="checkbox"/> Bed <input type="checkbox"/> Other		
LOC: <input checked="" type="checkbox"/> Alert/Awake <input type="checkbox"/> Drowsy <input type="checkbox"/> Difficult to arouse <input type="checkbox"/> Unresponsive <input type="checkbox"/> Anxious <input type="checkbox"/> Confused		
PRE-OP GIVEN: Time <u>0535</u>	<input type="checkbox"/> No	<input type="checkbox"/> N/A

ALLERGIES: NKA

**STANDARD OF CARE:**

1. Preoperative Assessment
2. Age Specific Interventions
3. Safety
4. Vital Sign Deviations
5. Test Deviations

NPO: <input type="checkbox"/> Yes If no _____	NO	N/A	Initials
ID Band: <input type="checkbox"/> Pt. Name <input type="checkbox"/> Acct. #			<u>S</u>
Anes. Consult: <input type="checkbox"/> On Chart <input type="checkbox"/> In H.A. <input type="checkbox"/> Called _____ In H.A.			<u>C</u>
Consent Complete: <input type="checkbox"/> Date <input type="checkbox"/> Signature/Witness <input type="checkbox"/> Correct Procedure			<u>F</u>
History & Physical: <input type="checkbox"/> On Chart <input type="checkbox"/> Dictated <input type="checkbox"/> Old Chart			<u>K</u>
Diagnostic test complete and on the chart: <input type="checkbox"/> Old Chart	YES	NO	N/A Initials
LAB: <input type="checkbox"/> CBC <input type="checkbox"/> LYTES <input type="checkbox"/> BS <input type="checkbox"/> U/A <input type="checkbox"/> Other <input type="checkbox"/> T&S <input type="checkbox"/> T&C <input type="checkbox"/> Result on Computer	<u>/</u>	<u>/</u>	<u>1</u>
EKG:	<u>/</u>	<u>/</u>	<u>1</u>
X-RAY: <input type="checkbox"/> Chest <input type="checkbox"/> Other _____	<u>/</u>	<u>/</u>	<u>1</u>
Remove or document if intact:	None	Secured	Removed Initials
A. Jewelry: Type: _____	<u>/</u>	<u>/</u>	<u>8</u>
B. Glasses/Contacts: <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	<u>/</u>	<u>/</u>	<u>8</u>
C. Hearing Aid: <input type="checkbox"/> AD <input type="checkbox"/> AS <input type="checkbox"/> AU	<u>/</u>	<u>/</u>	<u>8</u>
D. Dentures/Partials: <input type="checkbox"/> In Cup sent to _____	<u>/</u>	<u>/</u>	<u>8</u>
Disposition of personal items: <input type="checkbox"/> N/A <input type="checkbox"/> Security <input type="checkbox"/> Family <input type="checkbox"/> Floor Other _____ Name of person receiving: _____	<u>/</u>	<u>/</u>	<u>8</u>
Hose: <input type="checkbox"/> N/A <input checked="" type="checkbox"/> SCD <input type="checkbox"/> TED <input type="checkbox"/> ON <input type="checkbox"/> Applied in H.A. Brand <u>Knuocell</u> Lot # _____	<u>/</u>	<u>/</u>	<u>8</u>
Urinary: <input type="checkbox"/> N/A <input type="checkbox"/> Voided <input type="checkbox"/> Catheter <input checked="" type="checkbox"/> Diaper Thermal: <input type="checkbox"/> Blanket <input type="checkbox"/> Boots applied in H.A.	<u>/</u>	<u>/</u>	<u>8</u>
Personal Attire: <input type="checkbox"/> N/A <input type="checkbox"/> Socks <input type="checkbox"/> Underwear <input type="checkbox"/> Other	<u>/</u>	<u>/</u>	<u>8</u>

IV Fluids: <input checked="" type="checkbox"/> On Arrival <input type="checkbox"/> Started in H.A. <input type="checkbox"/> IV Pump <input type="checkbox"/> IV clamped off <input type="checkbox"/> Xylocaine for IV 0.5% plain <input type="checkbox"/> 1000cc <input type="checkbox"/> 500cc <input type="checkbox"/> Hep Lock _____ cc _____ cc _____ cc
<input checked="" type="checkbox"/> RL <input type="checkbox"/> D5W <input type="checkbox"/> D5 1/2 NS <input type="checkbox"/> D5LR with <u>8cc</u> @ KVO rate <input checked="" type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> 18G <input type="checkbox"/> 20G <input type="checkbox"/> 22G <input type="checkbox"/> 24G Attempt x _____
Condition of IV - Running Well: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Restarted: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Flushed: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Positional: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Site of IV: <input checked="" type="checkbox"/> No sign of inflammation <input type="checkbox"/> Redness <input type="checkbox"/> Swelling <input type="checkbox"/> Tenderness expressed <input type="checkbox"/> Discontinued
Piggyback: _____ <input type="checkbox"/> Infusing <input type="checkbox"/> Hung by (initials) _____
Piggyback: _____ <input type="checkbox"/> Infusing <input type="checkbox"/> Hung by (initials) _____
Time: <u>0636</u> Signature: <u>John Small</u>

Medications: <input type="checkbox"/> IV Push <input type="checkbox"/> IM <input type="checkbox"/> SQ <input type="checkbox"/> Other _____ Time _____ N/A
<input type="checkbox"/> Robinul _____ <input type="checkbox"/> Versed _____ <input type="checkbox"/> Fentanyl _____ <input type="checkbox"/> Zofran _____
<input type="checkbox"/> Tetracaine 0.5% 4 (four) gtt. <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU @ _____ <input type="checkbox"/> Other _____
If Eye Block complete: <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU @ _____ per Dr. _____

Nursing Notes: <input type="checkbox"/> Old Chart to OR	Time: <u>0636</u>	02 SAT	B/P: <u>136/77</u>	Pulse: <u>84</u>	Temp: <u>96.5</u>

SIGNATURE: <u>John Small</u>	INITIALS: <u>8</u>	SIGNATURE: <u>Kathleen</u>	INITIALS: <u>TC</u>
SIGNATURE: <u>John Small</u>	INITIALS: <u>8</u>	SIGNATURE: <u>Kathleen</u>	INITIALS: <u>TC</u>

Date: \_\_\_\_\_

Name: Name: John Brown

D.O. Account No: 12345

Attending Physician: Jeff T. Moore, M.D.

SS #: Consulting Physician

Dr.: Adm Date: 11/12/1999 DOB: 09/10/44

Community General Hospital

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### OPERATING ROOM COUNT SHEET

**INSTRUMENT COUNT**

TYPE	Pre-Op	Addition	1st	2nd	TYPE	Pre-Op	Addition	1st	2nd
Allis - Regular	10				Scissors	4			
- Long					Sponge Stick	2			
Ped. Allis - Short					Tennaculum				
- Long					Towel Clips				
Babcocks	4				Vanderbilts				
Bulldogs					Vascular Clamps				
Groove & Probe					Zeplins				
Heaney					Z-Clamps				
Hemostat- Curved	8				<b>RETRACTORS</b>				
- Straight					ABD - Round or REg.				
Common Duct Dilators					- Blades				
Kelly- Regular	10				- Screws				
- Long					Army - Navy	2			
Kidney Clamps					Deavers	2			
Knife Handles	2				Gelpi				
Kochers - Short	4				Rakes	4			
- Long					Ribbons	1			
- Curved					Richardson	4			
Leahays					Vein Retractors	2			
Mosquitoes	4				Mathews / Senn				
Needle Holders	4				Gomez / Upper Hand				
Pennington Clamps					Weitlaner	2			
Pickups	8				Chest Tray				
Potts					<b>SUCTIONS</b>				
Randal Stone Forceps					Pool				
Rt. Angles	4				Yankauer / T&A				
Rings					Frasier				
Trocars					Bull Ret	2			

 Not Applicable    Correct    Unresolved

COUNT SIGNATURES ON O.R. RECORD

**SPONGE / SHARP COUNT**

TYPE	PRE-OP	ADDITIONS	CLOSING POST-OP		
			ORGAN/CAVITY	PERITONEAL/FASCIAL	SKIN
Raytex	10				
Laps	5				
Appendix					
Pushers	5				
U-tapes					
Shods					
Tonsil					
Cotton-balls					
Cottonoids					
Vessel loops					
Blades	2	21 22 23 24 25 26 27			
Needles Total	17 + 2	19 + 2 + 2 + 2 + 2 + 1 + 1 + 1			
	<input type="checkbox"/> Correct	<input type="checkbox"/> Unresolved	COUNT SIGNATURES ON O.R. RECORD		
(SUTURE PACKS 8 Pk)		Single 9 + 2 + 2 + 2	Ties 4	2 Pk	3 Pk

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D.R.

