

Situation:

Patient Name: _____ Room/Bed: _____ MR #: _____ Pt Acct #: _____
 Adm Date: _____ Age: _____ Sex: _____ Birthdate: _____
 Admitting Doctor: _____ Language: _____ Pt Allergies: _____
 Adm. Diagnosis: _____
 Weight: _____
 Isolation Indicator: _____
 Isolation Order: _____

Background:

Brief and Significant Hx: _____

Safety Scores: Fall Risk Score: _____ Entrapment Score: _____ Elopement Score: _____ Password: _____
 Activity Level: _____ Influenza Administered: _____ Pneumo Administered: _____
 Post-op Day #: _____ Anesthesia End Time: _____

Discharge Needs: _____

Assessment:

Neuro LOC: _____ CIWA: _____

Resp: O2Sat: _____ % Resp Rate: _____ O2 Delivery Method: _____ O2 LPM: _____ L/S: _____
 Bipap: _____ Ventilator: _____ Endotube: _____ Trach Type: _____ Trach Size: _____
 Peak Flow: _____ I/S: _____ PEEP/Acapella: _____ Chest Tube: _____

CV: HR: _____ BP: _____ Rhythms: _____ Tele Rhythm 1: _____ Tele Rhythm 2: _____
 Pulses: _____ Edema: _____

GI: Diet: _____ Fluid Restriction: _____ Tolerating Diet: _____
 Enteral Feeding Type: _____ Supplements: _____

GU: Ostomy Type: _____ BM This Shift: _____ Bowel Sounds: _____
 Catheter Type: _____ Ostomy Type: _____ Dialysis: _____ Dialysis Last Date: _____

Output: Insulin Pump: YES NO
 Voided Urine: _____ ML Catheter Urine: _____ ML Ostomy Urine: _____ ML

Output: Due to Void: _____

Wounds/Tubes and Drains:

Type#1: _____ Location: _____
 Type#2: _____ Location: _____
 Type#3: _____ Location: _____

Incision: _____ Dressing Change Type/Frequency: _____

Skin: Braden Score: _____ Skin Condition: _____ Pneumatic Compression Device: _____

Social: _____ Suicide Precautions: _____

Pain Trends: Last Medicated: _____ PCA: Yes No Last Medicated: _____

Type of Line:

IV #1 Type: Site/Sz: _____ Dt Inserted: _____ Dressing Dt: _____
IV #2 Type: Site/Sz: _____ Dt Inserted: _____ Dressing Dt: _____

Temp Dialysis Access: Temp Site: _____ Perm Dialysis Access: _____ Perm Site: _____

Baseline Assessment:

Lab: Critical Labs (last 8hrs): _____ Fingerticks: _____

Pending Labs: _____

Rads: _____ Pending Rads: _____

Recommendations:

Concerns/What to watch for: _____

Scheduled Events: _____ MD Plan of Care/Consults: _____

Education Needed: _____ Major Procedures: _____

Clinical Events: _____

MAK Ck	<input type="checkbox"/>	Orders Reviewed	<input type="checkbox"/>	Safety Bedside Ck	<input type="checkbox"/>
--------	--------------------------	-----------------	--------------------------	-------------------	--------------------------