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 Lars

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

Nursing Notes

Date/Time:	
0630 Day 4	Pt out of bed this morning, slipped, almost fell. No visible injuries noted. PCP and daughter notified. On all antihypertensives now, BP has improved since admission, see flow sheet. T. Wade RN
1700	Discharged home accompanied by daughter. Jean Larsen, RN, BSN

Medication Administration Record

Allergies: NKDA

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 4
	Metoprolol	100 mg		every day	~~0800~~ JL	Day 4
	Furosemide	40 mg	po	twice per day	~~0800~~ JL, 1~~600~~ JL	Day 4
	Lipitor	50 mg		once daily	~~0800~~ JL	Day 4
	Pilocarpine eye drops	2 drops each eye		four times a day	~~0800,~~ JL ~~1200~~ JL ~~,1600~~ JL, 2000	Day 4
	Fosamax	10 mg		every day	~~0800~~ JL	Day 4
	Tramodol			for arthritis pain/prn		
	Ciprofloxacin	250 mg		every 12 hours	~~0800~~ JL,2000	Day 4
	Acetaminophen	325 mg	po	prn		
	Celebrex	200 mg	po	once a day	~~0800~~ JL	Day 4

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 4, ~~0900~~ JL

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

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature
J.L.	Jean Larsen, RN, BSN		

Vital Signs Record

Date:	Day 4					
Time:	0200	0600	0800	1200	1600	2000
Temperature:	37.1	37.2	37.1	37.2	37.2	
BP:	128/74	160/88	148/86	146/90	138/80	
Pulse:	72	68	72	76	76	
O^2 Saturation:	96	94	96	96	96	
Weight:						
Respirations:	12	12	14	14	16	
GMR:						
Nurse Initials:	TB	TB	JL	JL	JL	

Intake & Output Bedside Worksheet

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

ORAL	TUBE FEED	IV	IVPB	OTHER	URINE	Emesis	NG	Drains Type:	Other
240 480 240 240 240		720							
Total Intake this shift: 2160					Total Output this shift:				

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

ORAL	TUBE FEED	IV	IVPB	OTHER	URINE	Emesis	NG	Drains Type:	Other
Total Intake this shift:					Total Output this shift:				

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

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

☐ stimuli

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

FACE:
☒ symmetrical ☐ drooling
☐ drooping

EYES:
☒ PERRLA
☐ unequal
☐ drooping lid

SIGHT:
☐ no correction
☒ glasses
☐ contacts
☐ blind

HEARING:
☐ WNL ☒ hearing aid
☒ HOH

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

☐ hypoactive ☐ absent

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

LAST BM yesterday

☐ incontinent ☐ diarrhea
☐ stoma- _____ ☐ mucous
☐ constipation ☐ 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 ☒ cloudy
☐ light yellow ☐ sediment
☒ amber ☐ red/wine
☐ brown ☐ clots

BLADDER:
☒ soft ☐ firm/distended ☒ incontinent

FEMALES: LMP: " in the 70's sometime"

☒ WNL ☐ dysmenorrheal

BIRTH CONTROL:
☐ yes ☐ BSE monthly

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:_____

☐ no ☐ menopause ☐ 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**											
PAIN ASSESSMENT																	
Intensity (1-10/10)		**2**	**1**	**2**	**1**	**1**											
Pain Type (see legend)		**A**	**A**	**A**	**A**	**A**											
Intervention (see legend)		**3**	**3**	**3**	**3**	**3**											
PATIENT POSITION		**A**	**A**	**A**	**A**	**A**											
PO FLUIDS (ml)		**240**	**240**	**480**	**240**	**240**											
IV SITE/RATE CHECKED		**Y**	**Y**	**Y**	**Y**	**Y**											
PATIENT HYGIENE		**Y**	**Y**	**Y**	**Y**	**Y**											
WOUND ASSESSMENT		**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**										
WOUND DRAINAGE		**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**										
Nurse Initials		JL	JL	JL													

Initial	Nurse Signature	Initial	Nurse Signature
J.L.	Jean Larsen, 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+	146	
K+	3.6	
GLUCOSE	103	
UA	Urine color: Clear, yellow, cloudy Specific gravity: 1.0350 (normal 1.005-1.035) ph 6.0 (normal 4.5-8.0) RBC - 4 (normal 0-2) WBC - 150,000 (normal 0-5)	