# **Community General Hospital**

## **Anytown, USA**

## **PRE-OPERATIVE CHECKLIST**

**INSTRUCTIONS:** Nurse who sends patient to O.R. is responsible for reviewing form for completeness and signing patient out to surgery.

	CHECK AS APPROPRIATE		INITIALS
	YES	NO	
1. Is the patient an observation patient? . . . . .	<input type="checkbox"/>	<input checked="" type="checkbox"/>	SM
If yes, notify extension 4115 of name and account number. (Quality case management)	<input type="checkbox"/>	<input type="checkbox"/>	KC
2. Admission sheet on chart. . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SM
3. Informed consent completed (No abbreviation. Signed, witnessed, dated within 30 days) . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SM
4. Advanced Directive checklist completed and on chart . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SM
5. If applicable: STATEMENT OF REFUSAL (BLOOD, etc.) on chart . . . . .	<input type="checkbox"/>	<input checked="" type="checkbox"/>	SM
6. For OPNU: Anesthesia record complete and on the chart . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SM
All other areas: Stamped Anesthesia record on chart. (CRNA will leave at bedside for Anesthesiologist.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	SM
7. History and Physical - <input type="checkbox"/> On Chart (Within 15 days for IP; within 30 days for OP) . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SM
8. Allergies noted. Front of chart flagged . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SM
9. Diagnostic test completed and results on chart: <input checked="" type="checkbox"/> CBC <input checked="" type="checkbox"/> Lytes <input checked="" type="checkbox"/> BS <input checked="" type="checkbox"/> U/A <input checked="" type="checkbox"/> EKG <input type="checkbox"/> Pregnancy <input checked="" type="checkbox"/> PTT <input checked="" type="checkbox"/> PTT <input checked="" type="checkbox"/> BUN <input checked="" type="checkbox"/> Creatine . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SM
10. Physician notified of abnormal test results/vital signs . . . . .	<input type="checkbox"/>	<input checked="" type="checkbox"/>	SM
11. Height and weight documented . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SM
12. Prep done; by whom: <u>patient</u> . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SM
13. Enema given; by whom: . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SM
14. Pre-op bath; by whom: <u>patient</u> . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SM
15. NPO after <u>mid</u> o'clock except for medication as ordered . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>	KC
16. Identification band on & checked for accuracy . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>	KC
17. Check appropriate: status for each item . . . . .	Removed	Disposition	
A. <input type="checkbox"/> Dentures <input type="checkbox"/> Partials	<input type="checkbox"/>	<input type="checkbox"/>	SM
B. Prosthesis (type) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	SM
C. Hearing Aide (Removed for General Anesthesia cases only)	<input type="checkbox"/>	<input type="checkbox"/>	SM
D. Glass eye (leave in unless instructed otherwise)	<input type="checkbox"/>	<input type="checkbox"/>	SM
E. <input type="checkbox"/> Contacts <input type="checkbox"/> Glasses <input type="checkbox"/> Implant lens	<input type="checkbox"/>	<input type="checkbox"/>	KC
F. <input type="checkbox"/> Hair piece <input type="checkbox"/> Hair pins	<input type="checkbox"/>	<input type="checkbox"/>	SM
G. <input type="checkbox"/> Jewelry (Removed from all body parts)	<input type="checkbox"/>	<input type="checkbox"/>	KC
H. <input type="checkbox"/> Wedding band: <input type="checkbox"/> Removed <input type="checkbox"/> Taped	<input type="checkbox"/>	<input type="checkbox"/>	KC
I. <input type="checkbox"/> Nail polish/Makeup removed	<input type="checkbox"/>	<input type="checkbox"/>	SM
18. Clothing removed and hospital gown on (without snaps for all areas except O.R.) . . . . .			SM
19. <input type="checkbox"/> Voided <input type="checkbox"/> Straight Cath <input type="checkbox"/> Foley Cath <input type="checkbox"/> Condom Cath			KC
20. Vital signs documented before transport to O.R. <u>97°; 132/69, 79, 18</u>			KC
21. Medication Administration Record on chart (OPNU see Nurses notes) . . . . .			KC
22. If ordered: Heparin drip off @ _____ o'clock . . . . .			SM
23. Pre-op Med administered . . . . .			KC
24. Stamp plate/label attached to chart . . . . .			KC
25. IV pump if required for special drip / pediatric patients (HAF, Heparin, etc.) . . . . .			SM
26. Checklist reviewed on unit by: _____ RN: _____			
27. Patient accepted for O.R. transport by: <u>Lisa Snall</u> Date: <u>10/21/99</u> Time: <u>1015</u>			

## **SIGNATURES / INITIALS:**

Sheila Madison / gm  
SIGNATURE / INITIAL  
\_\_\_\_\_  
SIGNATURE / INITIAL  
\_\_\_\_\_  
SIGNATURE / INITIAL

Kate Craft RN / KC  
SIGNATURE / INITIAL  
\_\_\_\_\_  
SIGNATURE / INITIAL  
\_\_\_\_\_  
SIGNATURE / INITIAL

Name: John Brown  
 Account No: 12345  
 Attending Physician: Jeff T. Moore, M.D.  
 Consulting Physician

Adm Date: 11/12/1999 DOB: 09/10/44

## PRE-ANESTHETIC QUESTIONNAIRE

The following set of questions have been designed for use by the Department of Anesthesia. They are to be completed on the day before your operation. Please answer each question carefully and return the completed sheet to the nurse as soon as possible.

**To be filled out by patient or for patient by responsible person.**

Age 55 Approx. Weight 185 Approx. Height 5'9"

Circle below if you have or have ever had. NOTICE! USE BALL POINT PEN ONLY.

SYSTEM REVIEW

PATIENT HISTORY

MEDICATIONS

ANESTHESIOLOGIST USE ONLY

**RESPIRATORY SYSTEM**

- 1) Asthma / Wheezing
- 2) Emphysema
- 3) Bronchitis
- 4) Shortness of Breath
- 5) Cough
- 6) Smoke? Yes  No  When did you quit? \_\_\_\_\_
- 7) Packs per day 6 How Many Years? 10 years
- 8) Lung Surgery
- 9) Collapsed Lung
- 10) Date Last Chest X-Ray
- 11) Do you currently have a cold? Yes  No
- 12) TB
- 13) Other \_\_\_\_\_

**CIRCULATORY SYSTEM**

- 1) Heart Attack
- 2) Angina or Chest Pain
- 3) Heart Failure
- 4) Heart Surgery
- 5) Irregular Heart Beat
- 6) Mitral Valve Prolapse
- 7) Rheumatic Fever
- 8) Date Last EKG \_\_\_\_\_ Done where? \_\_\_\_\_
- 9) Surgery on blood vessels   
(Carotid, Aorta, Leg Vessels, etc.)
- 10) Heart Murmur
- 11) High Blood Pressure
- 12) Other \_\_\_\_\_

**CENTRAL NERVOUS SYSTEM**

- 1) Stroke
- 2) Paralysis
- 3) Seizures / Epilepsy
- 4) Weakness of Arm or Leg
- 5) Surgery on Spine or Brain
- 6) Motion Sickness
- 7) Spinal Cord Injury
- 8) Black-Out Spells
- 9) Mental Illness
- 10) Other \_\_\_\_\_

**Have You Had or Do You Have**

- 1) Liver Problems   
(Cirrhosis, Hepatitis, Jaundice)
- 2) Kidney Problems
- 3) Diabetes
- 4) Thyroid Disease
- 5) Sickle Cell Disease  O2C
- 6) Reflux of Food or Hiatal Hernia
- 7) Do you Drink Alcohol? Yes  No   
How Much? moderate
- 8) Joint Prosthesis
- 9) Known AIDS Antibody
- 10) Problems w/ blood clotting? Yes  No
- 11) Cancer
- 12) Chemotherapy
- 13) Radiation Therapy
- 14) Other \_\_\_\_\_

