MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
LOCAL FORM TITLE	

DATE:_____ ALLERGIES:_____ ISOLATION:_____ DIET:_____

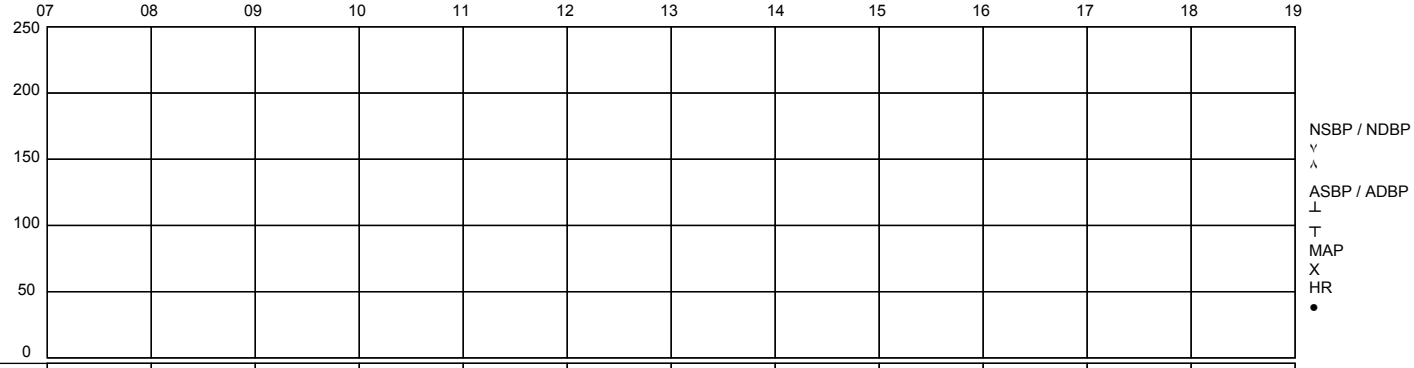
WEIGHT(kg)

Admit_____

Daily _____

BED#_____

☐ Full Code
☐ DNR
☐ Limited DNR



		07	08	09	10	11	12	13	14	15	16	17	18	19
VITAL SIGNS	HR													
	R/R													
	Temp (F)													
	Temp (Source)													
	Arterial S													
	Arterial D													
	Arterial M													
	NBP S													
	NBP D													
	NBP M													
	CVP													
	SpO2													
	O2 (L/minute)													
	Source													
	Pain Location													
	Pain Score													
	Pain Quality													
	Pain Duration													
	Interventions													
MISC	Blood Glucose													
INTAKE (IV/PO/NG)	Oral/TF													
	Hourly Intake													
	Total Intake													
	Diet (%)													
OUTPUT	Urine													
	NG													
	JP													
	Chest Tube													
	Emesis													
	Hourly Output													
	Total Output													
	Residuals													

Intake AM Totals

Output AM Totals

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19	20	21	22	23	24	01	02	03	04	05	06
250											
200											
150											
100											
50											
0											

NSBP / NDBP
ASBP / ADBP
MAP
HR

HR													VITAL SIGNS
R/R													
Temp (f)													
Temp (Source)													
Arterial S													
Arterial D													
Arterial M													
NBP S													
NBP D													
NBP M													
CVP													
SpO2													
O2 (L/minute)													
Source													
Pain Location													
Pain Score													
Pain Quality													
Pain Duration													
Interventions													
Blood Glucose													MISC
Oral/TF													Intake PM Totals / 24h Intake Totals
Hourly Intake													
Total Intake													
Diet (%)													
Urine													Output PM Totals / 24h Output Totals
NG													
JP													
Chest Tube													
Emesis													
Hourly Output													
Total Output													
Residuals													

