

Room #: _____ Code: _____ MD: _____
 Dx: _____ Allergies: _____

SITUATION Safety: Confused Fall Restraints Alarm Suicide
 Isolation: None Contact Droplet Airborne Neutropenic

BACKGROUND

Admit Date: _____ From: _____ Reason: _____ Hospital Course: _____	Tests Done	PMH:	Psychosocial: Decision Maker:
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ASSESSMENT

Temperature NOC T-Max _____ Day T-Max _____ Pain	Neuro: 4 3 2 1 <input type="checkbox"/> EVD RASS _____ CAM + - GCS _____	Cardiac EF: _____ Echo Date: _____ Rhythm: _____	Hemodynamics <input type="checkbox"/> A-Line <input type="checkbox"/> CVP Monitor <input type="checkbox"/> Swann
Respiratory <input type="checkbox"/> Clear <input type="checkbox"/> ET <input type="checkbox"/> Trach <input type="checkbox"/> Ch T <input type="checkbox"/> IS P/F Ratio: _____	Vent Settings <input type="checkbox"/> RT <input type="checkbox"/> ARDS MODE _____ FiO2 _____ PS _____ PEEP _____ Vt _____ RATE _____	GI <input type="checkbox"/> NG <input type="checkbox"/> OG <input type="checkbox"/> PEG <input type="checkbox"/> LWS _____ C-Diff: - + Last BM: _____ Diet	GU <input type="checkbox"/> Foley <input type="checkbox"/> BSC <input type="checkbox"/> BRP <input type="checkbox"/> Anuric <input type="checkbox"/> Dialysis NOCS DAYS In _____ Out _____ In _____ Out _____ In _____ Out _____ In _____ Out _____ In _____ Out _____ In _____ Out _____ Fluid Balance
Muskuloskeletal <input type="checkbox"/> SCDs <input type="checkbox"/> TEDs <input type="checkbox"/> Boots <input type="checkbox"/> Special Bed <input type="checkbox"/> Sling <input type="checkbox"/> Ambulating	Skin <input type="checkbox"/> Clear <input type="checkbox"/> Dsng: _____ <input type="checkbox"/> Wounds: _____ DVT & Stress Ulcer Prophylaxis: <input type="checkbox"/> Heparin <input type="checkbox"/> Lovenox <input type="checkbox"/> SCDs <input type="checkbox"/> Pepcid <input type="checkbox"/> Protonix	Drains Immune System Flu: <input type="checkbox"/> Needs <input type="checkbox"/> Received PNA: <input type="checkbox"/> Needs <input type="checkbox"/> Received MRSA: <input type="checkbox"/> Admit <input type="checkbox"/> > 7 Days in ICU	IV Sites <input type="checkbox"/> PIV: <input type="checkbox"/> Central: <input type="checkbox"/> PICC: <input type="checkbox"/> Other:
Gtts 1) _____ @ _____ 2) _____ @ _____ 3) _____ @ _____ 4) _____ @ _____ 5) _____ @ _____ 6) _____ @ _____ 7) _____ @ _____	Sepsis: <input type="checkbox"/> Infection <input type="checkbox"/> Simple <input type="checkbox"/> Severe Lactate: _____ CVP: _____ ScVO2: _____ <input type="checkbox"/> Abx: _____ Given @: _____ <input type="checkbox"/> Abx: _____ Given @: _____ <input type="checkbox"/> Abx: _____ Given @: _____ <input type="checkbox"/> Abx: _____ Given @: _____ Cultures: <input type="checkbox"/> Blood x2 <input type="checkbox"/> Urine <input type="checkbox"/> Sputum	Lab Draws <input type="checkbox"/> K <input type="checkbox"/> Mg <input type="checkbox"/> Ph <input type="checkbox"/> Ca Accu-Check:	Parameters PRNs Given

RECOMMENDATION / PT NEEDS **TO-DO LIST**

		Na: _____ K: _____ Mg: _____ Ca: _____ Ph: _____ Cr: _____ BUN: _____ WBC: _____ Hgb: _____ PLT: _____ PT: _____ INR: _____ Lactate: _____ HCO3: _____ Other:
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MISC