- 1) Do you lack full range of motion in any joints (including jaw)? Yes  No   
Explain \_\_\_\_\_
- 2) Do you have loose or false teeth, partial plate, caps or bridgework? Yes  No   
Explain Pearl Crown ↑
- 3) Have you or any family member ever had problems from anesthesia? Yes  No   
Explain \_\_\_\_\_
- 4) When was your last anesthetic? BLH 1992
- 5) Could you be pregnant? Yes  No

**List Medications You Take at Home**

- 1) Goodys
- 2) Ginger
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_
- 8) \_\_\_\_\_
- 9) \_\_\_\_\_
- 10) \_\_\_\_\_
- 11) \_\_\_\_\_
- 12) \_\_\_\_\_
- 13) \_\_\_\_\_
- 14) \_\_\_\_\_
- 15) \_\_\_\_\_

**DRUG / ALLERGIES**

- None
- 1) \_\_\_\_\_
  - 2) \_\_\_\_\_
  - 3) \_\_\_\_\_
  - 4) \_\_\_\_\_

NPO Yes  No

DO YOU HAVE A HISTORY OF SLEEP APNEA? YES  NO

ASA CLASSIFICATION:

1  2  3  4  5  E

TYPE ANESTHESIA PLAN:

Opium

AIRWAY OK Yes  No

REVIEWED BY:

BT

DATE:

11/14/00

NOTES: \_\_\_\_\_

# PERI-OPERATIVE/PROCEDURE TEACHING RECORD

Name: John Brown  
 Account No: 12345  
 Attending Physician: Jeff T. Moore, M.D.  
 Consulting Physician

Adm Date: 11/12/1999 DOB: 09/10/44

SOUTH  
GEORGIA  
MEDICAL  
CENTER

SHIFT INIT	SHIFT INIT
Unclear Issue	

LEARNER:  Patient  S/O  Other (specify):

NAME		RELATIONSHIP			
BOOKLETS GIVEN	DATE	INIT	VIDEOS SHOWN	DATE	INIT

**SPECIAL LEARNING NEEDS:** Indicate any physical or cognitive limitations, language barrier, emotional barrier.

SURGERY/PROCEDURE <i>Cl. dig fix 3</i>	✓ IF TEACHING NEEDED	PRE PROCEDURE			POST PROCEDURE			REINFORCEMENT		
		DATE	INITIALS	RESPONSE PATIENT S/O	DATE	INITIALS	RESPONSE PATIENT S/O	DATE	INITIALS	RESPONSE PATIENT S/O
A. NPO <i>p. m.</i>	✓	11/10	Dn	A						
B. Preparation of Operation/Procedure site	✓	L	D	A						
C. Enema/Laxative										
D. HS & Pre-Op/Procedure Medicines	✓	11/10	Dn	A						
E. Anesthesiologist Visit	✓									
F. Removal/Storage of Valuables/Prostheses	✓	L	D	A						
G. Removal of Nailpolish & Makeup										
H. <del>Voiding/Foley Cath</del> Surgery/Procedure	✓	11/10	Dn	A						
I. TED Hose										
J. Surgical/Procedure Waiting Area	✓	11/10	Dn	A						
K. Expectations during the procedure (noise, bright lights, personnel, equipment.)										
L. Expectations after procedure (monitoring of V/S, dressing, IV fluids, drainage tubes, pain mgmt., Need to TCDB & leg exercises.)	✓	11/10	Dn	A						
M. Activity Limitations:										
1-Bedrest										
2-TCDB, leg exercises	✓	11/10	Dn	A						
3-Up in Chair, Progressive Ambulation	✓	L	D	A						
N. Nutrition:										
1-NPO										
2-Special Diet										
O. Pain Management:										
1-Call for PRN medicines	✓	11/10	Dn	A						
2-PCA										
P. IV Fluids and Pump	✓	11/10	D	A						
Q. I & O	✓	L	D	A						
R. Drainage Tubes:										
1-Foley										
2-NGT, GT, PEG										
3-Chest tube										
4-Jackson Pratt										
5-Other (list)										
S. Telemetry										
T. Dressing Change										
U. Problems to report to Nurse (pain, SOB, N/V, difficulty voiding, tender IV site.)										

**\* USE FOR OPERATIVE/PROCEDURE USE ONLY**

Community General Hospital  
Anytown, USA

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

**OPERATIVE REPORT**

Adm Date: 11/12/1999      DOB: 09/10/44

Page 1 of 1

**PREOPERATIVE DIAGNOSIS:** Recurrent right inguinal hernia.

**POSTOPERATIVE DIAGNOSIS:** Recurrent right inguinal hernia.

**PROCEDURE PERFORMED:** Repair of recurrent right inguinal hernia,  
resection of lipoma of the cord, insertion of two  
Marlex plugs and mesh.

**SURGEON:** Jeff T. Moore, M.D.

**ASSISTANT:** Tom W. Smith, M.D.

**ANESTHESIA:** General.

**DESCRIPTION OF PROCEDURE:** Under adequate general anesthesia an incision was made in the old operative scar located in the right inguinal area through the skin and subcutaneous tissues. The external oblique was identified. The cord was identified and separated free from a large direct sac posteriorly, separated free to the inguinal wall. This was imbricated. A large Marlex plug was inserted, sutured in place to the posterior wall interrupted sutures of 2-O Vicryl. The patient was asked to cough, there was no evidence of any weakness. Above this there was a pantaloon type hernia adjacent to the cord, there was a small lipoma that was resected, submitted to pathology. Another plug was inserted adjacent to the cord which was snug. The plug was inserted, sutured to the internal crus with interrupted suture of 2-O Vicryl, the patient asked to cough, no evidence of any weakness. A segment of Marlex mesh was inserted over the cord, sutured in place above the cord and laid over the posterior inguinal canal, sutured in place with 2-O Vicryl. The patient was asked to cough, no evidence of any weakness. The cord was allow to lie over the new bed. The ilioinguinal nerve was identified on the left and preserved. The external oblique approximated with 2-O Vicryl, subcutaneous tissue approximated with 2-O plain and skin approximated with skin clips. Sponge, instrument and needle count correct.

cc: Dr. Tom Smith

D: 11/12/1999

T: 11/15/1999

ams

Jeff T. Moore, M.D.



Community General Hospital  
Anytown, USA

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

## SURGICAL PATHOLOGY REPORT

Adm Date: 11/12/1999      DOB: 09/10/44

Page 1 of 1

Case Number: S1999-008023  
Collection Date: 11/12/1999  
Received date: 11/12/1999

Ordering Physician: Jeff T. Moore  
Pathologist: Sally Johnson, M.D.  
Location: 3W 0328 P

**Physicians**  
Jeff Moore

### Clinical Information

Clinical hx: NONE GIVEN  
Pre-op: RIGHT INGUINAL HERNIA

### Specimen Submitted

HERNIA SAC

### Gross Description

Received in formalin and labeled hernia sac is a grossly identifiable encapsulated fragment of yellow fibroadipose tissue that measures 4.5 x 1.5 x 0.6 cm in widest dimensions. The specimen is cross sectioned which reveals a surface that is homogeneously balanced and encapsulated with a thin tan-brown membranous material. No ulceration, pigmentation or nodular abnormalities can be grossly identified. Representative portions submitted in one cassette.

### Diagnosis

**Soft tissue inguinal region: Hernia sac containing hemorrhage and areas of fibrosis, negative for malignancy.**

*Sally Johnson*  
Sally Johnson, M.D.  
Pathologist

# PHYSICIAN ORDERS

Name: \_\_\_\_\_  
 O.O.B.: Name: John Brown  
 Account No: 12345  
 Attending Physician: Jeff T. Moore, M.D.  
 SS #: Consulting Physician  
 Dr.: Adm Date: 11/12/1999 DOB: 09/10/44

1 AUTHORIZATION IS GIVEN FOR DISPENSING BY NON-PROPRIETARY NAME (PRODUCTS IDENTICAL IN DOSAGE FORM AND CONTENT OF ACTIVE INGREDIENT) UNDER S.G.M.C. FORMULARY MANAGEMENT SYSTEM UNLESS OTHERWISE SPECIFIED.

