CHOICE HEALTH
SERVICES AND RESOURCES

**Pt Name:** _____ **Age/DOB:** _____ **RM: #** _____

**Dr:** _____ **Admit Date:** _____ **Code status:** _____

**Dx:** _____ **Allergies**_____

**Past Med/Surg Hx:**_____
_____

**Neuro:**
A&O x _____ PERRLA: Y / N Dizziness/Blurred vision

Facial Symmetry: Y / N SPEECH: WNL OR _____

Ambulatory/Non-Ambulatory/Unsteady

Assist x _____ Weakness (Ext): _____

SUICIDAL Y/N: BAKER ACT:_____
NOTE:
_____

**CV:**
Tele monitor Y / N Rhythm: _____

Pulses present: All Ext. Y/N _____

Edema: _____

IV Access: _____

NOTE: _____

**Resp:**
RA OR O2 VIA: MASK/HI-FLOW/BIPAP/TRACH/VENT _____

BREATH SOUNDS: _____

(LOCATION) _____

COUGH Y / N PRODUCTIVE/ NON-PRODUCTIVE

COLOR: _____

NOTE: _____

**GI:**
DIET: _____

TF Y /N TYPE:_____ @: _____ FLUSH: _____ q _____

NAUSEA/VOMITTING/DRY HEAVING

LBM: _____

BOWEL SOUNDS x _____ Quads

NOTE: _____

**GU:**
VOIDS Y / N FOLEY/SP CATH/PUREWICK:

OTHER: _____

COLOR: _____ OP END OF SHIFT: _____

DIALYSIS Y / N _____ ACCESS: _____

Pregnant: Y / N LMP: _____

**SKIN:**

WARM/DRY/INTACT /COOL/CLAMMY/DIAPHORETIC

WOUNDS:
_____

_____

PIC TAKEN Y /N DRAINS: _____

**PLAN:**

1.

2.

3.

_____

**Consults:** Neuro/ Cardio / GI / Pulmonary / Uro / Psych

_____

**LABS:**

WBC: _____

HBG: _____

HCT: _____

PLT: _____

Cl: _____

Mag: _____

**LABS:**

K+: _____

Na: _____

BUN: _____

Creat: _____

Phos: _____

Lactic: _____

**LABS EXTRA:**

_____

_____

_____

_____

_____

_____

| 0800 V/S | 1200 V/S | 1600 V/S |
|---|---|---|
| BP:_____ | BP: _____ | BP: _____ |
| HR: _____ | HR: _____ | HR: _____ |
| RESP: _____ | RESP: _____ | RESP: _____ |
| O2: _____ | O2: _____ | O2: _____ |
| TEMP: _____ | TEMP:_____ | TEMP: _____ |
| ACCUCHECK: _____ | ACCUCHECK: _____ | ACCUCHECK: _____ |

| | | |
|---|---|---|
| **Pain level:**<br>**Last pain med:** _____<br>**Time:** _____ | **Pain level:**<br>**Last pain med:** _____<br>**Time:** _____ | **Pain level:**<br>**Last pain med:** _____<br>**Time:** _____ |

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# NURSING REPORT SHEET REFERENCE GUIDE

| | |
|---|---|
| **Dx = Diagnosis**<br>**Hx = History (Past Medical History/Surgical History)**<br>**A&O = Alert and Oriented**<br>**PERRLA = Pupils Equal Round Reactive Light Accommodation**<br>**WNL = Within Normal Limits**<br>**RA = ROOM AIR**<br>**SP CATH = Supra pubic Catheter**<br>**TF = Tube Feeding**<br>**Q/q = Every**<br>**Quads = Quadrants** | **NORMAL LAB VALUES**<br>**WBC - WHITE BLOOD CELLS: 4.5 – 11**<br>**HGB - HEMOGLOBIN: 13 -18 (M) 12 -16 (F)**<br>**HCT - HEMATOCRIT: 42 -50% (M) 40-48% (F)**<br>**PLT - PLATELETS: 100,000-400,000**<br>**Cl - Chloride: 95 – 105**<br>**Mag - Magnesium: 0.33 – 2.4**<br>**K+ - Potassium: 3.0 – 4.5**<br>**Na - Sodium: 135 -145**<br>**BUN - (Blood Urea Nitrogen): 10 -20**<br>**Creat - Creatinine: 0.7 – 1.4**<br>**Phos - Phosphorus: 3.0 – 4.5**<br>**Lactic/Lactate : 0.5 - 1** |
| • **SBAR means: Situation, Background, Assessments and Recommendation**<br>• **Throughout your shift, use your nursing template and write down pertinent information. And follow the flow of the template. When giving report you can flow easily through the top to the bottom.**<br>• **Having your vital signs on your paper, gives you understanding and a base line of how your patient vital has been through your shift. You will be able to give information.**<br>**Ex: "Mr. X blood pressure has been elevated throughout the shift, at 12pm I called MD for PRN blood pressure med. It was administered, rechecked shows this and current BP is this. PRN meds are on board if you need them for these parameters."**<br>• **Have the lab values on your template give you an idea of what a patient current lab result are. You can see which ones are normal or critical. (GET TO KNOW YOUR LABS!!)** | • **You can use the extra lines on your sheet to note if patient is a fall risk, seizure precaution etc.**<br>• **Ask questions!!! Especially, Whats the plan? If this is bedside report, this includes the patient in as well; so, they are aware of what is going to go on through the day. Then reiterate it verbally and on the white board (if your facility uses them).**<br>**Other questions would be: Does the patient have any PRN medication? How does the patient take their pills? Swallows whole or crushed? When was the last time the patient was out of bed? When is the next dressing changing? When was the IV placed? When was the midline/picc line dressing changed?**<br>• **After taking report, do your OWN HEAD TO TOE ASSESSMENT. NEVER EVER DOCUMENT FROM INFORMATION PROVIDED TO YOU. LOOK AT YOUR PATIENT.** |