PATIENT CHART

Julia Morales

Patient Name: Julia Morales	**MRN:** 123-456-78
Room:	**Doctor Name:** Dr. Ann Davis
DOB: 1951	**Date Admitted:** 9/24
Age: 65	

Physician's Orders

Allergies: NKA

Date/Time:	
9/24	Admit to Oncology Floor
9/24	Diet as tolerated
9/24	Oxygen per nasal cannula at 2 liters per minutes as needed for comfort
9/24	Meds: • Phenergan 25mg by mouth every 4-6 hours for nausea/vomiting • Vitamins and supplements for nutrition • Oxycodone 20mg by mouth every 4 hours as needed for pain • Ibuprofen 200mg by mouth every 4-6 hours as needed for pain
	Dr. Ann Davis

Nursing Notes

Date/Time:	
9/25 0000	Patient c/o pain 8/10. Medicated and reposition. Denies any nausea at this time. ----------T. Smyth, RN
9/25 0100	Patient asleep. ----------T. Smyth, RN
9/25 0420	Patient awake, Coughing forcefully. C/o pain 9/10. Medicated and repositioned. Denies any nausea at this time. ----------T. Smyth, RN
9/25 0530	Patient states pain at 4/10. No c/o nausea at this time. Ambulated to bathroom with assistance x 1. Urinated with difficulty. Returned to bed, chose to sit at bedside at this time. Assisted with bath.----------T. Smyth, RN
9/25 0830	Patient ate ¼ of breakfast. States dentures are too loose and mouth hurts to chew. Coughing forcefully. c/o pain 9/10. Medicated, guided imagery and positioned back in bed on right side. ----------M. Reyes, RN
9/25	Patient vomited 275 mL of greenish yellow emesis with some food noted. Medicated and

0925	repositioned. Her partner is at bedside. ----------M. Reyes, RN
9/25 1230	Patient up in chair. Ate ¼ of lunch. C/o pain after forceful coughing episode. Medicated and repositioned back in bed. Partner at bedside. Partner completed the Modified Caregiver Role Strain assessment. ----------M. Reyes, RN
9/25 1635	Patient ambulated slowly with partner down hallway and back. Medicated for pain at 9/10 after returned to room. ----------M. Reyes, RN
9/25 1800	Patient at ¼ of dinner. Continue to c/o difficulty with sores in mouth and lack of appetite. ----------M. Reyes, RN
9/25 2035	Patient coughing forcefully. c/o pain at 8/10. Medicated and repositioned. Partner left for the evening and will be back in the morning. ----------T. Smyth, RN
9/25 2120	Patient vomited yellow green emesis. Medicated and repositioned. ----------T. Smyth, RN

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature
TS	Teri Smyth, RN	MR	Maria Reyes, RN

Medication Administration Record

Allergies: NKA

Scheduled & Routine Drugs

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Hours to be Given:	Dates Given:
9/24	Multivitamin	1 tab	Orally	Daily	0800	9/25 ~~0830~~ MR

Intravenous Therapy

Date of Order:	IV Solution	Rate Ordered:	Date/Time Hung:

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature
TS	Teri Smyth, RN	MR	Maria Reyes, RN

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: NKA

PRN Medications

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Date/Time Given:	
9/24	Ibuprofen	200mg	Orally	Every 4-6 hours as needed for pain	Time:	
					Site:	
					Initials:	
9/24	Phenergan	25mg	Orally	Every 4-6 hours as needed for nausea/vomiting	Time:	~~0925~~
					Site:	
					Initials:	MR
					Time:	~~2120~~
					Site:	
					Initials:	TS
9/24	Oxycodone	20mg	Orally	Every 4 hours as needed for pain	Time:	~~0000~~
					Site:	
					Initials:	TS
					Time:	~~0420~~
					Site:	
					Initials:	TS
					Time:	~~0830~~
					Site:	
					Initials:	MR
					Time:	~~1230~~
					Site:	
					Initials:	MR ~~1635~~

						Time:		
						Site:	MR	
						Initials:		
						Time:	~~2035~~	
						Site:		
						Initials:	TS	

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
TS	Teri Smyth, RN	MR	Maria Reyes, RN

Date:	9/25	9/25	9/25	9/25	9/25	9/25
Time:	0000	0400	0800	1200	1600	2000
BP	145/86	153/92	150/88	148/86	140/82	144/90
Pulse	76	84	82	82	78	84
O^2 Saturation	94	93	94	94	94	93
Weight			110			
Respirations	20	24	20	22	20	22

Vital Signs Record

Temp	98.3 F	98.2 F	98.2 F	98.3 F	98.4 F	98.3 F
Nurse Initials	TS	TS	MR	MR	MR	TS

Intake & Output Bedside Worksheet

INTAKE					OUTPUT				
ORAL	TUBE FEED	IV	IVPB	OTHER	URINE	Emesis	NG	Drains Type:	Other
240mL 120mL 240mL 120mL 120mL 240mL 120mL					350mL 250mL 125mL 200mL	275mL 300mL			
Total Intake this shift: 1200					Total Output this shift: 1400				