2 AUTOMATIC STOP ORDER      NARCOTICS  
 (7 DAYS)                    ANTIBIOTICS

Allergies: *NKA*

ORDERED

USE SEPARATE LINE FOR EACH ORDER

DATE      TIME

Check one:  inpatient     outpatient observation     CCV     CCLP

## ANESTHESIA ORDERS

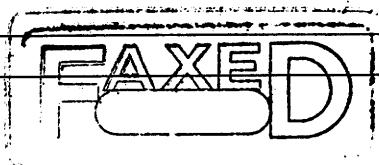
(Rev: 02/96)

01. NPO after *MN*  
 02. Clear liquids until *30 min*  
 03. AM Admissions  
 Medications to be taken prior to arrival *d*

### Other Admissions

Medications to be given prior to procedure *g*

04. Additional lab work *g*  
 05.  Glucoscan:     On Arrival     On Call    From:  Jelco  
 Venipuncture  
 Fingerstick  
 06. Other test *g*  
 07. Prior to IV start:  
 Emla cream 5gm applied to IV site 30 minutes prior to IV start on all pediatric patients 12 years and younger  
 Xylocaine 0.5% 0.25ml injection to IV site with 27G needle on all patients with IV catheter of 20 gauge or greater  
 08. Start IV on arrival with: *KVO*  
 1000ml LR at \_\_\_\_\_ ml/hour  
 1000ml D5RL at \_\_\_\_\_ ml/hour  
 \_\_\_\_\_ at \_\_\_\_\_ ml/hour  
 09.  Old chart to OR with patient  
 10. Pre-op on call to OR: *11/12/1999 2nd fl*



*Flaherty @dco 11/12/99*

# PYHICIAN'S ORDERS

DIET	AGE	WEIGHT	SEX
DIAGNOSIS			
DRUG ALLERGIES			

NAME: Name: John Brown  
ROOM NO. (ADDRESS): Account No: 12345  
HOSP. NO.: Attending Physician: Jeff T. Moore, M.D.  
PHYSICIAN: Consulting Physician

Adm Date: 11/12/1999 DOB: 09/10/44

Date & Time	Another brand of drug identical in form and content may be dispensed unless checked <input type="checkbox"/>	DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS <b>1</b>	Nurse's Initials
11/11 99	<ul style="list-style-type: none"><li>① NPO</li><li>② CBC + urine</li><li>③ Chest x-ray</li><li>④ CT/2 (H. gvt)</li><li>⑤ CMP</li><li>⑥ Protime + PTT</li><li>⑦ Prep</li><li>⑧ PSA</li><li>⑨ epidural or spinal anesthesia</li></ul>	Right ing Hernia (H&P Dictated) Recurrent	
11/12/99 0005	Phisohex Prep Dr. Moore - Have a Happy Day :- Aperche RN	JM	
11/12	<ul style="list-style-type: none"><li>① ice pack</li><li>② up when neurologically normal + alert</li><li>③ D5 ½ ns 125 cc/hr</li><li>④ VS q1h</li><li>⑤ trapeze bar II</li><li>⑥ fish net + elevate Scrotum</li><li>⑦ Keftab 800 mg po q 12 h</li><li>⑧ KUB</li><li>⑨ cath if unable to void 6-8 hrs</li></ul>	noted @ 0035 11/11/99 JM	

med C@10:45 11/12/99

# PYHICIAN'S ORDERS

DIET	AGE	WEIGHT	SEX
DIAGNOSIS			
DRUG ALLERGIES			

NAME: John Brown  
ROOM NO. (ADDRESS): Account No: 12345  
HOSP. NO.: Attending Physician: Jeff T. Moore, M.D.  
PHYSICIAN: Consulting Physician  
Adm Date: 11/12/1999 DOB: 09/10/44

Date & Time	Another brand or drug identical in form and content may be dispensed unless checked <input type="checkbox"/>	DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS <b>1</b>	Nurse's initials
11/12/99	Demerol 50 mg. IM q3hr prn pain Vistaril 50 mg. po Dr. Moore	S. Smith J.M. Lorraine Rat	
11/12/99	Lortab 10 mg po q4hr prn pain po. Dr. Moore / L Tomlin	J.M.	
11/12	Demerol 75 mg Vistaril 50 mg or Lortab 10 mg 1 g4 hr prn pain p.o. Spine care c Inst 3-4 times daily leg laxative of choice if needed	J.M.	

Day Thomas RN 11-12-99 @ 1700

# **PHYSICIAN'S ORDERS**

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

Adm Date: 11/12/1999      DOB: 09/10/44

## **Community General Hospital**

11-11-99 - 11-12-99

## MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO	Kathy Kenyon (W)	Sally Anderson (M)		( )
Brown, John	2388				( )
					( )
					( )

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician  
Adm Date: 11/12/1999 DOB: 09/10/44

Community General Hospital

11/12/99 - 11/13/99

MEDICATION ADMINISTRATION RECORD

ALLERGIES	MEDICATION ADMINISTRATION TIMES							
	7:01 - 15:00			15:01 - 23:00			23:01 -	
	TIME	SITE	INITIAL	TIME	SITE	INITIAL	TIME	SITE
Keftab 50mg po q12 <sup>o</sup>	1000 1345 po PRN			2200 po PRN				
Demerol 50mg Vistaril 50mg	IM q3 <sup>o</sup> PRN pain						1000 11/12/99	
Loratad 10 po q4hr PRN	AT PRN			1700 Tpo PRN	0025 p			0445 p
Demerol 75 mg Vistaril 50 mg	IM q3 hr PRN	AT PRN						
Location of chart if needed	AT							
PATIENT NAME	BED NO.	Lan Courtney (LW)	Deb Garris (DG)	Andy Tomash (AT)				
Brown, John	238B	Katy Davis (KD)	( )	( )	( )	( )	( )	( )

Community General Hospital  
Anytown, USA

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

Adm Date: 11/12/1999 DOB: 09/10/44

### Graphics Flowsheet

DATE:		11/11				Admit				11/12				11/13				11/14			
		04	08	12	16	20	24	04	08	12	16	20	24	04	08	12	16	20	24		
TEMPERATURE	104																				
	103																				
	102																				
	101																101.6				
	100																100.3				
	99																99.7				
	98																98.9				
	97																	97.6			
	96																		96.7		
PULSE RATE	140																				
	130																				
	120																				
	110																				
	100																				
	90																90				
	80																82				
	70																				
	60																				
RESP	40																				
	30																				
	20																20				
B/P																	134/79				
PAIN RATING (0-10)																		96	96		
																	120/75	159	154/159		
																	159	159/152	159/152		
INTAKE AND OUTPUT	WT																				
	SpO <sub>2</sub>																				
	INTAKE	0600-1800		1800-0600		0600-1800		1800-0600		0600-1800		1800-0600		0600-1800		1800-0600					
	DIET/SNACK %					SNACK 1						SNACK 1				SNACK 1					
						2						2				2					
						3						3				3					
	ORAL																				
	IV																				
	BLOOD																				
	SHIFT																				
	24 HR TOTAL																				
	OUTPUT	0600-1800		1800-0600		0600-1800		1800-0600		0600-1800		1800-0600		0600-1800		1800-0600					
	URINE/FOLEY																				
	BM																				
	HEMO DUVAL																				
	GAST SUCT																				
	EMESIS																				
	SHIFT TOTAL																				
	24 HR TOTAL																				
HYGIENE	AM		PM		AM		PM		AM		PM		AM		PM						
	BATHING																				
	ORAL CARE																				
	PERICARE																				
	LOTION RUB																				
ACTIVITY	REPOSITION																				
	EDGE OF BED																				
	UP IN C																				
	AMBULATION																				

# **Community General Hospital**

## **Anytown, USA**

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician:

Adm Date: 11/12/1999      DOB: 09/10/44

# PATIENT ADMISSION ASSESSMENT

Date 11/10/99 Time 1600 Admit from: Dr. Office ER Home Other Health Care Facility: \_\_\_\_\_

