

Today's Date: \_\_\_\_\_

VS: Q \_\_\_\_\_ hrs Date Admitted: \_\_\_\_\_

Room # \_\_\_\_\_

Admission Status:  Obs  Inpatient  Swing  Surgery

Code Status:  DNR  Confort Care  Full  DNI

Diagnosis:

Surgery:

<b>Medical History</b>	
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<u>Allergies</u>	

<u>Admission Checks</u>	<u>Consults</u>
Admission Hx <input type="checkbox"/> Y <input type="checkbox"/> N	PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/>
Ask 3 Teach 3 <input type="checkbox"/> Y <input type="checkbox"/> N	SW <input type="checkbox"/> GI <input type="checkbox"/> Urology <input type="checkbox"/>
Care Plan <input type="checkbox"/> Y <input type="checkbox"/> N	CM <input type="checkbox"/> OB/GYN <input type="checkbox"/>
Med Requisition <input type="checkbox"/> Y <input type="checkbox"/> N	Other: _____

<u>IV</u>			
Type	Gauge	Location	Date inserted

Drips

<u>Glucose Monitoring</u>	
<u>Medications</u>	<u>Times:</u> _____
<u>Meds not to give:</u>	
<b>PRN MEDS</b>	

<u>Cerner Checklist</u>
<input type="checkbox"/> Handoff <input type="checkbox"/> Acuity <input type="checkbox"/> Braden <input type="checkbox"/> Fall/Precautions <input type="checkbox"/> Assessment <input type="checkbox"/> Education <input type="checkbox"/> Chart Checks <input type="checkbox"/> Task List <input type="checkbox"/> Care Plan <input type="checkbox"/> Midnight Census <input type="checkbox"/> Swingbed Activity Log <input type="checkbox"/> Purposeful Rounding <input type="checkbox"/> Note <input type="checkbox"/> Discrepancy <b>Peds:</b> <input type="checkbox"/> Cummings/ Braden Q <input type="checkbox"/> Q1hr IV Checks

<u>Glucose Results</u>			Pilot X <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Initiate	<u>Labs</u>			
Time	Result	Units		WBC	HGB	HCT	PLT
PENDING LABS:							

<u>TESTING</u>		
SPECIMEN	DATE	RESULTS

<u>DIAGNOSTIC TESTING</u>		
Type	Date	Result

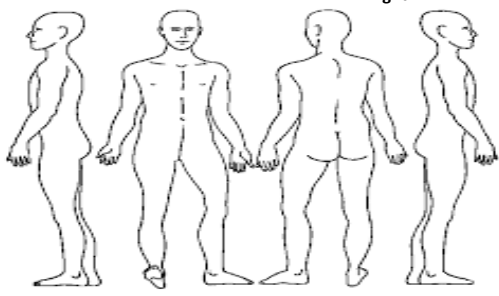
UPCOMMING TEST:

<u>ISOLATION /SPECIAL PRECAUTIONS</u>
<input type="checkbox"/> Standard _____ <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne <input type="checkbox"/> Other: _____

<u>Post Surgery</u>
Procedure: _____
ESBL: _____ Intake: _____ Output: _____ <input type="checkbox"/> General <input type="checkbox"/> Duramorph Expires: _____

<u>Pain Management</u>
Last Pain Score: ____/ 10 Goal: ____/10 <input type="checkbox"/> PCA: _____
Last Med Given: _____ Pain Site: _____

Notes:

