Patient Name: Millie Larsen	**MRN:** 000-555-000
Room: 616	**Doctor Name:** Dr. Eric Lund
DOB: 01/23/1926	**Date Admitted:**
Age: 84	

PATIENT CHART

Chart for Millie Larsen

Physician's Orders

Allergies: NKA

Date/Time:	
Day 1, 0900	Bedrest, BRP with assist
	Regular, low fat diet
	I & 0
	captopril 25 mg po three times a day
	metoprolol 100 mg every day
	furosemide 40 mg po twice per day
	Lipitor 50 mg once daily
	pilocarpine eye drops 2 drops each eye 4 times a day
	Fosamax 10 mg every day
	Celebrex 200 mg po once a day
	tramodol for arthritis pain prn
	Ciprofloxacin 250 mg every 12 hours
	Acetaminophen 325 mg po prn
	IV fluids D5 .45 NaCl 20 mEq KCL at 60ml/hr
	Dr. Eric Lund

Physician Progress Notes

Allergies:

Date/Time:	
Day 1, 0900	Admit. Will see later in a.m.
	Dr. Eric Lund

Nursing Notes

Date/Time:	
0200	Admitted to ER with daughter, stable; no bed available T. Wade RN
0900	Admit to 6E. see flow sheet Jean Larsen, RN, BSN

Medication Administration Record

Allergies: NKDA

Scheduled & Routine Drugs

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Hours to be Given:	Dates Given:
Day 1	Captopril	25 mg	po	three times a day	~~0800,~~ JL ~~1200~~ JL ~~,1600~~ JL	Day 1
	Metoprolol	100 mg		every day	~~0800~~ JL	Day 1
	Furosemide	40 mg	po	twice per day	~~0800~~ JL, ~~1600~~ JL	Day 1
	Lipitor	50 mg		once daily	~~0800~~ JL	Day 1
	Pilocarpine eye drops	2 drops each eye		four times a day	~~0800,~~ JL ~~1200~~ JL ~~,1600~~ JL,~~2000~~ KC	Day 1
	Fosamax	10 mg		every day	~~0800~~ JL	Day 1
	Tramodol			for arthritis pain/prn		
	Ciprofloxacin	250 mg		every 12 hours	~~0800~~ JL,~~2000~~ KC	Day 1
	Acetaminophen	325 mg	po	prn		
	Celebrex	200 mg	po	once a day	~~0800~~ JL	Day 1

Intravenous Therapy

Date of Order:	IV Solution	Rate Ordered:	Date/Time Hung:
Day 1	IV fluids D5 .45 NaCl 20 mEq KCL	60ml/hr	Day 1, ~~0900~~ JL

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature
J.L.	Jean Larsen, RN, BSN	K.C.	Kathy Clark, RN, BSN.

Medication Administration Record

Intramuscular legend:	Subcutaneous site code:
A=RUOQ ventrogluteal	1=RUQ abdomen
B=LUOQ ventrogluteal	2=LUQ abdomen
C=R Deltoid	3=RLQ abdomen
D=L Deltoid	4=LLQ abdomen
E=R Thigh Lateral	5=RU arm
F=L Thigh Lateral	6=LU arm
	7=R leg
	8=L leg

Allergies:

PRN Medications

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Date/Time Given:	
					Date:	
					Time:	
					Site:	
					Initials:	

Insulin Administration

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Date/Time Given:	
					Date:	
					Time:	
					Site:	
					GMR:	
					Initials:	

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature
J.L.	Jean Larsen, RN, BSN	K.C.	Kathy Clark, RN, BSN.

Vital Signs Record

Date:	Day 1					
Time:	0200	0600	0800	1200	1600	2000
Temperature:	37.3	37.2	37.2	37.3	37.2	37.1
BP:	156/88	160/88	148/86	146/90	138/80	136/78
Pulse:	78	80	80	76	78	72
O^2 Saturation:	96	94	96	96	96	94
Weight:						
Respirations:	14	12	16	14	14	14
GMR:						
Nurse Initials:	TB	TB	JL	JL	JL	K.C.

