

Memorial Hospital	DATE	PATIENT LABEL
------------------------------	------	---------------

RESPIRATORY CARE VENTILATOR FLOWSHEET

DATE	TIME	HR PRE	HR POST	RR PRE	RR POST
------	------	--------	---------	--------	---------

LOC <input type="checkbox"/> Alert & Oriented <input type="checkbox"/> Alert & Confused <input type="checkbox"/> Combative	<input type="checkbox"/> Semi Conscious <input type="checkbox"/> Unconscious <input type="checkbox"/> Other _____	AMBULATORY <input type="checkbox"/> Yes <input type="checkbox"/> No	TOLERATION <input type="checkbox"/> Good <input type="checkbox"/> Bad <input type="checkbox"/> Poor	ADVERSE SIDE EFFECTS <input type="checkbox"/> No <input type="checkbox"/> Yes _____
--------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------

BREATH SOUNDS Before		MEDICATION ADMINISTRATION	DOSAGE	CPT	CXR	COUGH EFFORT	SPUTUM
<input type="checkbox"/> Clear <input type="checkbox"/> Wheezes <input type="checkbox"/> Rhonchi <input type="checkbox"/> Rales <input type="checkbox"/> ↓ <input type="checkbox"/> ↓↓ <input type="checkbox"/> RUL <input type="checkbox"/> RLL <input type="checkbox"/> LUL <input type="checkbox"/> LLL	After <input type="checkbox"/> Clear <input type="checkbox"/> Wheezes <input type="checkbox"/> Rhonchi <input type="checkbox"/> Rales <input type="checkbox"/> ↓ <input type="checkbox"/> ↓↓ <input type="checkbox"/> RUL <input type="checkbox"/> RLL <input type="checkbox"/> LUL <input type="checkbox"/> LLL	<input type="checkbox"/> Albuterol Sulfate <input type="checkbox"/> Metaproterenol Sulfate <input type="checkbox"/> Ipratropium Bromide <input type="checkbox"/> Cromolyn Sodium <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Unit Dose <input type="checkbox"/> 1/2 Unit Dose <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Nebulizer <input type="checkbox"/> Air <input type="checkbox"/> O ₂ <input type="checkbox"/> MDI	<input type="checkbox"/> RUL <input type="checkbox"/> RML <input type="checkbox"/> RLL <input type="checkbox"/> LUL <input type="checkbox"/> LLL	<input type="checkbox"/> Clear <input type="checkbox"/> Infiltrate <input type="checkbox"/> Atelectasis <input type="checkbox"/> Effusion <input type="checkbox"/> Consolidation <input type="checkbox"/> Hyper / Hypo-inflation <input type="checkbox"/> Not Available	<input type="checkbox"/> Strong NPROD <input type="checkbox"/> Strong PROD <input type="checkbox"/> Mod NPROD <input type="checkbox"/> Mod PROD <input type="checkbox"/> Weak NPROD <input type="checkbox"/> N/A	<input type="checkbox"/> Clear <input type="checkbox"/> Mucoid <input type="checkbox"/> Small Amount <input type="checkbox"/> Large Amount
COMMENTS						THERAPIST / TECH SIGNATURE	

DATE	TIME	HR PRE	HR POST	RR PRE	RR POST
------	------	--------	---------	--------	---------

LOC <input type="checkbox"/> Alert & Oriented <input type="checkbox"/> Alert & Confused <input type="checkbox"/> Combative	<input type="checkbox"/> Semi Conscious <input type="checkbox"/> Unconscious <input type="checkbox"/> Other _____	AMBULATORY <input type="checkbox"/> Yes <input type="checkbox"/> No	TOLERATION <input type="checkbox"/> Good <input type="checkbox"/> Bad <input type="checkbox"/> Poor	ADVERSE SIDE EFFECTS <input type="checkbox"/> No <input type="checkbox"/> Yes _____
--------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------

