

CARDIOVASCULAR

Capillary Refill: _____ seconds	Nail Beds: Pink _____ Dusky _____ Cyanotic _____ Clubbing _____	JVD
HEART SOUNDS: Regular _____ Irregular _____	Cardiac Rhythm: _____	Telemetry: <input type="checkbox"/> Yes <input type="checkbox"/> No
Peripheral Pulses:	Radial: R +/– _____ L +/– _____	Dorsal Pedal: R +/– _____ L +/– _____
Edema: Yes _____ No _____	If Yes, Measure Circumference: Rt Calf _____ Rt Thigh _____	
Location/Description _____	Lt Calf _____	Lt Thigh _____
CHEST PAIN: Absent _____ Present _____	Location: _____	Compression Stockings: Yes _____ No _____

PULMONARY

SECRETION MGMT:	<input type="checkbox"/> Manages Independently	<input type="checkbox"/> *With Assist, Describe: _____
BREATH SOUNDS:	R _____ L _____	*Short of Breath Yes _____ No _____ *Nasal Flaring Yes _____ No _____
Clear _____	<input type="checkbox"/> <input type="checkbox"/>	*Supplemental O ₂ : _____
Pleural Rub _____	<input type="checkbox"/> <input type="checkbox"/>	*Trach _____ Size / Type: _____ Midline: Yes _____ No, Describe: _____
Crackles _____	<input type="checkbox"/> <input type="checkbox"/>	SpO ₂ _____ O ₂ % _____ Via: *Vent _____ Trach Collar _____ Mask _____ Nasal Cannula _____
Rhonchi _____	<input type="checkbox"/> <input type="checkbox"/>	*ETT: _____ CM: _____
Wheeze _____	<input type="checkbox"/> <input type="checkbox"/>	COUGH: <input type="checkbox"/> None <input type="checkbox"/> Non-Productive
Equal Bilaterally Circle: Y _____ N _____	<input type="checkbox"/> *Productive, Describe: _____	
RESPIRATORY EFFORT:		
Labored Circle One: Y _____ N _____	*RESPIRATORY CONSULT INDICATED: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Non-labored Circle One: Y _____ N _____	Respiratory Notified Yes _____ No _____	

GASTROINTESTINAL

LAST BM DATE: _____	BOWEL SOUNDS:	ABDOMEN:
Bowel Patterns:	<input type="checkbox"/> Normal	<input type="checkbox"/> Soft
<input type="checkbox"/> Continent	<input type="checkbox"/> Hypoactive	<input type="checkbox"/> Firm
<input type="checkbox"/> Incontinent, Length of Incontinence _____	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Non-Tender
<input type="checkbox"/> Constipation, Effective Treatments _____	<input type="checkbox"/> None	<input type="checkbox"/> Tender
<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Distended
<input type="checkbox"/> Colostomy / Ileostomy		
PROBLEMS:	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Fissures/Fistulas
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Irritations
	<input type="checkbox"/> Pain	<input type="checkbox"/> Impaction
USUAL ELIMINATION PATTERN: Frequency _____	Time of Day: _____	
TUBE FEEDING:	Current Diet: _____	
<input type="checkbox"/> *NG Type: _____ Rate: _____	Appetite: Good _____ Fair _____ *Poor _____	
<input type="checkbox"/> *G-TUBE Type: _____ Rate: _____	Dentition: Intact _____ Poor _____	
<input type="checkbox"/> *J-TUBE Type: _____ Rate: _____	Dentures: Upper _____ Lower _____	
<input type="checkbox"/> *PEG Type: _____ Rate: _____	*Problems: (Circle All That Apply) Nausea _____ Vomiting _____ Diarrhea _____ GERD _____	
<input type="checkbox"/> *PARENTERAL FEEDING	Constipation _____ Chewing _____ Swallowing _____ Mouth/Tongue Lesions _____	
Type: _____ Rate: _____	*Food Allergies / Intolerances: _____	
<input type="checkbox"/> *Other: _____	_____	
Type: _____ Rate: _____	_____	

***NUTRITION CONSULT INDICATED:** YES NO Nutrition Notified Yes _____ No _____

RN Signature _____ Date _____