Reason for Admission: (Patient's own words) Hernia Surgery

Primary Care Physician: J. Moore

**Previous Health Problems (Patient Only)**

- |                              |                          |                         |                                       |                        |
|------------------------------|--------------------------|-------------------------|---------------------------------------|------------------------|
| 1. Diabetes                  | <input type="checkbox"/> | 7. Respiratory          | <input type="checkbox"/>              | previous hernia repair |
| 2. Epilepsy/seizure disorder | <input type="checkbox"/> | 8. GU/GYN               | <input type="checkbox"/>              |                        |
| 3. High Blood Pressure       | <input type="checkbox"/> | 9. GI                   | <input type="checkbox"/>              |                        |
| 4. Heart Disease             | <input type="checkbox"/> | 10. Steroid use         | <input type="checkbox"/>              |                        |
| 5. Kidney Disease            | <input type="checkbox"/> | 11. Flu Vaccine Current | <input checked="" type="checkbox"/> N |                        |

VITALS: TEMP 96.7 PULSE 82 RESP 20 B/P 134/79 Ht 5'9" Wt 190.9 lbs

ALLERGIES

Medications \_\_\_\_\_ *N/A* Food \_\_\_\_\_ Environmental \_\_\_\_\_

Anesthetics \_\_\_\_\_ Dyes \_\_\_\_\_ Rubber/latex/balloons: Yes  No  N/A

**Other** \_\_\_\_\_

## HABITS

Tobacco: Yes No \_\_\_\_\_ per day \_\_\_\_\_ Yrs. Chew: Yes No \_\_\_\_\_ per day \_\_\_\_\_ Yrs. Other \_\_\_\_\_

Alcohol: Yes No \_\_\_\_ per day \_\_\_\_ yrs. Drug use/abuse: Yes No Type \_\_\_\_\_

**MEDICATIONS:** Brought to hospital: Y N Sent Home: Y N To Pharmacy: Y N Personal Pharmacy \_\_\_\_\_

**Orientation to room:** Call Light TV/telephone bathroom location lights meal time visitor policy

**Personal belongings kept on person or at bedside:** None Eye glasses Contacts Hearing aids Glass eye Walker Wheelchair

**Denture (Upper/Lower)      Partial (Upper/Lower)      Crutches      Clothing/Other**

**Money \$**      **(circle) Home**    **Safe**    **Kept**    **Jewelry**      **(circle) Home**    **Safe**    **Kept**

**WE ARE NOT RESPONSIBLE FOR BELONGINGS/VALUABLES. WE STRONGLY SUGGEST YOU SEND ITEMS HOME.**

I acknowledge that the above belongings are in my possession. I have received information on Advanced Directives and Organ Tissue

## PACKDOWN Donation

**Witness:** *[Signature]*

Witness JMC

## NEUROLOGICAL

Oriented X3 (person, place, time); Alert Confused  
 Psychologic: No problems Insomnia Difficulty relaxing Anxious  
 Pupils: equal reactive to light dilated WNL  
 \*Language: understands expresses clearly limited understanding poor verbal expression

Level of Consciousness: Awake Lethargic Stupor Coma

Hearing: Normal Hard of Hearing Sensitive

\*Speech: Clear Slurred Difficult Slowed

## SKIN

Skin Integrity - Good Lesion, Bruises/Abrasions (location and appearance) surgiced incision  
 Turgor: Good Fair Poor Temperature: Warm Cool Dry Hot Damp Diaphoretic  
 Color: Pink (normal for heritage) Pale Ashen Flushed Cyanotic Jaundiced

## CARDIOVASCULAR

HOB: Flat raised # of pillows WNL Vertigo: None Standing Sitting Lying Occasionally  
 Chest Pain: None Associated with Dyspnea Radiates to (Left arm, right arm, back, neck, jaw) Associated with Deep Inspiration  
 Rhythm: Regular Irregular (slightly, very) Murmur: Yes No Rate: Normal Bradycardia Tachycardia  
 Edema: (DAR note if present) Pacemaker: Yes No  
 Pulses: (R) Radial: Strong Bounding Weak Absent Noted with Doppler (R) Pedal: Present Absent Noted with Doppler  
 (L) Radial: Strong Bounding Weak Absent Noted with Doppler (L) Pedal: Present Absent Noted with Doppler

## RESPIRATORY

Respirations: Even Regular Hypoventilated Tachypneic Labored Dyspneic Stridor: Nocturnal dyspnea Congested Cheyne-Stokes  
 Cough: None Non-Productive Productive Sputum: Yes No Color: Yellow Green Clear Bloody Other \_\_\_\_\_  
 Lung Sounds: RUL: Clear Adventitious LUL: Clear Adventitious \_\_\_\_\_  
 RLL: Clear Adventitious LLL: Clear Adventitious \_\_\_\_\_  
 Night Sweats: Yes No Increased Fatigue: Yes No Recent TB skin test: Yes No, if yes reactor: Yes No  
 \*Respiratory therapy notified for abnormal assessment findings: Yes No (DAR note abnormal finding)

## GASTROINTESTINAL/NUTRITION

Bowel Sounds: Normal Hypoactive Hyperactive Absent Abdomen: Soft Firm Hard Pain \_\_\_\_\_  
 BM: Continent Incontinent Constipation Diarrhea Bloody Mucus Other: fec. BS in all 4 fund.  
 Laxative Usage: N/A Last BM: 11/11/99

## NUTRITIONAL RISK ASSESSMENT

(circle Yes or No)

*Any chewing or swallowing problems:	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Poor appetite > 3 days	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
History of cancer, diabetes, or renal disease	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Poor skin integrity	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Has > 3 alcohol drinks/day (Women) > 4 (Men)	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Surgical Patient > 70 years of age	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Recent weight gain	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	*Recent weight loss	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Open wounds, decubitus ulcers or trauma	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
*Is on a special diet/or special diet ordered	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		

\*If any "yes" answers, registered dietitian or dietary manager notified: Yes No

Speech Pathology Referral: If any \* items under neurological or nutrition please notify physician for possible speech referral order

## GENITOURINARY/REPRODUCTIVE

Urination: Continent Incontinent Normal Painful Bloody Foul Odor Frequency Urgency WNL problems  
 Last Menstrual Period: N/A Post menopausal Menses: Regular Irregular Heavy  
 Vaginal Discharge: None White Green Clear Odor Bloody Last pap smear: Prostate Problems: N/A

## MUSCULOSKELETAL

Extremities: Weakness Gait: Normal for Age Limp Stiff Unsteady Slowed WNL  
 Numbness or Tingling (circle) Back: Normal for Age Painful (low, mid, high) Radiates to leg: Yes No  
 ROM: RUE: Normal Limited RLL: Normal Limited LUE: Normal Limited LLE: Normal Limited  
 Able to walk up 4 or more steps: Yes No Limitation in ROM noted: Yes No Weakness to extremities noted: Yes No  
 Requires assistance with dressing: Yes No Requires assistance with hygiene: Yes No Requires assistance with feeding: Yes No  
 Any significant "yes" answers, please notify physician for possible rehab referral.  
 \*Rehab notified after physician's orders received: Yes No

## PAIN ASSESSMENT

Do you have pain now? Yes No Do you have chronic pain? Yes No (\*DAR note if yes)

\*If yes to either above, ask the following questions:

Where is the pain located: \_\_\_\_\_

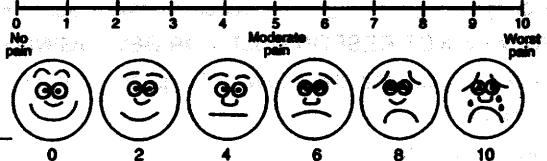
How long does the pain last: \_\_\_\_\_

Describe the pain: \_\_\_\_\_

What relieves the pain: \_\_\_\_\_

Rate the pain on a scale of 0-10 (0= no pain 10= worst pain): N/A \_\_\_\_\_

face pain scale number: N/A \_\_\_\_\_



SIGNATURE: Lisa Collins RN

62-6018-4-0803

DATE/TIME: 11/12/99

Community General Hospital  
Anytown, USA

## TRANSITION/DISCHARGE PLANNING ASSESSMENT

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

Adm Date: 11/12/1999      DOB: 09/10/44

### COMMUNITY SERVICES:

ON ADMISSION  
 Home/Apartment  
Lives Alone  
Lives with Family  
Supervised Living  
Long Term Care

### CURRENTLY RECEIVING

Home Health Care  
 Homemaker  
Hospice  
Meals on Wheels

### ANTICIPATED NEEDS/SERVICES UPON DISCHARGE

Financial  
Transportation  
Adult Day Care  
Swing Bed  
Home Health  
Lifeline

PT/OT  
Long Term Care  
Cardio/Pulmonary Rehab  
Hospice  
Supervised Living  
Move in with Family

### DURABLE MEDICAL EQUIPMENT:

Has  Needs \_\_\_\_\_

### DISCHARGE PLANNING:

Are you currently able to care for yourself at home?