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TREATMENT FLOWSHEET

TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	
Visitor @ BS Yes(Y), No(N)																									Safety
Alarms Audible and Limits Set																									
Pressure Lines Zeroed																									
Side Rails Up: No, x2, x4																									
Call Bell in Reach: Yes (Y), N/A																									
Bed Height Low: Yes (Y), No (N), N/A																									
TF Bag Δ																									
IV Bag Δ / Tubing Δ																									
Bath (B) Peri-care (P) Linen Δ (L) Foley care (F) Skin Care (S)																									ADLs
Range of Motion: Active (A),Passive (P)																									
Activity: Physical Therapy (PT) Standing (S) Ambulation(A) OOBTC (O)																									
Chest PT																									Respiratory
ICS																									
Position: Left (L) Right (R) Chair (C) Supine (S)																									
Suction: ETT (E), Oral (O), Trach (T)																									
Trach Care																									
Oral Care																									
SCDs: On(O); Off (X)																									
HOB elevated (in degrees)																									
																									Other

MECHANICAL VENTILATION / RESPIRATORY THERAPY

TIME		07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
MODE																									
Rate: Pt/Vent																									
Tidal Volume: Pt/Vent																									
PS/PEEP																									
FiO2%																									
PIP/Vte																									
MAAS																									
ABG'S	PH																								
	PaO2																								
	PaCO2																								
	HCO3																								
	Be																								
	SaO2																								
	FiO2																								

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PRESSURE SORE ASSESSMENT

BRADEN SCALE	1	2	3	4	AM	PM
Sensory Perception: Ability to respond meaningfully to pressure-related discomfort.	Completely Limited	Very Limited	Slightly Limited	No Impairment		
Moisture: Degree that skin is exposed to moisture	Constantly Moist	Very Moist	Occasionally Moist	Rarely Moist		
Activity: Degree of physical activity	Bedfast	Chair fast	Walks Occasionally	Walks Frequently		
Mobility: Ability to change and control body position	Completely Immobile	Very Limited	Slightly Limited	No Limitations		
Nutrition: Usual food intake pattern	Very Poor	Probably Inadequate	Adequate	Excellent		
Friction and Shear: Ability to be moved in a way that prevents skin contact with bedding or other surface	Problem	Potential Problem	No Apparent Problem	N/A		
				Total:		

INTEGUMENTARY ASSESSMENT

Time/ Initials	Location	Stage/ Type	Length/Width/ Depth (in cm)	Drainage	Odor	Color	Intervention	Dressing/Topical

KEY:

Color
R = Red
P= Pale
Pi= Pink
C= Cyanotic
O= Other (specify)

Drainage
SS= Serosanguineous
S= Sanguineous
P= Purulent
N= None

Odor
M = Mild
F= Foul
N = None

Stage
I- Reddened, skin intact
II- Blister, superficial skin loss
III- Exposed subcutaneous tissue
IV- Exposed subdermal tissue/ muscle/ bone

Type
A= Abrasion
Bl= Blister
Bu= Burn
E= Ecchymosis
H= Healing Wounds
I = Incision
L= Laceration
Le= Lesion
P= Petechaie
R= Rash
S= Sloughing
St= Skin Tear
M= Maceration
U= Ulcer

Intervention
T= Turn Q2h
E= Elevation
SB= Specialty Bed
O= Other (specify)

VASCULAR ACCESS

Location	Type	Gauge	Assessment	External Length	Flushed (Y/N)	Date to Δ Drsg	Date ↑	Date to Δ IV	D/C'd Reasons:

Assessment: 1= Clean, Dry, Intact 2= no S/S of infection P= Patent DR= Dressing Reinforced **D/C'd Reasons**: L= Leaking B= Bleeding R= Reddened I= Infiltrated CL= Clotted

SCHMID FALLS RISK ASSESSMENT

ITEM	SCALE	AM	PM
Mobility: Ambulates without gait disturbance	0		
Ambulates/ transfers w/ assistance or assist devices	1		
Ambulates w/ unsteady gait and no assistance	1		
Unable to ambulate or transfer	0		
Mentation: Alert, oriented x3	0		
Confusion	1		
Comatose/ unresponsive	0		
Medications: Anticonvulsants, sedatives, psychotropics, hypnotics	1		
None of the above medications	0		
Elimination: Independent in elimination	0		
Independent with frequency or diarrhea	1		
Incontinence	1		
Needs assistance with toileting	1		
Fall history: No prior fall history	0		
Yes, before admission	1		
Yes, during admission	2		
Unknown	1		
	TOTAL:		

