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:	
9/26 0000	Patient resting quietly with eyes closed. ----------T. Smyth, RN
9/26 0200	Patient awake, Coughing. C/o pain 6/10 with coughing. Medicated and repositioned. Denies any nausea at this time. ----------T. Smyth, RN
9/26 0430	Patient awake. Pain is 2/10 and tolerable at this time. Repositioned. T. Smyth, RN
9/26 0600	Patient states pain at 2/10. Denies nausea. Ambulated to bathroom with assistance x 1. Semi-formed stool output. Assist with bath in chair. Returned to bed. -T. Smyth, RN
9/26 0830	Patient ate 50% of soft breakfast. States that mouth hurts with eating. Pt states pain is 4/10. Requested pain medication. Pain medication administered. Partner at bedside. Repositioned back in bed on right side. ----------M. Reyes, RN
9/26 0925	Dr. Davis at bedside. Orders received for discharge and home health/hospice. ----------M. Reyes, RN

9/26 1130	Discharge teaching completed with patient and partner regarding pain management, nutrition, medications. Pt ate 1/3 to ½ of lunch. ----------M. Reyes, RN
9/26 1230	Patient discharged home with partner. ----------M. Reyes, 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	9/26 ~~0815~~ 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:	
					Site:	
					Initials:	
9/24	Oxycodone	20mg	Orally	Every 4 hours as needed for pain	Time:	
					Site:	TS
					Initials:	~~0200~~
					Time:	
					Site:	
					Initials:	MR
					Time:	~~0830~~
					Site:	
					Initials:	
					Time:	
					Site:	
					Initials:	
					Time:	
					Site:	
					Initials:	
					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
TS	Teri Smyth, RN	MR	Maria Reyes, RN

Vital Signs Record

Date:	9/26	9/26	9/26	9/26	9/26	9/26
Time:	0000	0400	0800	1200	1600	2000
BP	142/84	151/91	149/86	148/86		
Pulse	87	88	81	82		
O^2 Saturation	93	93	92	94		
Weight			110			
Respirations	20	24	22	22		
Temp	98.3 F	98.1 F	98.3 F	98.2 F		
Nurse Initials	TS	TS	MR	MR		

Intake & Output Bedside Worksheet

INTAKE					OUTPUT				
ORAL	TUBE FEED	IV	IVPB	OTHER	URINE	Emesis	NG	Drains Type:	Other
240 480 240 480					500 450				
Total Intake this shift: 1440					Total Output this shift: 900				

(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 9/26 0600

☐ 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: 0600

REASSESSMENT:

TIME: 0930

☐ no change ☒ see nurses notes ☒ initials: MR

TIME:

MUCOUS MEMBRANES:

☐ moist ☒ sticky ☐ dry
☒ pink ☐ coated

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

☐ no change ☐ see nurses notes ☐ initials

TIME:

☐ no change ☐ see nurses notes ☐ initials MR

TIME:

☐ no change ☐ see nurses notes ☐ initials MR

TIME:

☐ no change ☐ see nurses notes ☐ initials

TIME: 2120

☐ no change ☐ see nurses notes ☐ initials

Risk Assessments & Nursing Care

	Date: 9/26 **Braden Scale Score: 17** **Fall Risk Score: 4**									
Time Hourly	**0200**	**0430**	**0600**	**0830**						
PAIN ASSESSMENT										
Intensity (1-10/10)	**6**	**2**	**2**	**4**						
Pain Type (see legend)	**A**	**A**	**A**	**A**						
Intervention (see legend)	**3, 4**	**3**	**3**	**1, 3, 4**						
PATIENT POSITION	**L**	**R**	**L**	**R**						
PO FLUIDS (ml)										
IV SITE/RATE CHECKED	**n/a**	**n/a**	**n/a**	**n/a**						
PATIENT HYGIENE			**A**							
WOUND ASSESSMENT	**n/a**	**n/a**	**n/a**	**n/a**						
WOUND BED										
WOUND DRAINAGE										

WOUND CARE										
Nurse Initials	TS	TS	TS	MR						

Initial	Nurse Signature	Initial	Nurse Signature
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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 **