Yes

No if no, explain: \_\_\_\_\_

Do you plan to return to your home after discharge?

Yes

No if no, explain: \_\_\_\_\_

Will you have someone to assist you when you leave the hospital?

Yes

No

### ADVANCE DIRECTIVES: (circle those that apply)

Information Packet Given:  Yes  No Social Services Notified:  Yes  No  N/A

Living Will: Copy on Chart:  Yes  No

Power of Attorney: Copy on Chart:  Yes  No

Organ/Tissue Donor:  Yes  No

### FAMILY INVOLVEMENT/CARE GIVERS:

Patient support systems  Spouse  Parent(s)  Children  Friend  Neighbor How many hours/day? \_\_\_\_\_  
Name/Phone of support person: \_\_\_\_\_

### BEHAVIORAL/SOCIAL/COGNITIVE FACTOR:

Are you currently receiving treatment for emotional or behavioral problems?  Yes  No

Do you have any special cultural or spiritual practices that we should know about in order to better meet your needs here?

No  Yes, explain: \_\_\_\_\_

### PATIENT EDUCATIONAL NEEDS:

How do you learn best? (circle) Reading Discussion Hands On Video Diagrams Audio Tapes Listening

Readiness to learn: (circle) Receptive Poor What language(s) do you read, write and understand: English

Are you still in school?  Yes  No Is the school and/or your teacher aware of your hospitalization?  Yes  No

### COPING:

Do you have concerns or fears regarding this hospitalization?  No  Yes If yes, explain \_\_\_\_\_

### CARE COORDINATION/SOCIAL SERVICE SCREENING:

Circle as appropriate:

- Clients with no identifiable support system; homeless; transient Yes  No
- Elderly patients, age 70 or older, living alone, or with a no-capable caregiver Yes  No
- Suicide attempt/ideation Yes  No
- Suspected chemical dependency Yes  No
- Clients with no identifiable source of medical payment Yes  No
- High Risk Obstetrical (unmarried, pregnant minors, high risk or complicated pregnancy) Yes  No
- Potential or actual history of noncompliance with health care plan Yes  No
- Clients admitted with high risk diagnosis (example: COPD, CHF, Diabetes) Yes  No
- Suspected victim of abuse (see below) Yes  No

For any 'Yes' answers above, please notify Care Coordination Department and/or Social Service Department

Signature \_\_\_\_\_

Date/Time: \_\_\_\_\_

# **Community General Hospital**

## **Anytown, USA**

## **DISCHARGE INSTRUCTION SHEET**

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

Adm Date: 11/12/1999      DOB: 09/10/44

<b>Education/Handouts Given:</b>	<b>Special Instructions:</b>
<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NA	Primary Diagnosis
<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NA	Wound Care
<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NA	Daily Weight
<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NA	Smoking cessation
<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NA	Vaccines—information (Influenza, Pneumococcal)
<hr/>	
<b>NUTRITION</b>	
Diet <u>Regular</u>	<b>Special Instructions:</b>
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Meals On Wheels Ordered	<hr/> <hr/> <hr/>
Special Instructions: <u>NA</u>	<hr/> <hr/> <hr/>
<b>Activities:</b>	
<input type="checkbox"/> YES <input type="checkbox"/> NO Resume Usual Activities	<hr/> <hr/> <hr/>
Special Instructions: <u>NA</u>	<hr/> <hr/> <hr/>
<hr/>	
<b>Follow up Care:</b>	
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA	Dr. Appointment <u>pt. to make appt. w/ J. Moore</u>
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> NA	Lab/X-Ray _____
<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NA	Therapy Services _____
<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NA	Home Care (Provider List) _____
<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NA	Equipment/Supplies (Provider List) _____
<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NA	Transportation Arranged _____
Special Instructions: _____	<hr/> <hr/> <hr/>

**Patient Signature/Date:** John Brown

**Person Giving Instructions/Date:** Glenn Lewis

**Physician Signature/Date:**  / 10/2023

**DISCHARGE CHECKLIST:**

- ADMISSION CONSENT SIGNED  
 IMPORTANT MESSAGE TO MEDICARE PATIENTS  
 BILL OF RIGHTS  
 BLADDER FUNCTIONING (if not - addressed)  
 RECENT BM (if not, education done)

# 24 HOUR NURSING CARE FLOW SHEET

DATE: 11/11/99

SPACES LEFT BLANK INDICATE CONDITION NOT APPLICABLE AT THAT TIME

SHIFT INIT	NURSE SIGNATURE	SHIFT INIT	NURSE SIGNATURE
<u>955</u>	<u>Sally Madison RN</u>		

Name: John Brown  
 Account No: 12345  
 Attending Physician: Jeff T. Moore, M.D.  
 Consulting Physician  
 Adm Date: 11/12/1999 DOB: 09/10/44

ASSESSMENT	7-3	3-11	11-7	ASSESSMENT	7-3	3-11	11-7	ASSESSMENT	7-3	3-11	11-7	
			<u>2400</u>				<u>2400</u>					
NEURO/MENTAL STATUS	AWAKE			BATH / HYGIENE	ENEMA			TUBES	NG / PEG			
	ALERT				INCONTINENT					PLACEMENT		
	ORIENTED				COMPLETE BATH					RESIDUAL		
	CONFUSED				PARTIAL ASSISTANCE					IRRIGATION		
	APPARENTLY SLEEPING				SELF HYGIENE					SUCTION TYPE:		
	LETHARGIC				ORAL CARE GIVEN					CHEST TUBE		
SEIZURE PRECAUTIONS			SITZ				CATH: <input type="checkbox"/> FOLEY					
RESPIRATORY	LUNGS: CLEAR			PERICARE				<input type="checkbox"/> SUPRA				
	COARSE			CATH CARE BID				MURPHY DRIP				
	COUGH			BEDREST				HEMODIALYSIS/PERITONEAL				
	CHARACTER: LABORED			UP IN CHAIR / DANGLE				TRACTION: (TYPE)				
	UNLABORED			BRP / BSC				OTHER:				
	COUGH & DEEP BREATHE			UP AD LIB								
PULSE OXIMETER			AMBULATE									
O <sub>2</sub> LITER VIA			TURN Q 2 HRS									
CARDIOVASCULAR	HEART: REGULAR			ROM								
	IRREGULAR			ID BAND								
	CIRCULATION EXTREMITIES: PRESENT			SIDE RAILS - UP								
	ABSENT			SIDE RAILS - REFUSED								
	EDEMA			BED IN LOW POSITION								
	MUCOUS MEMBRANE: (P) Pink (C) Cyanotic			CALL BELL IN REACH								
SKIN: WARM			TYPE RESTRAINTS									
DRY			CIRC. ✓									
MOIST			ISOLATION DRESSING									
GI	MONITOR: TELEMETRY			DRY & INTACT								
	ABD: BOWEL SOUNDS: PRESENT			SUTURES/STAPLES								
	ABSENT			DRESSING CHANGE								
	SOFT			DRAINAGE								
	DISTENTION			OSTOMY								
	INITIALS		<u>S 3200</u>									

