

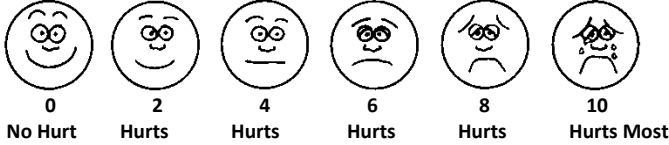
Patient Name	Date	Time in	Time Out	Total Hours
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VITAL SIGNS

Time	Temperature <input type="checkbox"/> Oral <input type="checkbox"/> Axillary <input type="checkbox"/> Other	Pulse <input type="checkbox"/> Apical <input type="checkbox"/> Radial	Respiration	Blood Pressure <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Sitting <input type="checkbox"/> Lying

PAIN ASSESSMENT

Wong-Baker FACES Pain Rating Scale ©



Location: _____ Current Pain Regime: _____

Is pain regime effective: ☐ Yes ☐ NO

Comment: _____

NUTRITION ASSESSMENT

Diet: ☐ NPO ☐ Regular ☐ Restricted/Type: _____

☐ Breast ☐ Formula-Type: _____ Other: _____

Amount: _____ Frequency: _____

Nutritional Risk Screening: ☐ LOW ☐ MED ☐ HIGH

Appetite: ☐ Good ☐ Fair ☐ Poor

Food Allergy: _____

Blood Sugar: _____ ☐ N/A

☐ Patient/Caregiver independent in diabetes management

Comment: _____

PATIENT/CAREGIVER EDUCATION

☐ Night shift/ teaching not appropriate ☐ PCG not available (or not living with patient) ☐ Paid Caregiver on duty Caregiver Name: _____

Topics Discussed and Individual

Taught to: ☐ Patient ☐ Family ☐ PCG ☐ Other: _____

Method: ☐ Discussion ☐ Demo ☐ Handout Other: _____

Level of Understanding: ☐ Good ☐ Fair ☐ Poor ☐ Needs reinforcement

Evaluation Method: ☐ Verbal ☐ Return Demo

Further Education needed: ☐ Equipment ☐ Therapies ☐ Medications

Medication Administration Management Nurse Notes:

Patient left in care of: _____

(RN/LPN/LVN)
Nurse name, Signature and Credentials / date

Patient/Family Signature Date