(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

DOB: 1951
AGE: 65
ETHNICITY: Caucasian
OCCUPATION: Retired
RELIGION: Unitarian

☒ 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:

RESPIRATORY: ☐ see nursing notes

RESPIRATIONS:
RATE: 24
O_2:Room Air
SPO_2: 90%

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

BREATH SOUNDS:

LEFT:	RIGHT:
☒ clear	☐ clear
☐ crackles	☐ crackles
☐ wheezes	☐ wheezes
☐ rhonchi	☒ rhonchi
☐ 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:

☒ name ☐ non-responsive
☐ 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

☒ active ☐ hyperactive
☐ hypoactive ☐ absent

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

LAST BM: loose stool 9/24 1200

☐ incontinent ☒ diarrhea
☐ stoma- _____ ☐ mucous
☐ constipation ☐ blood

DIET: Regular, soft

☐ impaired swallowing
☐ choking
☐ NG tube
color drainage:_____
☐ feeding tube
☐ tube feeding
type: _____ rate:_____
☒ Other:
Sores in mouth – loose dentures

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

RIGHT:
☐ strong
☒ weak

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: Post-menopause

☐ WNL ☐ dysmenorrheal

BIRTH CONTROL:

☐ flaccid
☐ contractures

☐ flaccid
☐ contractures

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:_____

☐ yes
☒ no

☐ BSE monthly
☒ menopause
☐ taking estrogen

SEXUALITY:
☐ sexually active

☐ safe sex
☒ not sexually active

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

PAIN ASSESSMENT: ☐ see nursing notes
☒ see MAR

PRECIPITATING: With coughing and activity

QUALITY: Dull

REGION: Right upper chest

SEVERITY (0-10/10):

NOW: 3 AT WORST: 9-10 AT BEST: 3

TIMING: Intermittent and with activity

SAFETY: ☐ see nursing notes
☒ fall risk

PRECAUTIONS:

☒ side rails x 2
☒ bed down
☒ call light
☐ nightlight

☐ restraints
☐ wrist
☐ vest

EDEMA:
☐ none ☐ generalized (anasarca)

SITE #1: Bilateral LE

pitting
☒ 1+
☐ 2+
☐ 3+
☐ 4+
☐ non-pitting

SITE #2: _____

pitting
☒ 1+
☐ 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: Pain management, home oxygen therapy

TYPE OF LEARNER:
☒ visual
☐ auditory
☐ kinesthetic

EDUCATIONAL LEVEL: _____

FAMILY PRESENT:
☐ yes
☒ no

FLUID BALANCE: ☐ see nursing notes

INTAKE:
☒ PO ☐ IV

SOLUTION: _____ RATE:_____ ml/hr

SITE LOCATION: _____

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

NURSE SIGNATURE: T. Smith

TIME COMPLETED: 0520

REASSESSMENT:

TIME: 0830

☐ no change ☒ see nurses notes ☒ initials: MR

TIME: 0925

MUCOUS MEMBRANES:

☐ moist ☒ sticky ☐ dry
☒ pink ☐ coated

TODAY'S WT: 110 **YESTERDAY'S WT:** 113

☐ no change ☒ see nurses notes ☒ initials MR

TIME: 1230

☐ no change ☒ see nurses notes ☒ initials MR

TIME: 1630

☐ no change ☒ see nurses notes ☒ initials MR

TIME: 2035

☐ no change ☒ see nurses notes ☒ initials TS

TIME: 2120

☐ no change ☒ see nurses notes ☒ initials TS

Risk Assessments & Nursing Care

	Date: 9/25 **Braden Scale Score: 17** **Fall Risk Score: 4**									
Time Hourly	**0000**	**0420**	**0530**	**0830**	**1230**	**1330**	**1635**	**1745**	**2035**	**2120**
PAIN ASSESSMENT										
Intensity (1-10/10)	**8**	**9**	**4**	**9**	**9**	**3**	**9**	**4**	**8**	**4**
Pain Type (see legend)	**A**	**A**	**A**	**A**	**A**	**A**	**A**	**A**	**A**	**A**
Intervention (see legend)	**3, 4**	**3, 4**	**3**	**1, 3, 4**	**1, 3, 4**	**3**	**1, 3, 4**	**3, 4**	**3,4**	**3**
PATIENT POSITION	**B**	**L**	**A, C**	**R**	**C, L**	**B**	**R**	**C**	**L**	**R**
PO FLUIDS (ml)	**240**	**120**	**0**	**240**	**120**	**0**	**120**	**0**	**240**	**120**
IV SITE/RATE CHECKED	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
PATIENT HYGIENE			**A**							
WOUND ASSESSMENT	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
WOUND BED										
WOUND DRAINAGE										

WOUND CARE										
Nurse Initials	TS	TS	TS	MR	MR	MR	MR	MR	TS	TS

Initial	Nurse Signature	Initial	Nurse Signature
TS	Teri Smyth, RN	MR	Maria Reyes, RN

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 **