Intake & Output Bedside Worksheet

0900-2100 **INTAKE**					**OUTPUT**				
ORAL	TUBE FEED	IV	IVPB	OTHER	URINE	Emesis	NG	Drains Type:	Other
240 480 240 240		720			500 750 650 250				
Total Intake this shift: 1920					Total Output this shift: 2150				

2100-0900 **INTAKE** **OUTPUT**

ORAL	TUBE FEED	IV	IVPB	OTHER	URINE	Emesis	NG	Drains Type:	Other
240		720			200 400 400				
Total Intake this shift: 960					Total Output this shift: 1000				

(This is a worksheet to be used at the bedside to keep track of each intake or output. The totals will then be recorded on the 24 hour Fluid Balance sheet.)

Fluid Measurements:	Sample Measurements:
1 ml = 1 cc	Coffee cup = 200 cc
1 ounce = 30 cc	Clear glass = 240 cc
8 ounces = 240 cc	Milk carton = 240 cc
1 cup = 8 ounces = 240 cc	Small milk carton = 120 cc
4 cups = 32 ounces = 1 quart or liter= 1000 cc	Juice, gelatin or ice cream cup = 120 cc
	Soup bowl = 160 cc
	Popsicle half = 40 cc

Nursing Assessment Flowsheet

GENERAL APPEARANCE:
☐ male ☒ female

☒ awake ☐ sleeping ☐ agitated
☐ cheerful ☐ lethargic ☐ anxious
☐ crying ☒ calm ☐ combative
☐ fearful

SKIN: ☐ see wound care sheet ☐ see nursing notes

BRADEN SCALE SCORE: ☐ risk skin breakdown

COLOR:
☒ acyanotic
☐ pale
☐ ruddy
☐ jaundiced
☐ cyanotic

TURGOR:
☒ <3 sec
☐ > 3 sec

TEMP:
☒ warm/dry
☐ hot
☐ cool
☐ cold/clammy
☐ diaphoretic

HAIR:
☒ shiny
☐ dry/flaking
☐ balding
☐ lesions
☐ lice

NEUROLOGICAL: ☐ see nursing notes

ORIENTATION:
☒ person ☐ disoriented
☒ place ☐ confused
☒ time ☐ impaired memory

RESPONDS TO:
☒ name ☐ non-responsive
☐ stimuli

RESPIRATORY: ☐ see nursing notes

RESPIRATIONS:
RATE: 14
O_2: RA
SPO_2:94%

☒ regular ☐ labored
☒ even ☐ uses accessory muscles
☐ irregular ☐ cough

BREATH SOUNDS:

LEFT:	RIGHT:
☒ clear	☒ clear
☐ crackles	☐ crackles
☐ wheezes	☐ wheezes
☐ decreased	☐ decreased
☐ absent	☐ absent

THORAX:
☒ even expansion
☐ uneven expansion

SMOKING:
☐ cigarettes pk/day _____
☐ cigars
☐ marijuana
☐ cocaine

GASTROINTESTINAL/NUTRITION: ☐ see nursing notes

APPEARANCE:
☐ flat ☒ soft
☒ round ☐ gravid
☐ obese

BOWEL SOUNDS:
☒ active ☐ hyperactive
☐ hypoactive ☐ absent

SPEECH:
- ☒ clear
- ☐ garbled
- ☐ slurred
- ☐ aphasic
- ☐ inappropriate
- ☐ cannot follow conversation

FACE:
- ☒ symmetrical
- ☐ drooping
- ☐ drooling

EYES:
- ☒ PERRLA
- ☐ unequal
- ☐ drooping lid

SIGHT:
- ☐ no correction
- ☒ glasses
- ☐ contacts
- ☐ blind

HEARING:
- ☐ WNL
- ☒ HOH
- ☒ hearing aid

HX:
- ☐ seizures
- ☐ CVA
- ☐ brain injury
- ☐ spinal injury
- ☐ other

PALPATION:
- ☒ non-tender
- ☐ tender (location)_____
- ☐ mass (location) _____

LAST BM yesterday
- ☐ incontinent
- ☐ stoma- _____
- ☐ constipation
- ☐ diarrhea
- ☐ mucous
- ☐ blood

DIET: normal
- ☐ impaired swallowing
- ☐ choking
- ☐ NG tube
  color drainage:_____
- ☐ feeding tube
- ☐ tube feeding
  type: _____ rate:_____

