

<u>Room#/ISO:</u>	<u>Foley/Ext Catheter:</u>	<u>Diet/Restrictions:</u>	<u>Activity:</u>
<u>Vitals:</u>	<u>Labs:</u>	<u>I&O:</u>	
<u>Safety ADLs:</u> Name: Fall Risk: DNR: Pink: Allergy: Blood Band: Other:	<u>IV:</u>	<u>Comments:</u>	
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