

Room #: \_\_\_\_\_ Code: \_\_\_\_\_ MD: \_\_\_\_\_  
 Dx: \_\_\_\_\_ Allergies: \_\_\_\_\_

**SITUATION** Safety:  Confused  Fall  Restraints  Alarm  Suicide  
 Isolation:  None  Contact  Droplet  Airborne  Neutropenic

**BACKGROUND**

Admit Date: _____ From: _____ Reason: _____  Hospital Course: _____	Tests Done	PMH: _____	Psychosocial:   Decision Maker: _____
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**ASSESSMENT**

<b>Temperature</b> NOC T-Max _____ Day T-Max _____  <b>Pain</b>	<b>Neuro:</b> 4 3 2 1 <input type="checkbox"/> EVD RASS _____ CAM + -  GCS _____	<b>Cardiac</b> EF: _____ Echo Date: _____ Rhythm: _____	<b>Hemodynamics</b> <input type="checkbox"/> A-Line <input type="checkbox"/> CVP Monitor <input type="checkbox"/> Swann
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<b>Respiratory</b> <input type="checkbox"/> Clear <input type="checkbox"/> ET <input type="checkbox"/> Trach <input type="checkbox"/> Ch T <input type="checkbox"/> IS  P/F Ratio: _____	<b>Vent Settings</b> <input type="checkbox"/> RT <input type="checkbox"/> ARDS MODE _____ FiO2 _____ PS _____ PEEP _____ Vt _____ RATE _____	<b>GI</b> <input type="checkbox"/> NG <input type="checkbox"/> OG <input type="checkbox"/> PEG <input type="checkbox"/> LWS _____ C-Diff: - + Last BM: _____  <b>Diet</b>	<b>GU</b> <input type="checkbox"/> Foley <input type="checkbox"/> BSC <input type="checkbox"/> BRP <input type="checkbox"/> Anuric <input type="checkbox"/> Dialysis <b>NOCS</b> <b>DAYS</b> In _____ Out _____ In _____ Out _____ In _____ Out _____ In _____ Out _____ In _____ Out _____ In _____ Out _____ <b>Fluid Balance</b>
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<b>Muskuloskeletal</b>  <input type="checkbox"/> SCDs <input type="checkbox"/> TEDs <input type="checkbox"/> Boots <input type="checkbox"/> Special Bed <input type="checkbox"/> Sling <input type="checkbox"/> Ambulating	<b>Skin</b> <input type="checkbox"/> Clear <input type="checkbox"/> Dsng: _____ <input type="checkbox"/> Wounds: _____  <b>DVT &amp; Stress Ulcer Prophylaxis:</b> <input type="checkbox"/> Heparin <input type="checkbox"/> Lovenox <input type="checkbox"/> SCDs <input type="checkbox"/> Pepcid <input type="checkbox"/> Protonix	<b>Drains</b>   <b>Immune System</b> Flu: <input type="checkbox"/> Needs <input type="checkbox"/> Received PNA: <input type="checkbox"/> Needs <input type="checkbox"/> Received MRSA: <input type="checkbox"/> Admit <input type="checkbox"/> > 7 Days in ICU	<b>IV Sites</b> <input type="checkbox"/> PIV:  <input type="checkbox"/> Central:  <input type="checkbox"/> PICC:  <input type="checkbox"/> Other:
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<b>Gtts</b> 1) _____ @ _____ 2) _____ @ _____ 3) _____ @ _____ 4) _____ @ _____ 5) _____ @ _____ 6) _____ @ _____ 7) _____ @ _____	<b>Sepsis:</b> <input type="checkbox"/> Infection <input type="checkbox"/> Simple <input type="checkbox"/> Severe Lactate: _____ CVP: _____ ScVO2: _____ <input type="checkbox"/> Abx: _____ Given @: _____ <input type="checkbox"/> Abx: _____ Given @: _____ <input type="checkbox"/> Abx: _____ Given @: _____ Cultures: <input type="checkbox"/> Blood x2 <input type="checkbox"/> Urine <input type="checkbox"/> Sputum	<b>Lab Draws</b> <input type="checkbox"/> K <input type="checkbox"/> Mg <input type="checkbox"/> Ph <input type="checkbox"/> Ca  <b>Accu-Check:</b>	<b>Parameters</b>  <b>PRNs Given</b>
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<b>RECOMMENDATION / PT NEEDS</b>	<b>TO-DO LIST</b>	Na: _____ K: _____ Mg: _____ Ca: _____ Ph: _____ Cr: _____ BUN: _____ WBC: _____ Hgb: _____ PLT: _____ PT: _____ INR: _____ Lactate: _____ HCO3: _____ Other: _____
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**MISC**