MUSCULOSKELETAL: ☐ see nursing notes

GAIT:
- ☐ steady
- ☒ unsteady
- ☐ non-ambulatory

ACTIVITY:
- ☐ up ad lib
- ☐ walker
- ☐ cane
- ☐ crutches
- ☐ wheelchair

ASSIST:
- ☒ x1
- ☐ x2
- ☐ lift
- ☐ bed bound

HAND GRIPS:
AMPUTATION: ☐ left ☐ right
LOCATION:_____

LEFT:
- ☐ strong
- ☒ weak
- ☐ flaccid
- ☐ contractures

RIGHT:
- ☐ strong
- ☒ weak
- ☐ flaccid
- ☐ contractures

GENITOURINARY: ☐ see nursing notes

- ☒ voids
- ☐ catheter
- ☐ stoma

APPEARANCE OF URINE:
- ☐ clear
- ☐ light yellow
- ☒ amber
- ☐ brown
- ☒ cloudy
- ☐ sediment
- ☐ red/wine
- ☐ clots

BLADDER:
- ☒ soft
- ☐ firm/distended
- ☒ incontinent

FEMALES: LMP: " in the 70's sometime"
- ☒ WNL
- ☐ dysmenorrheal

BIRTH CONTROL:
- ☐ yes
- ☐ no
- ☐ BSE monthly
- ☐ menopause

ROM:

ARMS:
- ☒ full
- ☐ weak
- ☐ flaccid
- ☐ contractures

LEGS:
- ☒ full
- ☐ weak
- ☐ flaccid
- ☐ contractures
- ☐ TED hose

AMPUTATION:
- ☐ right
- ☐ left
- ☐ BKA
- ☐ AKA
- ☐ other

SPINE:
- ☐ kyphosis
- ☐ scoliosis
- ☐ osteoporosis

OTHER:
- ☐ CAST LOCATION:_____
- ☐ TRACTION:_____

☐ taking estrogen

SEXUALITY:
- ☐ sexually active
- ☐ safe sex

MED HX:
- ☐ urinary retention
- ☐ BPH
- ☐ Frequent UTI

CARDIOVASCULAR: ☐ see nursing notes

HEART SOUNDS:
- ☒ normal S_1-S_2
- ☐ abnormal S_3-S_4
- ☐ murmur

PULSE:

APICAL:	**RADIAL**:	**PEDALIS**:
☒ regular	☒ regular	☒ regular
☐ irregular	☐ irregular	☐ irregular
☐ strong	☐ strong	☐ strong
☐ faint	☐ faint	☐ faint
	☐ nonpalpable	☐ nonpalpable

EXTREMITY COLOR & TEMP:
- ☒ warm
- ☐ cool
- ☐ cold
- ☒ acyanotic
- ☐ cyanotic
- ☐ discolor

EDEMA:
- ☒ none
- ☐ generalized (anasarca)

SITE #1:_____ SITE #2: _____

pitting
- ☐ 1+

pitting
- ☐ 1+

PAIN ASSESSMENT: ☐ see nursing notes
☐ see MAR

PRECIPITATING: walking, general movement

QUALITY:_ dull, aching

REGION: bilateral knees

SEVERITY (0-10/10): 3

NOW: 3 AT WORST: 6 AT BEST: 1

TIMING:_____

SAFETY: ☐ see nursing notes
☐ fall risk

PRECAUTIONS:
- ☒ side rails x 2
- ☒ bed down
- ☒ call light
- ☒ nightlight
- ☐ restraints
- ☐ wrist
- ☐ vest

☐ 2+
☐ 3+
☐ 4+
☐ non-pitting

☐ 2+
☐ 3+
☐ 4+
☐ non-pitting

CAPILLARY REFILL:

FINGERS:
☒ brisk
☐ slow

TOES:
☒ brisk
☐ slow

HX:
☐ Pacemaker
☒ HTN
☐ CAD
☐ CHF
☐ PVD
☐ Other: _____

DISCHARGE/TEACHING: ☐ see nursing notes

NEEDS:_____
_____
_____

TYPE OF LEARNER:
☒ visual
☐ auditory
☐ kinesthetic

EDUCATIONAL LEVEL: High school

FAMILY PRESENT:
☒ yes
☐ no

FLUID BALANCE: ☐ see nursing notes

INTAKE:
☒ PO ☐ IV

SOLUTION: D5 .45 RATE: 60 ml/hr

SITE LOCATION: L FA

☒ clean ☐ swelling ☐ pain
☒ patent ☐ cool ☐ tubing change
☐ redness ☐ hot ☐ dressing change