<u>Assessment</u>		<u>Room#</u> _____	
<b>Neuro</b>		<b>Integumentary</b>	
<input type="checkbox"/> Alert & Oriented Disoriented to: <input type="checkbox"/> Time <input type="checkbox"/> Situation <input type="checkbox"/> Place <input type="checkbox"/> Self Neuro Checks: Q <input type="checkbox"/> Ext. ROM WDL ____ hrs <input type="checkbox"/> Except: _____ <input type="checkbox"/> Grips/Pulls/Pushes WDL <input type="checkbox"/> Except: _____ Pupils: <input type="checkbox"/> WDL <input type="checkbox"/> Except: _____ Neuro Deficits: _____		<input type="checkbox"/> Wound <input type="checkbox"/> Wound Care <input type="checkbox"/> Incision <input type="checkbox"/> Drain <input type="checkbox"/> Dressing	
<b>Cardio/Respiratory</b>		Last Time Changed: _____ Freq: _____ <input type="checkbox"/> Other: _____	
Tele Monitor <input type="checkbox"/> Y <input type="checkbox"/> N Box #: _____ Alarms Reviewed <input type="checkbox"/> Parameters Changed _____ Rhythm _____ Pacer <input type="checkbox"/> Y <input type="checkbox"/> N Daily Wt <input type="checkbox"/> _____ Edema <input type="checkbox"/> Y <input type="checkbox"/> N Location: _____ Lung Sounds: <input type="checkbox"/> CTA All Lobes <input type="checkbox"/> Other: _____ Oxygen <input type="checkbox"/> Y <input type="checkbox"/> N LPM _____ I.S. <input type="checkbox"/> Y <input type="checkbox"/> N SVN <input type="checkbox"/> Y <input type="checkbox"/> N Freq _____ Suction <input type="checkbox"/> Y <input type="checkbox"/> N Cont Pulse Ox <input type="checkbox"/> Y <input type="checkbox"/> N Anticoagulation Edu Done <input type="checkbox"/> Y <input type="checkbox"/> N TEDS ____ SCDs ____ Coumadin ____ Lovenox ____		<b>ADLs/ Musculoskeletal</b>	
		Activity Level: _____ Devices: _____ <b><input type="checkbox"/> Fall Precautions <input type="checkbox"/> Bed Alarm <input type="checkbox"/> Personal Alarm</b> Interventions: _____ <input type="checkbox"/> Constant Observer <input type="checkbox"/> Chemical Restraint <input type="checkbox"/> Physical Restraint Order Placed: _____ Expires: _____	
<b>GI</b>		<b>Vaccines</b>	<b>Discharge Planning</b>
Diet: _____ NPO After: _____ Feeder <input type="checkbox"/> Y <input type="checkbox"/> N NG Suction: _____ BS <input type="checkbox"/> Present <input type="checkbox"/> Except: _____ Supplements: _____ Freq: _____ Tenderness <input type="checkbox"/> RUQ <input type="checkbox"/> LUQ <input type="checkbox"/> RLQ <input type="checkbox"/> LLQ ABD Appearance: _____		Influenza <input type="checkbox"/> Y <input type="checkbox"/> N Date: _____ PNA <input type="checkbox"/> Y <input type="checkbox"/> N Date: _____	Anticipated Date: _____ <b>D/C to:</b> <input type="checkbox"/> Home <input type="checkbox"/> Assist. Living <input type="checkbox"/> SNIF <input type="checkbox"/> Other: _____ Barriers to D/C: _____
<b>GU</b>		<b>Vitals</b>	
<input type="checkbox"/> Continent Urine/Stool <input type="checkbox"/> Incontinent Urine/Stool <input type="checkbox"/> Foley <input type="checkbox"/> Y <input type="checkbox"/> N Size: ____ Type: _____ Date Inserted: _____ <input type="checkbox"/> VAG Pack Removed: _____		BP ____/____ HR ____ T ____ SpO2: ____ RR: ____ BP ____/____ HR ____ T ____ SpO2: ____ RR: ____	
		BP ____/____ HR ____ T ____ SpO2: ____ RR: ____ BP ____/____ HR ____ T ____ SpO2: ____ RR: ____	D/C Time _____ <input type="checkbox"/> Order Placed
<b>Cerner Checklist</b>			
<input type="checkbox"/> Handoff <input type="checkbox"/> Acuity <input type="checkbox"/> Braden <input type="checkbox"/> Fall/Precautions <input type="checkbox"/> Assessment <input type="checkbox"/> Education <input type="checkbox"/> Chart Checks <input type="checkbox"/> Task List <input type="checkbox"/> Care Plan <input type="checkbox"/> Midnight Census <input type="checkbox"/> <input type="checkbox"/> Swingbed Activity Log <input type="checkbox"/> Purposeful Rounding <input type="checkbox"/> Note <input type="checkbox"/> Discrepancy <b>Peds:</b> <input type="checkbox"/> Cummings/ Braden Q <input type="checkbox"/> Q1hr IV Checks			
OBS: 19 20 21 22 23 00 01 02 03 04 05 06		IV I & O's: 19 20 21 22 23 00 01 02 03 04 05 06	
OBS: 07 08 09 10 11 12 13 14 15 16 17 18		IV I & O's: 07 08 09 10 11 12 13 14 15 16 17 18	
<b>Wound Diagram</b>		<b>Notes</b>	
<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">LEFT</div> <div style="text-align: center;">Right</div> </div> 			
<b>Hand Off</b>			
Nurse Reporting		Nurse Receiving	Date & Shift