

Opportunity Medical Center  
1912 Lake Pleasant Dr.  
Pleasantville, Anystate 19480

DATE	TIME	USE BALL POINT PEN ONLY
		Admit Med Surg - Observer
		Dx: MVA
		Allergy: NKA
		BRB BRP
		Foley to gravity
		Fluid NPO
		Regular diet
		Clean all abrasions w/ 1/2 H <sub>2</sub> O <sub>2</sub> 1/2 Strick A/D
		Apply Neosporin & cover w/ galls

DATE	TIME	USE BALL POINT PEN ONLY
		Ice bag to R knee prn
		N: 100cc D <sub>5</sub> 1/2 N <sub>5</sub> @ 175cc/hr
		Tylenol ii tabs PO q 4° PRN #A
		MOM 15ml PO prn indigestion
		Lasix ii PO q 4-6° prn pain
		Call Mr. R. Donohue for further orders
		Milton Burke MD

DATE	TIME	USE BALL POINT PEN ONLY
		Transfer to Telemetry floor
		Cardiac Monitor
		M. Milton Burke / Nancy Nurse RN

<b>Diagnosis</b>		<b>Allergies</b>		<b>Advance Care Plan</b>	
Admit Date to Family Medicine _____ Admit Date to Hospital _____		Age: _____		Review Date _____	
<b>Past Hx</b>		<b>Language Spoken:</b>		<b>Health Directive</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Risk Management:</b> Close Observation: <input type="checkbox"/> q15 min <input type="checkbox"/> q30 min Side Rails <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 High Risk For: <input type="checkbox"/> Falls <input type="checkbox"/> Wandering <input type="checkbox"/> Aggression <input type="checkbox"/> Bed Check <input type="checkbox"/> Chair Check <input type="checkbox"/> Braden Scale # _____ Reassess _____ <input type="checkbox"/> Falls Risk Assess. # _____ Reassess _____ Oriented: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time		<b>Physician Consults</b>			
<b>Activity Transfer Logo Updated</b> <input type="checkbox"/> Date _____ <input type="checkbox"/> Self <input type="checkbox"/> Assist: SBA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Hoyer <input type="checkbox"/> Sara <input type="checkbox"/> Mediman <input type="checkbox"/> Bedrest <input type="checkbox"/> BRP Only <input type="checkbox"/> Turns <input type="checkbox"/> Chair _____ <input type="checkbox"/> Ambulate <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Physio _____ ROM q _____ <input type="checkbox"/> HOB Elevate <input type="checkbox"/> FOB Elevate		<b>Contact:</b> Name: _____ Relationship _____ Phone _____ H) _____ W) _____			
<b>Elimination:</b> <input type="checkbox"/> BR <input type="checkbox"/> Bedpan <input type="checkbox"/> Urinal <input type="checkbox"/> Commode <input type="checkbox"/> Foley <input type="checkbox"/> Incontinent <input type="checkbox"/> Brief <input type="checkbox"/> Incl Pad <input type="checkbox"/> Ostomy <input type="checkbox"/> Change Bag _____ BM Due _____ BR Routine _____ <input type="checkbox"/> Bowel Sounds _____		<b>Hygiene</b> Bath: <input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Complete Tub Day _____ <input type="checkbox"/> Shower <input type="checkbox"/> Dentures _____ <input type="checkbox"/> Hearing Aids _____ <input type="checkbox"/> Glasses		<b>Vital Signs</b> Frequency _____ <input type="checkbox"/> Chani Checks _____ <input type="checkbox"/> Reassess _____	
		<b>Nutrition</b> <input type="checkbox"/> Weight _____ Diet _____ <input type="checkbox"/> NPO <input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Feed <input type="checkbox"/> I/O <input type="checkbox"/> Push Fluids <input type="checkbox"/> Fluid Restrictions _____ <input type="checkbox"/> Crush Meds _____ <input type="checkbox"/> Tube Feed: _____ <input type="checkbox"/> Aspir. & Flush: _____ <input type="checkbox"/> NG Tube <input type="checkbox"/> Low Suction <input type="checkbox"/> Clamped _____ Change Bag _____		<b>Intravenous Therapy</b> Site _____ Change _____ Sol'n/Rate _____ Change _____ Site _____ Change _____ Sol'n/Rate _____ TPN: Amino: _____ Lipids _____ <input type="checkbox"/> Heparin Protocol PPT Due _____	
		<b>Diagnosis</b>		<b>Diagnosis</b>	

Nursing Dx: Focus Update:

Nursing Interventions

Teaching/Goals/Additional Comments

Dressings:  
Drsg #1 Site \_\_\_\_\_

Blood Work  
Date \_\_\_\_\_ Type \_\_\_\_\_ Repeat \_\_\_\_\_

Service Consult  
 OT \_\_\_\_\_  
 PT \_\_\_\_\_  
 SW \_\_\_\_\_  
 Speech \_\_\_\_\_  
 Dietary \_\_\_\_\_  
 Other \_\_\_\_\_  
Pass  Yes  No  PRN  
Date Ordered \_\_\_\_\_

Type \_\_\_\_\_  
Change \_\_\_\_\_

In House Tests:  
Date \_\_\_\_\_ Type \_\_\_\_\_ Dept. \_\_\_\_\_

Discharge Planning  
 Home  Home with Services  
 Home Care Consult Date \_\_\_\_\_

Drsg #2 Site \_\_\_\_\_  
Type \_\_\_\_\_  
Change \_\_\_\_\_

Referred Out Procedures:  
Test \_\_\_\_\_ Date/Time \_\_\_\_\_  
Facility \_\_\_\_\_ Trans. Time \_\_\_\_\_  
Type of Trans \_\_\_\_\_  
Escort:  RN  HCA  Confirmed

Paneling  
 Papers Completed \_\_\_\_\_  
Panel Date \_\_\_\_\_

Drsg #3 Site \_\_\_\_\_  
Type \_\_\_\_\_  
Change \_\_\_\_\_

Test \_\_\_\_\_ Date/Time \_\_\_\_\_  
Facility \_\_\_\_\_ Trans. Time \_\_\_\_\_  
Type of Trans \_\_\_\_\_  
Escort:  RN  HCA  Confirmed

Med Card  
 Yes  No  
Date Ordered \_\_\_\_\_  
RX on Chart:  Yes  No  
Own Meds:  Yes  No  
Valuables:  Yes  No  
Date Assessed: \_\_\_\_\_

Sutures/Staples In \_\_\_\_\_ Out \_\_\_\_\_  
Orthotics \_\_\_\_\_  
Teds: On @ \_\_\_\_\_ Off @ \_\_\_\_\_  
CWC: \_\_\_\_\_

Test \_\_\_\_\_ Date/Time \_\_\_\_\_  
Facility \_\_\_\_\_ Trans. Time \_\_\_\_\_  
Type of Trans \_\_\_\_\_  
Escort:  RN  HCA  Confirmed

Pacemaker:  Yes  No  
Defibrillator:  Yes  No  
(If Yes mark in Red)