MUCOUS MEMBRANES:
☒ moist ☐ sticky ☐ dry
☒ pink ☐ coated

TODAY'S WT: 48 kg **YESTERDAY'S WT:**_____

NURSE SIGNATURE: Jean Larsen, RN, BSN

TIME COMPLETED: 1000

REASSESSMENT:

TIME: _____

☒ no change ☐ see nurses notes Initials JL

TIME: 1600

☒ no change ☐ see nurses notes Initials JL

TIME: _____

☒ no change ☐ see nurses notes Initials K.C.

	Date: Day 1 0900-2100 Braden Scale Score: 20 Morse Fall Risk Score: 70								Date: Braden Scale Score: 20 Morse Fall Risk Score: 70							
Time		**09**	**11**	**13**	**15**	**17**	**19**		**21**	**23**	**01**	**03**	**05**	**07**		
PAIN ASSESSMENT																
Intensity (1-10/10)		**2**	**1**	**2**	**1**	**1**	**2**		**1**	**1**	**1**	**1**	**1**	**1**		
Pain Type (see legend)		**A**	**A**	**A**	**A**	**A**	**A**		**A**	**A**	**A**	**A**	**A**	**A**		
Intervention (see legend)		**3**	**3**	**3**	**3**	**3**	**3**		**3**	**3**	**3**	**3**	**3**	**3**		
PATIENT POSITION		**B**	**B**	**C**	**A**	**A**	**B**		**B**	**B**	**R**	**L**	**A**	**B**		
PO FLUIDS (ml)		240		480	240	240			240		480	240	240			
IV SITE/RATE CHECKED		**Y**	**Y**	**Y**	**Y**	**Y**	**Y**		**Y**	**Y**	**Y**	**Y**	**Y**	**Y**		
PATIENT HYGIENE		**Y**	**Y**	**Y**	**Y**	**Y**	**Y**		**Y**	**Y**	**Y**	**Y**	**Y**	**Y**		
WOUND ASSESSMENT		n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a	n/a	n/a	n/a	n/a		
WOUND BED		n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a	n/a	n/a	n/a	n/a		
WOUND DRAINAGE		n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a	n/a	n/a	n/a	n/a		
WOUND CARE		n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a	n/a	n/a	n/a	n/a		
Nurse Initials		JL	JL	JL												

Initial	Nurse Signature	Initial	Nurse Signature
J.L.	Jean Larsen, RN, BSN	K.C.	Kathy Clark, RN, BSN.

LEGEND: *= see nursing notes

PAIN TYPE:
A- aching **T-** throbbing
ST- stabbing **B-** burning
SH- shooting **P-** pressure

PAIN INTERVENTIONS:
1- Relaxation/Imagery **2 -** Distraction
3- Reposition **4-**Medication

POSTIONING:
B- back
R- right
L- left
C- chair
A- ambulatory

PT. HYGIENE:
b- bedbath **a-** assist bath
p- partial bath **sh-** shower
g- grooming **m** mouth care
f- foot care **n-** nail care

WOUND ASSESSMENT
 # 1-4 Pressure Ulcer stage
I – Incision
R – Rash
SK – skin tear
E –Echymosis
A – Abrasion

WOUND BED:
D– Dry & intact
S – Sutures/ staples
G – Granulation tissue
P – Pale
Y – Yellow
B- Black

WOUND DRAINAGE:
0 – none
S – Serous
P – Purlulent
S – Serosanguinous
B – Bright red blood
D – Dark old blood

WOUND CARE:
C – Cleaned with NS
G – Gauze dressing
W – Gauze wrap
A – ABD pad
M – Medication
O – other **

LAB TEST	RESULT	NORMAL RANGE
WBC	12,000	
HGB	9.9	
HCT	32	
NA+	149	
K+	3.5	
GLUCOSE	105	
UA	Urine color: dark amber, cloudy Specific gravity: 1.050 (normal 1.005-1.035) ph 6.0 (normal 4.5-8.0) RBC - 9 (normal 0-2) WBC - 150,000 (normal 0-5)	