

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

TIME ↷	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
Temp																								
HR																								
BP																								
MAP																								
A-Line																								
Resp/SaO2																								
PA:																								
Insertion S																								
Date D																								
CVP																								
C.O./CI																								
PCWP																								
PAS/PAD																								
CVR/PVR																								
<b>SHIFT ↷</b>	<b>0700-1900</b>												<b>1900-0700</b>						<b>24 HOUR TOTAL</b>	<b>24 HOUR CUMULATIVE TOTAL</b>				
<b>TIME ↷</b>	<b>08</b>	<b>10</b>	<b>12</b>	<b>14</b>	<b>16</b>	<b>18</b>	<b>20</b>	<b>22</b>	<b>24</b>	<b>02</b>	<b>04</b>	<b>06</b>												
<b>IVF</b>																								
<b>IVBP</b>																								
<b>DRIPS</b>																								
<b>BLOOD PROD</b>																								
<b>PO</b>																								
Tube Feeding	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Residual																								
Supplemental																								
Other																								
<b>DIETARY</b>	<b>BREAKFAST</b> % EATEN			<b>AM SNACK</b> <input type="checkbox"/> NOT ORDERED % EATEN			<b>LUNCH</b> % EATEN			<b>SNACK</b> <input type="checkbox"/> NOT ORDERED % EATEN			<b>SUPPER</b> % EATEN			<b>PM SNACK</b> <input type="checkbox"/> NOT ORDERED % EATEN								
<b>OUTPUT</b>	<b>08</b>	<b>10</b>	<b>12</b>	<b>14</b>	<b>16</b>	<b>18</b>	<b>20</b>	<b>22</b>	<b>24</b>	<b>02</b>	<b>04</b>	<b>06</b>	<b>TOTAL OUTPUT</b>											
Urine																								
Emesis																								
NG																								
Stool																								
Other																								
<b>CULTURES OBTAINED</b>						<b>I &amp; O TOTALS</b>						<b>RECONCILED</b>												
<input type="checkbox"/> Sputum <input type="checkbox"/> Wound <input type="checkbox"/> Urine <input type="checkbox"/> Eye <input type="checkbox"/> Blood <input type="checkbox"/> Other: _____						Previous Days I & O Today's Total Output Today's Total Intake Cumulative I & O						<div style="display: flex; align-items: center; justify-content: center;"> <span style="margin-right: 10px;">+/-</span> <div style="border: 1px solid black; padding: 5px; margin-right: 10px;"> <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="border-right: 1px solid black; width: 100%;"></div> </div> <span style="margin-right: 10px;">+/-</span> </div>												

7A Signature/Title: **X**

7P Signature/Title: **X**