Report Sheet / Nurse 🧠

S

Pt name _____ Rm # ____ Primary Dx _____ Admit date __/__/__ Age___
Code Status _____ HCP _____ Allergies_____

B

Hx_____
Isolation_____ Recent Lab/tests/procedures_____

A

Neuro🧠:

Cardio🫀:

Resp🫁:

GI:

GU:

Daily Wt_____
_____
Today's Wt_____

Meds:

LBM💩 __/__/__

I&O🚽

R

Discharge Plan _____
Possible Discharge date __/__/__
Discharge Teaching _____
Pending Tests/ Recommendation/Plan:

When walking into Pt's Room:
[ ] Introduce yourself
[ ] Provide privacy
[ ] Hand hygiene
[ ] 2 Pt identifiers
[ ] Lock bed
[ ] Raise/Lower position of the bed
[ ] Inspect: tubes [ ], lines [ ], drains [ ]
Gait [ ]

When leaving the Pt's Room:
[ ] Make sure call light is within reach
[ ] Bed in lowest position
[ ] Upper rails on bed are up
(4 rails up is considered a form of restraint)

Assessment Steps:
1. Inspection
2. Palpation
3. Percussion
4. **Auscultation**

Abdominal Assessment Steps:
1. Inspection
2. **Auscultation**
3. Palpation
4. Percussion

Head to Toe Assessment:

Head:

[ ] A&O X ___ (person, place, time, reason/purpose
[ ] Inspect ALL Skin:
Color_____, Moisture_____, Turgor_____,
Temp_____, Tenderness_____, Lesions_____,
Rash_____, Bruising/trauma_____,
Tattoos/piercing_____
[ ] Test CN VII:
[ ] Facial movements:😄😛😗
[ ] Mouth:
Tonsils_____, Tongue_____, Teeth_____, Moisture_____,
Pink_____, Gums_____
[ ] Eyes: PERRLA
Pupils are Equal_____ Round_____ Reactive_____
to Light_____ and Accommodating_____
[ ] Neck: JVD jugular vein distention @ 30-45 degrees

Peripherals:

[ ] Inspect ALL Skin:
Color_____, Moisture_____, Turgor_____,
Temp_____, Tenderness_____, Lesions_____,
Rash_____, Bruising/trauma_____,
[ ] CRT capillary refill time: < or = to 2 seconds_____secs
[ ] Pedis & Posterior tibial pulses_____
Strength_____ Symmetry _____ Edema_____
[ ] Hair distribution_____
[ ] **Vital Signs:**
Pain level_____ Pulse___(radial, equal/bilateral)
Temp___F/C BP_____ SpO2_____ RR_____