BREATH SOUNDS Before		MEDICATION ADMINISTRATION	DOSAGE	CPT	CXR	COUGH EFFORT	SPUTUM
<input type="checkbox"/> Clear <input type="checkbox"/> Wheezes <input type="checkbox"/> Rhonchi <input type="checkbox"/> Rales <input type="checkbox"/> ↓ <input type="checkbox"/> ↓↓ <input type="checkbox"/> RUL <input type="checkbox"/> RLL <input type="checkbox"/> LUL <input type="checkbox"/> LLL	After <input type="checkbox"/> Clear <input type="checkbox"/> Wheezes <input type="checkbox"/> Rhonchi <input type="checkbox"/> Rales <input type="checkbox"/> ↓ <input type="checkbox"/> ↓↓ <input type="checkbox"/> RUL <input type="checkbox"/> RLL <input type="checkbox"/> LUL <input type="checkbox"/> LLL	<input type="checkbox"/> Albuterol Sulfate <input type="checkbox"/> Metaproterenol Sulfate <input type="checkbox"/> Ipratropium Bromide <input type="checkbox"/> Cromolyn Sodium <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Unit Dose <input type="checkbox"/> 1/2 Unit Dose <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Nebulizer <input type="checkbox"/> Air <input type="checkbox"/> O ₂ <input type="checkbox"/> MDI	<input type="checkbox"/> RUL <input type="checkbox"/> RML <input type="checkbox"/> RLL <input type="checkbox"/> LUL <input type="checkbox"/> LLL	<input type="checkbox"/> Clear <input type="checkbox"/> Infiltrate <input type="checkbox"/> Atelectasis <input type="checkbox"/> Effusion <input type="checkbox"/> Consolidation <input type="checkbox"/> Hyper / Hypo-inflation <input type="checkbox"/> Not Available	<input type="checkbox"/> Strong NPROD <input type="checkbox"/> Strong PROD <input type="checkbox"/> Mod NPROD <input type="checkbox"/> Mod PROD <input type="checkbox"/> Weak NPROD <input type="checkbox"/> N/A	<input type="checkbox"/> Clear <input type="checkbox"/> Mucoid <input type="checkbox"/> Small Amount <input type="checkbox"/> Large Amount
COMMENTS						THERAPIST / TECH SIGNATURE	

DATE	TIME	HR PRE	HR POST	RR PRE	RR POST
------	------	--------	---------	--------	---------

LOC <input type="checkbox"/> Alert & Oriented <input type="checkbox"/> Alert & Confused <input type="checkbox"/> Combative	<input type="checkbox"/> Semi Conscious <input type="checkbox"/> Unconscious <input type="checkbox"/> Other _____	AMBULATORY <input type="checkbox"/> Yes <input type="checkbox"/> No	TOLERATION <input type="checkbox"/> Good <input type="checkbox"/> Bad <input type="checkbox"/> Poor	ADVERSE SIDE EFFECTS <input type="checkbox"/> No <input type="checkbox"/> Yes _____
--------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------

BREATH SOUNDS Before		MEDICATION ADMINISTRATION	DOSAGE	CPT	CXR	COUGH EFFORT	SPUTUM
<input type="checkbox"/> Clear <input type="checkbox"/> Wheezes <input type="checkbox"/> Rhonchi <input type="checkbox"/> Rales <input type="checkbox"/> ↓ <input type="checkbox"/> ↓↓ <input type="checkbox"/> RUL <input type="checkbox"/> RLL <input type="checkbox"/> LUL <input type="checkbox"/> LLL	After <input type="checkbox"/> Clear <input type="checkbox"/> Wheezes <input type="checkbox"/> Rhonchi <input type="checkbox"/> Rales <input type="checkbox"/> ↓ <input type="checkbox"/> ↓↓ <input type="checkbox"/> RUL <input type="checkbox"/> RLL <input type="checkbox"/> LUL <input type="checkbox"/> LLL	<input type="checkbox"/> Albuterol Sulfate <input type="checkbox"/> Metaproterenol Sulfate <input type="checkbox"/> Ipratropium Bromide <input type="checkbox"/> Cromolyn Sodium <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Unit Dose <input type="checkbox"/> 1/2 Unit Dose <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Nebulizer <input type="checkbox"/> Air <input type="checkbox"/> O ₂ <input type="checkbox"/> MDI	<input type="checkbox"/> RUL <input type="checkbox"/> RML <input type="checkbox"/> RLL <input type="checkbox"/> LUL <input type="checkbox"/> LLL	<input type="checkbox"/> Clear <input type="checkbox"/> Infiltrate <input type="checkbox"/> Atelectasis <input type="checkbox"/> Effusion <input type="checkbox"/> Consolidation <input type="checkbox"/> Hyper / Hypo-inflation <input type="checkbox"/> Not Available	<input type="checkbox"/> Strong NPROD <input type="checkbox"/> Strong PROD <input type="checkbox"/> Mod NPROD <input type="checkbox"/> Mod PROD <input type="checkbox"/> Weak NPROD <input type="checkbox"/> N/A	<input type="checkbox"/> Clear <input type="checkbox"/> Mucoid <input type="checkbox"/> Small Amount <input type="checkbox"/> Large Amount
COMMENTS						THERAPIST / TECH SIGNATURE	

RESPIRATORY CARE VENTILATOR FLOWSHEET