



ONE OF THE VERY BEST

Nursing

Report

Sheet

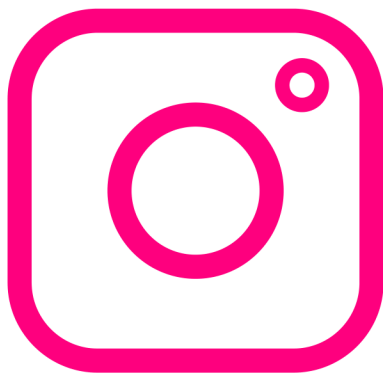
For Bedside Registered Nurses

PATIENT BACKGROUND

Name:		Complaint:										
Room #:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:										
Code: <input type="checkbox"/> Full <input type="checkbox"/> DNR <input type="checkbox"/> Limited		Admit Date:										
Diagnosis:		Mobility: <input type="checkbox"/> Indep <input type="checkbox"/> Assist <input type="checkbox"/> Bedrest										
Allergies:		MD:										
Hospital Course:												
MEDICAL HISTORY		SAFETY			LABS							
<input type="checkbox"/> CKD	<input type="checkbox"/> DM	<input type="checkbox"/> PAD	<input type="checkbox"/> Fall Risk	<input type="checkbox"/> Suicide	WBC	HGB	PLT					
<input type="checkbox"/> CAD	<input type="checkbox"/> BPH	<input type="checkbox"/> MI	<input type="checkbox"/> Aspiration	<input type="checkbox"/> Confused	INR	PT	PTT					
<input type="checkbox"/> CABG	<input type="checkbox"/> AFIB	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Restraints	<input type="checkbox"/> _____	CR	BUN	NA					
<input type="checkbox"/> COPD	<input type="checkbox"/> ETOH	<input type="checkbox"/> GERD	ISOLATION			CA	K	MG				
<input type="checkbox"/> AAA	<input type="checkbox"/> PVD	<input type="checkbox"/> Stroke	<input type="checkbox"/> Contact	<input type="checkbox"/> Airborne	Gluco	Phos	CO2					
<input type="checkbox"/> HTN	<input type="checkbox"/> HLD	<input type="checkbox"/> TIA	<input type="checkbox"/> None	<input type="checkbox"/> Droplet	Trop	PH	_____					
<input type="checkbox"/> CHF	<input type="checkbox"/> DLD	<input type="checkbox"/> Depression	<input type="checkbox"/> Seizure	<input type="checkbox"/> _____								
NEURO		CARDIAC			RESPIRATORY							
<input type="checkbox"/> A&Ox	<input type="checkbox"/> Confused	<input type="checkbox"/> Agitated	<input type="checkbox"/> EF ____%	<input type="checkbox"/> Telemetry	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Pattern ____	<input type="checkbox"/> NRB	<input type="checkbox"/> Clear				
<input type="checkbox"/> Forgetful	<input type="checkbox"/> Sundowns	<input type="checkbox"/> RASS	<input type="checkbox"/> Pulses ____	<input type="checkbox"/> Rhythm	<input type="checkbox"/> GERD	<input type="checkbox"/> Diminished	<input type="checkbox"/> CPAP	<input type="checkbox"/> Room Air				
<input type="checkbox"/> ICP	<input type="checkbox"/> Unconscious		<input type="checkbox"/> VS	<input type="checkbox"/> Bilateral	<input type="checkbox"/> Edema ____	<input type="checkbox"/> BiPAP	<input type="checkbox"/> Crackles					
<input type="checkbox"/> NiHSS Q ____ H	<input type="checkbox"/> TIA		<input type="checkbox"/> Notes			<input type="checkbox"/> HFNC	<input type="checkbox"/> Trach/ETT					
<input type="checkbox"/> Notes					<input type="checkbox"/> Notes			<input type="checkbox"/> Lung Sounds				
SKIN/ WOUNDS		GASTROINTESTINAL			GENITOURINARY							
<input type="checkbox"/> Intact	<input type="checkbox"/> Clean	<input type="checkbox"/> Infected	<input type="checkbox"/> Diet: <input type="checkbox"/> Lipid <input type="checkbox"/> TPN <input type="checkbox"/> Tube Feed			<input type="checkbox"/> Continent			<input type="checkbox"/> Bedpan	<input type="checkbox"/> Purewick		
<input type="checkbox"/> Pressure Ulcer: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> PEG			<input type="checkbox"/> NGT @Nare: <input type="checkbox"/> Right <input type="checkbox"/> Left			<input type="checkbox"/> BSC			<input type="checkbox"/> Urinal	<input type="checkbox"/> Commode
<input type="checkbox"/> Surgical Incision(s): <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> LBM: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent			<input type="checkbox"/> Bedpan			<input type="checkbox"/> Bathroom			<input type="checkbox"/> Incontinent	
<input type="checkbox"/> Location		<input type="checkbox"/> Dressing _____			<input type="checkbox"/> Colostomy			<input type="checkbox"/> Notes			<input type="checkbox"/> Condom Cath	
<input type="checkbox"/> Notes		<input type="checkbox"/> Ileostomy			<input type="checkbox"/> FMS			<input type="checkbox"/> Foley Cath				
<input type="checkbox"/> Notes		<input type="checkbox"/> Notes										
MUSCULOSKELETAL		VITALS			ACCU CHECK							
<input type="checkbox"/> Numbness: <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE		Temp	BP	HR	RR	SpO2	<input type="checkbox"/> AC		<input type="checkbox"/> HS	<input type="checkbox"/> Hourly		
<input type="checkbox"/> Weakness: <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE							Time	BS	Cover			
<input type="checkbox"/> Mobility: <input type="checkbox"/> Indep <input type="checkbox"/> Bedrest												
<input type="checkbox"/> OOB To Chair												
<input type="checkbox"/> Notes												
DRIPS/ FLUIDS		IV SITES			MED & TO DO							
_____		<input type="checkbox"/> PIV _____			<input type="checkbox"/> PICC _____			Time	Task			
_____		<input type="checkbox"/> Central _____			<input type="checkbox"/> Others _____							
_____		Time	Input	Output								
<input type="checkbox"/> PIV												
<input type="checkbox"/> PICC												
<input type="checkbox"/> CVC												
<input type="checkbox"/> HD												
PLAN OF CARE		SCHEDULED PROCEDURES										
		<input type="checkbox"/> Cath			<input type="checkbox"/> Echo	<input type="checkbox"/> EKG	<input type="checkbox"/> Pacemaker					
		<input type="checkbox"/> MRI			<input type="checkbox"/> X-Ray	<input type="checkbox"/> CT	<input type="checkbox"/> _____					
DISCHARGE PLAN		CONSULTS										
		<input type="checkbox"/> GI			<input type="checkbox"/> PT/OT	<input type="checkbox"/> Nephro	<input type="checkbox"/> Surg					
		<input type="checkbox"/> Ortho			<input type="checkbox"/> Onco	<input type="checkbox"/> Speech		<input type="checkbox"/> _____				
		<input type="checkbox"/> Medi			<input type="checkbox"/> Urology	<input type="checkbox"/> Neuro	<input type="checkbox"/> _____					
		<input type="checkbox"/> Cardio			<input type="checkbox"/> Psych	<input type="checkbox"/> Pulmo	<input type="checkbox"/> _____					
NOTES		PRN MEDS										

**For More Help On
Resources to help you succeed**

LET'S STAY CONNECTED



happynursesshop.com

Ready to Join!

Take the next step in your nursing journey and
become a Happy Nurse member today!

**Free and supporting memberships
available**

www.happynursesshop.com/membership