*See admission assessment*

SPECIMEN SENT		DIAGNOSTIC TEST OR THERAPY		TIME OUT	TIME IN

FALL ASMT. CRITERIA

- Multiple Medications, Antidepressant, Narcotics, Sedatives, Antihypertensive, Seizure Drugs ..... 1
- Impairment of Hearing, Vision, Sensory Deficit of Extremities ..... 1
- Confusion, Language Barrier, Agitation, Risk Taking, Unfamiliar Surroundings, Short Term Memory Loss ..... 1
- Seizure Disorder, Substance Abuse, Loss of Consciousness, Orthostatic Hypotension, Parkinsons, Cardiac Dysrhythmia ..... 1
- Weakness, Hx of Previous Falls, Impaired Muscular Control, Less than 24 Hours Post-op ..... 1
- Greater than 75 Years ..... 1
- Other Refer to 24 H Nursing Flowsheet

INSTRUCTIONS: If points total 15 or more, implement Fall Risk Plan. Score Each Shift

## **INTRAVENOUS THERAPY FLOW SHEET**

FLUID DOCUMENTATION

**KEY:**

CONDITION CODE:      LOCATION:      NEEDLE TYPE:

- |                                |                  |                   |
|--------------------------------|------------------|-------------------|
| ✓ - No complications           | SV - Scalp vein  | B - Butterfly     |
| A - Abnormal<br>(see comments) | C - Central line | J - Jelco         |
|                                | RH - Right hand  | CV - CVP          |
|                                | LH - Left hand   | HB - Huber        |
|                                | RA - Right arm   | HL - Heparin lock |
|                                | LA - Left arm    |                   |
|                                | RF - Right foot  |                   |
|                                | LF - Left foot   |                   |
|                                | W - Wrist        |                   |

**IV START / RESTART** (change site every 72 hours)

IV START PIGEON

#### **IV SITE INSPECTION**

7-3

3-11

11-7

I.V.	START	D/C JELCO INTACT	START	D/C JELCO INTACT	Time			
Time	0045				Location			0045
Type / Gauge Needle	20g				Condition			RA ✓
Location	RA				Dressing Change			
IV Start Kit	✓				CVP Kit			/
Other / # Attempts	X	Site:		Site:	Other			
Initials	SM				Initials			SM

## **NEUROLOGICAL CHECK LIST**

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

Adm Date: 11/12/1999      DOB: 09/10/44

**D = Data      A = Action      R = Response**

SHIFT INIT	NURSE SIGNATURE	SHIFT INIT	NURSE SIGNATURE
9:30 AM	Dally Madison		

## 24 HOUR NURSING CARE FLOW SHEET

DATE: 11/12/99

SPACES LEFT BLANK INDICATE CONDITION NOT APPLICABLE AT THAT TIME

Name: John Brown  
 Account No: 12345  
 Attending Physician: Jeff T. Moore, M.D.  
 Consulting Physician

Adm Date: 11/12/1999 DOB: 09/10/44

SHIFT INIT	NURSE SIGNATURE	SHIFT INIT	NURSE SIGNATURE
7-3 <i>L Cenler RN</i>	11-7 <i>Tom Gardner RN</i>	7-3 <i>Andria Shandee RN</i>	11-7 <i></i>
3-11 <i></i>	11-7 <i></i>	3-11 <i></i>	11-7 <i></i>

NEURO/MENTAL STATUS	ASSESSMENT			ELIM.	BATH / HYGIENE	ACTIVITY LEVEL	SAFETY	WOUND CARE	ASSESSMENT			TUBES	PROCEDURES	EQUIPMENT / MISC.	FALL ASMT. CRITERIA	TIME OUT	TIME
	7-3	3-11	11-7						7-3	3-11	11-7						
AWAKE	✓	✓	✓		ENEMA					NG / PEG							
ALERT	✓	✓	✓		INCONTINENT					PLACEMENT							
ORIENTED	✓	✓	✓		COMPLETE BATH					RESIDUAL							
CONFUSED					PARTIAL ASSISTANCE					IRRIGATION							
APPARENTLY SLEEPING					SELF HYGIENE				✓	SUCTION TYPE:							
LETHARGIC					ORAL CARE GIVEN					CHEST TUBE							
SEIZURE PRECAUTIONS					SITZ					CATH: <input type="checkbox"/> FOLEY							
LUNGS: CLEAR			✓		PERICARE					<input type="checkbox"/> SUPRA							
COARSE	✓		✓		CATH CARE BID					MURPHY DRIP							
COUGH					BEDREST					HEMODIALYSIS/PERITONEAL							
CHARACTER: LABORED					UP IN CHAIR / DANGLE					TRACTION: (TYPE)							
UNLABORED	✓	✓	✓		BRP / BSC					OTHER:							
COUGH & DEEP BREATHE			✓		UP AD LIB	✓	✓	✓		TCDB							
PULSE OXIMETER					AMBULATE					Spiracura							
O <sub>2</sub> LITER VIA					TURN Q 2 HRS												
HEART: REGULAR	✓	✓	✓		ROM												
IRREGULAR					ID BAND	✓	✓	✓									
CIRCULATION EXTREMITIES: PRESENT	✓	✓	✓		SIDE RAILS - UP	✓	✓	✓									
ABSENT					SIDE RAILS - REFUSED												
EDEMA					BED IN LOW POSITION	✓	✓	✓									
MUCOUS MEMBRANE: (P) Pink (C) Cyanotic	✓	P	P		CALL BELL IN REACH	✓	✓	✓									
SKIN: WARM	✓	✓	✓		TYPE RESTRAINTS												
DRY	✓	✓	✓		CIRC. ✓												
MOIST					ISOLATIONDRESSING												
MONITOR: TELEMETRY					DRY & INTACT	✓	✓	✓									
ABD: BOWEL SOUNDS: PRESENT	✓	Hypo	Hypo		SUTURES/STAPLES												
ABSENT					DRESSING CHANGE												
SOFT	✓	✓	✓		DRAINAGE												
DISTENTION					OSTOMY												
INITIALS	✓	AT	TS						✓	AT	TS						

SPECIMEN SENT

DIAGNOSTIC TEST OR THERAPY

Multiple Medications, Antidepressant, Narcotics, Sedatives, Antihypertensive, Seizure Drugs  
 Impairment of Hearing, Vision, Sensory Deficit of Extremities  
 Confusion, Language Barrier, Agitation, Risk Taking, Unfamiliar Surroundings, Short Term Memory Loss  
 Seizure Disorder, Substance Abuse, Loss of Consciousness, Orthostatic Hypotension, Parkinson's, Cardiac Dysrhythmia  
 Weakness, Hx of Previous Falls, Impaired Muscular Control, Less than 24 Hours Post-op  
 Greater than 75 Years  
 Other\* Refer to 24 Hr. Nursing Flowsheet  
 INSTRUCTIONS: If points total 15 or more, implement Fall Risk Plan. Score Each Shift

# INTRAVENOUS THERAPY FLOW SHEET

## FLUID DOCUMENTATION

TIME	AMOUNT	IV SOLUTIONS, ADDITIVES	RATE	TUBING $\Delta$	PUMP	INITIALS
0930	100	D5 1/2 NS	125	C C		L
1105	infusing	D5 1/2 NS	125	✓	AH	
0115	1000	D5 1/2	125	V	PW	

## KEY:

### CONDITION CODE:

### LOCATION:

### NEEDLE TYPE:

✓ - No complications  
 A - Abnormal  
 (see comments)

SV - Scalp vein  
 C - Central line  
 RH - Right hand  
 LH - Left hand  
 RA - Right arm  
 LA - Left arm  
 RF - Right foot  
 LF - Left foot  
 W - Wrist

B - Butterfly  
 J - Jelco  
 CV - CVP  
 HB - Huber  
 HL - Heparin lock

## IV START / RESTART (change site every 72 hours)

### IV SITE INSPECTION

7-3

3-11

11-7

I.V.	START	D/C JELCO INTACT	START	D/C JELCO INTACT	Time	0930	1105	0020
Time					Location	LH	RH	RA
Type / Gauge Needle					Condition	Y	✓	✓
Location					Dressing Change	Y		
IV Start Kit					CVP Kit	Y		
Other / # Attempts		Site:		Site:	Other	Y	Y	
Initials					Initials	L	AH	JF