AM	PM	INTERVENTIONS (√) each box when done
		Standard Risk: (Score <3)
☐	☐	Pt education on environment of care
☐	☐	Call bell within reach
☐	☐	Telephone/ personal items within reach
☐	☐	Room clean & uncluttered
☐	☐	All wheeled equipment locked
☐	☐	Ambulatory aids positioned with reach on dominant side
☐	☐	Bed in low position, at least one side rail lowered, wheels locked
☐	☐	Provide/ encourage use of non-slip footwear
☐	☐	Adequate lighting
☐	☐	Adequate staff assistance when assessing gait and balance
☐	☐	Orient pt to surroundings, room, ward
☐	☐	Closely monitor pts following use of new medications
		High Risk: (Score ≥3)
☐	☐	All "Standard Risk" interventions performed PLUS:
☐	☐	Frequent reorientation of confused/ disoriented pts
☐	☐	Red dots applied to pt profile & chart
☐	☐	Notification of falls risk status to unit staff/ charge nurse
☐	☐	Offer assistance and as needed supervision during ADLs
☐	☐	Provide/ encourage use of assistive devices and mobility aids
☐	☐	Use of bed alarm
☐	☐	Locating pt in room w/ direct visual access from nursing station
☐	☐	Use of 1:1 staff monitoring of pt
☐	☐	Constant supervision/ assistance during ambulating & ADLs
☐	☐	Physical Therapy Consult

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AM= 0700-1900 Time:_____ RN Initials:_____

PSYCHOSOCIAL

Behavior/Emotional State

☐ Interactive ☐ Depressed ☐ Appropriate
☐ Flat affect ☐ Angry ☐ Shows interest in care
☐ Happy ☐ Cooperative ☐ Maintains eye contact
☐ Emotional ☐ Uncooperative ☐ Good coping
☐ Distressed ☐ Poor Grooming ☐ Poor coping
☐ Manic ☐ Expresses needs ☐ Has goal of care

NEUROLGICAL

Glasgow Coma Scale

Eyes	1 2	**No eye opening** **To noxious stimuli**	3 4	**To speech** **Spontaneous**	
Verbal	1 2 3	**No vocalization** **Moans or groans** **Verbalization, exclamatory or disorganized**	4 5 1	**Confused** **Oriented** **Intubated**	
Motor	1 2 3	**No motor response** **Abnormal extension** **Abnormal flexion**	4 5 6	**Flexion withdrawal** **Localizes to noxious stimuli** **Obeys simple Commands**	
				Total:	

Pupil Size	
Right	Left
Pupil Reaction	
Right	Left
Pupil Shape	
Right	Left

B= Brisk
S= Sluggish
N= Fixed
I= Irregular
R= Round
U= Unable to assess

Orientation: ☐Time ☐Sedated ☐Not Testable
☐Place ☐Confused
☐Person ☐Intubated

Strength Key:

RUE	LUE	RLE	LLE

4= WNL 3=Weak 2=Mild Weakness 1=Severely weak 0=Flaccid
U=Unable to assess

CARDIAC

Heart Sounds: ☐S1/S2 ☐S3 ☐S4 ☐Rub
☐Gallop ☐Murmur ☐Click

Rhythm:_____ **Ectopy:**_____

Capillary Refill:

RUE	LUE	RLE	LLE

N=Normal (<3sec) S= Sluggish (3-5sec) D= Delayed (>5sec)

Mucous Membranes: ☐ Pink ☐Pale ☐Cyanotic

Skin: ☐Dry ☐ Warm ☐Cool ☐Hot
☐Mottled ☐ Cyanotic ☐Diaphoretic

Peripheral Pulses:

Pulse	Radial	DP	PT	Fem	Brach
Left					
Right					

+3= Bounding +2=Normal +1= Weak D=Doppler 0= Absent

Neck Veins: ☐ Flat ☐Distended

Peripheral Edema:

L Hand		R Hand		Facial	
L Arm		R Arm		Scleral	
L Foot		R Foot		Periorbital	
L Leg		R Leg		Sacral	
Other:					

Edema: 0=none 1+=mild (<1/4") 2+=moderate (1/4-1/2") 3+=severe (1/2-1")

