PATIENT CHART

Chart for Jennifer Hoffman

STUDENT NAME:	
PATIENT INITIALS:	
CLINICAL DATE(S):	
INSTRUCTOR:	

Jennifer Hoffman	**Gender:** Female	**Allergies:** Seasonal allergies (hay fever)		
DOB: 01/31/XX	**Age:** 33	**Height:** 155 cm (61 in)	**Weight:** 45 kg (99 lbs)	**MRN:** PCS13100
Adm DX: Acute asthma	**Adm Date:**	**Adm Provider:** John Arron, MD		
Adv Directive: Full code	**Location:** Emergency Department	**Contact Precaution:** Standard		

PATIENT INFORMATION

Marital Status: Married	**Religion:** Catholic
Next of Kin: Husband (Michael Hoffman)	**Race:** Caucasian
Primary Language: English	**Occupation:** Lawyer

History of Present Illness:
Recent upper respiratory infection

Past Medical History:
History of asthma since childhood with multiple emergency visits within the past year. Medications used at home include beclomethasone dipropionate (Qvar), salmeterol xinafoate inhaled (Serevent), and albuterol sulfate (ProAir) inhaler.

Immunizations:
Up to date

Surgeries/Procedures:
None

Social History:

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NURSING NOTES

Date:	Order:
Initials:	**Nurse Signature:**

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PROVIDER'S ORDERS

Date:	Order:
	Continuous ECG, SpO_2 monitoring, and vital signs every 5 minutes Oxygen to maintain SpO_2 greater than 92% IV normal saline at 150 mL/hour Meds: Albuterol 5 mg in 3 mL normal saline via nebulizer every 20 minutes × 3 doses Ipratropium 500 mcg with first dose of albuterol Methylprednisolone 125 mg IV push
Initials:	**Provider Signature:**
JA	John Arron

Jennifer Hoffman		**Gender:** Female	**Allergies:** Seasonal allergies (hay fever)	
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MEDICATION ADMINISTRATION RECORD

Scheduled and Routine Drugs

Medication:	Dose:	Route:	Frequency:	Ordering provider:	Times given:				
Albuterol	5 mg in 3 mL normal saline	Nebulizer	Every 20 minutes x 3 doses	JA					
Ipratropium	500 mcg	Nebulizer	With first dose of albuterol	JA					
Methylprednisolone	125 mg	IV push	x 1	JA					

PRN

Medication:	Dose:	Route:	Frequency:	Ordering provider:	Times given:				

Continuous Infusions

Medication:	Dose:	Route:	Frequency:	Ordering provider:	Times given:				
Normal saline	150 mL/hr	IV	Continuous	JA					

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INTAKE & OUTPUT

	Intake					Output				
Time/ date	**Oral**	**Tube feed**	**IV**	**IVPB**	**Other**	**Urine**	**Emisis**	**NG**	**Drains type**	**Other**
23-07										
Shift total:										
07-15										
Shift total:										
15-23										
Shift total:										

This is a worksheet to be used at the bedside to keep track of each intake and output. The totals will then be recorded on the 24 Hour Fluid Balance Sheet

Fluid Measurements

- 1 cc = 1 mL
- 1 ounce = 30 mL
- 8 ounces = 240 mL
- 1 cup = 8 ounces = 240 mL
- 4 cups = 32 ounces = 1 quart or 1 liter = 1000 mL

Sample Measurements

- Coffee cup = 200 mL
- Clear glass = 240 mL
- Milk carton = 240 mL
- Small milk carton = 120 mL
- Juice, gelatin or ice cream cup = 120 mL
- Soup bowl = 160 mL

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VITAL SIGNS

Date												
Time												
BP												
HR												
RR												
SpO_2												
Temperature	C° 40	F° 104										
	39.5	103										
	39	102										
	38.5	101										
	38	100										
	37.5	99										
	37	98										
	36.5	97										
	36	96										
Nurse Initials												

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NURSING ASSESSMENT FLOWSHEET

GENERAL APPEARANCE:
[ ] awake [ ] cheerful [ ] crying [ ] sleeping [ ] lethargic
[ ] calm [ ] agitated [ ] anxious [ ] combative [ ] fearful

SKIN: [ ] (see wound care sheet) [ ] see nursing notes
Braden scale score: [ ] risk skin breakdown
COLOR: [ ] acyanotic [ ] pale [ ] ruddy [ ] jaundiced
[ ] cyanotic
TEMP: [ ] warm/dry [ ] hot [ ] cool [ ]c old/clammy
[ ] diaphoretic
TURGOR: [ ] < 3 sec [ ] > 3 sec
HAIR: [ ] shiny [ ] dry/faking [ ] balding [ ] lesions [ ] lice

RESPIRATORY: [ ] see nursing notes
RESPIRATIONS: Rate______ O2_________ SPO2______%
[ ] reg [ ] even [ ] irreg [ ] labored
[ ] uses accessory muscles [ ] cough
BREATH SOUNDS:
RIGHT: [ ] clear [ ] crackles [ ] wheezes [ ] decreased
[ ] absent
Left: [ ] clear [ ] crackles [ ] wheezes [ ] decreased [ ] absent
THORAX: [ ] even expansion [ ] uneven expansion
SMOKING: cigarettes pk/day____________ [ ] cigars
[ ] marijuana [ ] cocaine

NEUROLOGICAL: [ ] see nursing notes
ORIENTATION: [ ] person [ ] place [ ] time
[ ] Disoriented: [ ] confused [ ] impaired memory
RESPONDS TO: [ ] name [ ] stimuli [ ] non-responsive
SPEECH: [ ] clear [ ] garbled [ ] slurred [ ] aphasic
[ ] inappropriate [ ] cannot follow conversation
FACE: [ ] symmetrical [ ] drooping [ ] drooling
EYES: [ ] PERRLA [ ] unequal [ ] drooping lid
SIGHT: [ ] no correction [ ] glasses [ ] contacts [ ] blind
HEARING: [ ] WNL [ ] HOH [ ] hearing aid
Hx: [ ] seizures [ ] CVA [ ] brain injury [ ] spinal injury [ ] other