TIME	0930	0945	1000	1015	1045	1115	1145	
BLOOD PRESSURE	110/77	110/70	114/72	115/75	120/81	114/66	138/97	
PULSE	70	70	69	66	65	62	68	
RESPIRATION	16	16	16	16	16	16	16	
VERBAL RESPONSE	ORIENTED X 3							
	CONFUSED							
	NO RESPONSE							
PUPIL REACTION	PERL							
	NON REACTIVE							
VISUAL DISTURBANCES	YES							
	NO							
HEADACHE	YES							
	NO							
SEIZURES AND TYPE	YES							
	NO							
VOMITING	YES							
	NO							
ARMS	NORMAL POWER							
	WEAKNESS							
	PARALYSIS							
LEGS	NORMAL POWER							
	WEAKNESS							
	PARALYSIS							
COMA	YES							
	NO							
NURSE'S INITIALS								

## NEUROLOGICAL CHECK LIST

Name: John Brown  
 Account No: 12345  
 Attending Physician: Jeff T. Moore, M.D.  
 Consulting Physician

Adm Date: 11/12/1999 DOB: 09/10/44

D = Data A = Action R = Response

SHIFT INIT	NURSE SIGNATURE	SHIFT INIT	NURSE SIGNATURE
3 <sup>rd</sup> D	Kim Daniels RN	11 <sup>th</sup> 78	Tam Sardar RN
13 <sup>th</sup> D	Gina Campion RN	3 <sup>rd</sup> AT	Andrea Thomas RN

TIME	FOCUS	D, A, R	FOCUS NOTES
0930	Post-op	D	Recl post-op (R) Inguinal Hernia. Drg dry & intact. Alert & oriented. VSS 70-16-98 <sup>2</sup> . IV (R) Dorn infusing 1L 0.9% NS. S/d to D 5 1/2 @ 125 as ordered. A ice pack to scrotum & fresh net Party Applied as ordered.
1028		D	C/o Pain at Surgical Area
		A	Demand 50 + U. start 50 mg. Given for some
1400		D	Still C/o Pain
		A	Lortab 10mg po given
1500		R	No Net c/o. - Not distressed - L
1700	All in Comfort	D	Pt C/o lower abd. pain
		A	Lortab 1 po given
1800		R	Pt states partial relief by discomfort
2130		D	Pt resting c eyes closed, no distress noted, drg dry/hrt IVF's infusing & difficulty, resp even/unlabored, skin w/o, continue to monitor
0020	All Comfort	D	pt c/o, incisional site pain ask for pm med - 2
		A	Lortab 1 administered po will continue to monitor & assist as needed
0200		R	resting quietly respirations even/unlabored, will continue to monitor
0415	All Comfort	D	pt. c/o incisional pain ask for pm med.
		A	Lortab 1 administered po.
0600		R	pt further c/o voiced, resting quietly, respiration even/unlabored, D 1 in pt. statis

## 24 HOUR NURSING CARE FLOW SHEET

NOV 13 1999

DATE:

SPACES LEFT BLANK INDICATE CONDITION NOT APPLICABLE AT THAT TIME

Name: John Brown  
 Account No: 12345  
 Attending Physician: Jeff T. Moore, M.D.  
 Consulting Physician

Adm Date: 11/12/1999 DOB: 09/10/44

SHIFT INIT	NURSE SIGNATURE	SHIFT INIT	NURSE SIGNATURE
7:30	L Cmead Rn		

ASSESSMENT		7-3	3-11	11-7	ELIM.	ASSESSMENT	7-3	3-11	11-7	TUBES	ASSESSMENT	7-3	3-11	11-7
NEURO/MENTAL STATUS	AWAKE	/					ENEMA							NG / PEG
	ALERT	/			INCONTINENT					PLACEMENT				
	ORIENTED	/			COMPLETE BATH					RESIDUAL				
	CONFUSED				PARTIAL ASSISTANCE	/				IRRIGATION				
	APPARENTLY SLEEPING				SELF HYGIENE					SUCTION TYPE:				
	LETHARGIC				ORAL CARE GIVEN					CHEST TUBE				
	SEIZURE PRECAUTIONS				SITZ					CATH: <input type="checkbox"/> FOLEY				
RESPIRATORY	LUNGS: CLEAR	/		PERICARE					<input type="checkbox"/> SUPRA					
	COARSE	/		CATH CARE BID					MURPHY DRIP					
	COUGH			BEDREST					HEMODIALYSIS/PERITONEAL					
	CHARACTER: LABORED			UP IN CHAIR / DANGLE	/				TRACTION: (TYPE)					
	UNLABORED	/		BRP / BSC					OTHER:					
	COUGH & DEEP BREATHE			UP AD LIB										
	PULSE OXIMETER			AMBULATE	/									
O <sub>2</sub> LITER VIA			TURN Q 2 HRS											
CARDIOVASCULAR	HEART: REGULAR	/		ROM										
	IRREGULAR			ID BAND	/									
	CIRCULATION EXTREMITIES: PRESENT	/		SIDE RAILS - UP	/									
	ABSENT			SIDE RAILS - REFUSED										
	EDEMA			BED IN LOW POSITION	/									
	MUCOUS MEMBRANE: (P) Pink (C) Cyanotic	/		CALL BELL IN REACH	/									
	SKIN: WARM	/		TYPE RESTRAINTS										
GI	DRY	/	CIRC. ✓											
	MOIST			ISOLATIONDRESSING										
	MONITOR: TELEMETRY			DRY & INTACT	/									
	ABD: BOWEL SOUNDS: PRESENT	/		SUTURES/STAPLES										
	ABSENT			DRESSING CHANGE										
	SOFT	/		DRAINAGE										
	DISTENTION			OSTOMY										
INITIALS	/													

FALL ASSESS: CRITERIA

Multiple Medications, Antidepressant, Narcotics, Sedatives, Antihypertensive, Seizure Drugs ..... 10  
 Impairment of Hearing, Vision, Sensory Deficit of Extremities ..... 5  
 Confusion, Language Barrier, Agitation, Risk Taking, Unfamiliar Surroundings, Short Term Memory Loss ..... 15  
 Seizure Disorder, Substance Abuse, Loss of Consciousness, Orthostatic Hypotension, Parkinson's, Cardiac Dysrhythmia ..... 15  
 Weakness, Hx of Previous Falls, Impaired Muscular Control, Less than 24 Hours Post-op ..... 15  
 Greater than 75 Years ..... 5  
 Other\* Refer to 24 Hr. Nursing Flowsheet

INSTRUCTIONS: If points total 15 or more, implement Fall Risk Plan.  
 Score Each Shift

SPECIMEN SENT	DIAGNOSTIC TEST OR THERAPY	TIME OUT	TIME IN

## **INTRAVENOUS THERAPY FLOW SHEET**

## FLUID DOCUMENTATION

**KEY:**

<b>CONDITION CODE:</b>	<b>LOCATION:</b>	<b>NEEDLE TYPE:</b>
✓ - No complications	SV - Scalp vein	B - Butterfly
A - Abnormal (see comments)	C - Central line	J - Jelco
	RH - Right hand	CV - CVP
	LH - Left hand	HB - Huber
	RA - Right arm	HL - Heparin loc.
	LA - Left arm	
	RF - Right foot	
	LF - Left foot	
	W - Wrist	

**IV START / RESTART** (change site every 72 hours)

IV START / RESTART (change site every 72 hours)					IV SITE INSPECTION	7-3	3-11	11-7
I.V.	START	D/C JELCO INTACT	START	D/C JELCO INTACT	Time	0730		
Time					Location	RA		
Type / Gauge Needle					Condition	✓		
Location					Dressing Change			
IV Start Kit					CVP Kit			
Other / # Attempts		Site:		Site:	Other			
Initials					Initials	LR		

## **NEUROLOGICAL CHECK LIST**

Name: John Brown  
Account No: 12345  
Attending Physician: Jeff T. Moore, M.D.  
Consulting Physician

Adm Date: 11/12/1999      DOB: 09/10/44

**D = Data      A = Action      R = Response**

SHIFT INIT	NURSE SIGNATURE	SHIFT INIT	NURSE SIGNATURE
73fc	L. Conrad Lee		
73pc	Diamond Campbell CN		