PAIN

Scale: ☐Numeric ☐Visual Analog ☐FACES Pain Rating

Pain location & quality:_____

Patient's description of pain:_____

Treatment:_____

AM= 1900-0700 Time:_____ RN Initials:_____

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Skin: ☐Dry ☐ Warm ☐Cool ☐Hot
☐Mottled ☐ Cyanotic ☐Diaphoretic

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Other:					

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Pain location & quality:_____

Patient's description of pain:_____

Treatment:_____

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PULMONARY

Breath Sounds:

☐Clear Bilateral ☐Clear with diminished bases bilateral

RUL	RLL	LUL	LLL

C=Clear W=Wheeze Rh=Rhonchi R=Rales D=Diminished
S= Stridor A=Absent

Respirations: ☐Normal ☐Retractions ☐Regular
☐Labored ☐Shallow ☐Irregular ☐Short of Breath
☐Tachypneic ☐Slow ☐Apneic ☐Agonal

Cough: ☐Spontaneous ☐Frequent
☐Productive ☐Nonproductive

Secretions: ☐None ☐ETT ☐Oral ☐Trach ☐Nasal
☐Thick ☐Thin ☐Copious ☐Frothy

Color: _____

Trach: ☐Edema ☐Redness ☐SubQ Emphysema

Size: _____

ETT location: ☐Oral ☐Nasal (R___/ L___ Nare)

Size: _____

Level: _____cm @ ☐Lips ☐Teeth ☐Other: _____

Chest Tube	#1	#2
Location:		
Drainage:		
Air Leak:		
Crepitus:		
Suction:		

GASTROINTESTINAL

Bowel Sounds:

RUQ	LUQ	RLQ	LLQ

N= Normal A= Absent = Hyperactive = Hypoactive

Abdomen: ☐ Flat ☐ Round ☐ Obese
☐ Soft ☐ Distended ☐ Taut
☐ Tender ☐ Non-tender

	#1	#2
Tube:		
Location:		
@ cm:		
Drainage/ Status:		
O/NGT checked for placement:		

1= TF 2= Clamped 3= LCWS 4= LIWS

Stool: ☐Continent ☐ Incontinent ☐ Liquid ☐ Soft
☐Frequent ☐ Ostomy ☐ Rectal Tube ☐ Formed

Color: _____ Last BM: _____

GENITOURINARY

Voiding: ☐ w/o Difficulty ☐ Incontinent
☐ Urinal ☐ Foley
☐ Bed Pan ☐ Suprapubic Cath
☐ BS Commode ☐ Condom Cath

Urine: ☐ Clear ☐ Concentrated ☐ Sediment
☐ Cloudy ☐ Malodorous ☐ Anuric

Color: _____

Catheter Site: ☐ w/o redness / drainage
☐Redness _____
☐Drainage_____
☐Other_____

PULMONARY

Breath Sounds:

☐Clear Bilateral ☐Clear with diminished bases bilateral

RUL	RLL	LUL	LLL

C=Clear W=Wheeze Rh=Rhonchi R=Rales D=Diminished
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☐Thick ☐Thin ☐Copious ☐Frothy

Color: _____

Trach: ☐Edema ☐Redness ☐SubQ Emphysema

Size: _____

ETT location: ☐Oral ☐Nasal (R___/ L___ Nare)

Size: _____

Level: _____cm @ ☐Lips ☐Teeth ☐Other: _____

Chest Tube	#1	#2
Location:		
Drainage:		
Air Leak:		
Crepitus:		
Suction:		

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Tube:		
Location:		
@ cm:		
Drainage/ Status:		
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Stool: ☐Continent ☐ Incontinent ☐ Liquid ☐ Soft
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Urine: ☐ Clear ☐ Concentrated ☐ Sediment
☐ Cloudy ☐ Malodorous ☐ Anuric

Color: _____

Catheter Site: ☐ w/o redness / drainage
☐Redness _____
☐Drainage_____
☐Other_____

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EKG STRIPS

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NURSING NOTES

INIT	SIGNATURE	INIT	SIGNATURE	INIT	SIGNATURE

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