GASTROINTESTINAL/NUTRITION [ ] see nursing notes
APPEARANCE: [ ] flat [ ] round [ ] obese [ ] soft [ ] gravid
BOWEL SOUNDS:
[ ] active [ ] hypoactive [ ] hyperactive [ ] absent
PALPATION:
[ ] non-tender [ ] tender (location)__________
[ ] mass (location) _____________
LAST BM:________ [ ] incontinent [ ] stoma- _______
[ ] constipation [ ] diarrhea [ ] mucous [ ] blood
Diet:______________ [ ] impaired swallowing [ ] choking
[ ] NG tube Color drainage______________ [ ] Feeding tube
[ ] tube feeding Type: ______________ Rate:_________

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 [ ] right [ ] left Location____________
RIGHT: [ ] strong [ ] weak [ ] flaccid [ ] contractures
LEFT: [ ] strong [ ] weak [ ] 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_____________

GENITOURINARY: [ ] see nursing notes [ ] Voids [ ] catheter
[ ] stoma
APPEARANCE OF URINE:
[ ] clear [ ] light yellow [ ] amber [ ] brown [ ] cloudy
[ ] sediment [ ] red/wine [ ] clots
BLADDER: [ ] soft [ ] firm/distended [ ] incontinent

FEMALES: LMP:_________ [ ] WNL [ ] dysmenorrheal
Birth control: [ ] yes [ ] no [ ] BSE monthly
[ ] menopause [ ] taking estrogen

SEXUALITY: [ ] sexually active [ ] safe sex
MED Hx: [ ] urinary retention [ ] BPH [ ] Frequent UTI

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NURSING ASSESSMENT FLOWSHEET – CONTINUED

CARDIOVASCULAR: [ ] see nursing notes
HEART SOUNDS: [ ] normal S1-S2 [ ] Abnormal S3-S4
[ ] murmur
PULSE: APICAL: [ ] reg [ ] irreg [ ] strong [ ] faint
RADIAL: [ ] reg [ ] irreg [ ] strong [ ] faint [ ] nonpalpable
PEDALIS: [ ] reg [ ] irreg [ ] strong [ ] faint [ ] nonpalpable
EXTREMITY COLOR & TEMP:
[ ] warm [ ] cool [ ] cold [ ] acyanotic [ ] cyanotic [ ] discolor
EDEMA: [ ] none [ ] generalized (anasarca)
Site #1______________
[ ] 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:_______

PAIN ASSESSMENT: [ ] see nursing notes [ ] see MAR
PRECIPITATING:________________________________
QUALITY:____________________________________
REGION:_____________________________________
SEVERITY 0-10/10: Now _____ at worst ______ at best _______
TIMING:

SAFETY: [ ] see nursing notes [ ] Fall risk
PRECAUTIONS: [ ] side rails x_______ [ ] bed down
[ ] call light
[ ] nightlight [ ] restraints [ ] wrist [ ] vest

DISCHARGE/TEACHING: [ ] see nursing notes
NEEDS:___________________________________

____

TYPE OF LEARNER: [ ] visual [ ] auditory [ ] kinesthetic
Educational level _____________ Family present: [Y] [N]

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
MUCOUS MEMBRANES: [ ] moist [ ] pink [ ] dry [ ] sticky
[ ] coated
Today's wt:______________ Yesterday's wt:________________

NURSE SIGNATURE:
Time completed:
REASSESSMENT:
TIME ________ [ ] no change [ ] see nurses notes [ ] initials___
TIME ________ [ ] no change [ ] see nurses notes [ ] initials___
TIME ________ [ ] no change [ ] see nurses notes [ ] initials___

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LABORATORY

Time:						
Arterial Blood Gas						
Oxygen flow (L/min or %)						
pH (7.35-7.45)						
PCO_2 (35-45 mmHg)						
PO_2 (80-100 mmHg)						
HCO_3 - (22-26 mEq/L)						
Base excess (±2)						
SaO_2 (>95%)						
Venous Blood Analysis						
Complete Blood Count:						
Hgb (13.5-17.5 g/dL)						
HCT (40-45%)						
WBC (5-11*10^9)						
Platelets (150-400*10^9)						
Basic Metabolic Panel:						
Na^+ (135-143 mEq/L)						
K^+ (3.5-5.1 mEq/L)						
Cl^- (90-110 mEq/L)						
HCO_3- (22-26 mEq/L)						
BUN (8-23 mg/dL)						
Creatinine (0.6-1.1 mg/dL)						
Glucose (70-110 mg/dL)						
Miscellaneous:						
Prothrombin time (10-14 s)						
INR (0.8-1.1)						
APTT (25-40 s)						
CRP (<10 mg/L)						
D-dimer (<0.5 mcg/mL)						
CK-MB (0-4.9 ng/mL)						
Troponin T (0-0.1 ng/mL)						
BUN (< 167 pg/mL)						
Lactate (0.5-2.2 mmol/L)						

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SBAR

Before calling the provider:

1. Assess the patient
2. Have charts and relevant information in front of you

SBAR Report	Patient Information	Notes
Situation	Identify yourself: Patient's name and reason for report: Concerns:	
Background	History includes: Current problems are: Any patient complaints:	
Assessment	Vital signs: Pain level: Lab values: Interventions completed: Give your conclusions:	
Recommendation	What I need from you is: Be specific about a time frame: Suggestions for tests/treatments: Verify orders and when to call back:	