DIAGNOSIS:	EATING:	
	INDEPENDENT:	
	SET - UP:	
	ASSIST:	
DATE OF ADMISSION:	TOTAL ASSISTANCE:	
HISTORY:	FLUIDS / IVs:	
	ADL PERFORMANCE:	
	SELF:	
	ASSIST:	
	SET UP HELP:	
	TOTAL ASSISTANCE:	
OPERATIVE PROCEDURES:	HYGIENE:	☐ BED BATH
	□shower	☐ PARTIAL BATH
	ACTIVITY:	TURN:
	☐ BED REST	☐ AMBULATE
NURSING ORDERS:	□BRP	□нов
	☐ CHAIR	☐ SPECIAL POSITION:
	□BSC	
	MODE OF TRANSP: □	W/C ☐ STR ☐ H/C ☐ AMBULATE ☐ BEI
	ALLERGIES:	□ NK
	PA	TIENT IDENTIFICATION

PART OF THE MEDICAL RECORD

DATE	CONSULTS / APPOINTMENTS			DIAGNOSTIC TESTS and SPECIMENS				
	DENTAL:	C Date:	A Date:	DATE ORDERED	TESTS	DATE TO BE DONE	DONE	ORDER #
	DIETARY:	C Date:	A Date:					
	ENT:	C Date:	A Date:					
	PODIATRY:	C Date:	A Date:					
	PSYCH:	C Date:	A Date:					
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REHAB THE							+	
PHYSICAL		,		 			+	
	ONAL THERAP	Υ: 					+	
SPEECH TH				1			+	
REHAB NU	RSING:						+	
ROM:			☐ PASSIVE ☐ ACTIVE				+	
WALKING:				 			+	
BLADDER:		10.0455	☐ TRAINING ☐ BOWEL				+	
	ON PROSTHES	IS CARE:		 			+	
SPLINT ASS				 			+	
BED MOBIL								
TRANSFER		0-00	NO.	CODE STATU				
DRESSING:		GROOMII	NG:	☐ FULL CODE	□ DNR	☐ DO NOT	HUSP	'I I ALIZE
COMMUNIC	CA FION:			SAFETY:				

EATING / SWALLOWING	<u>:</u>		☐ BED ALARM	☐ CHAIR ALARM		☐ LOW BED			
TOILET USE:			TRANSFERS:						
BOWEL:			1 PERSON:						
CONTINENT:			2 PERSON:						
INCONTINENT:			PHYSICAL LIFT:						
BOWEL PROGRAM:			MECHANICAL LIFT:						
COLOSTOMY: ILEOSTOMY:			WEIGHT BEARING ST	WEIGHT BEARING STATUS:					
BLADDER:			□FWB	□PWB	□TTWB				
CONTINENT:			EQUIPMENT:						
INCONTINENT:			TEDS:		☐ KNEE	☐ THIGH			
INDWELLING / SUPRAPL	JBIC CATHETER:		KNEE IMMOBILIZER:						
POST VOID RESIDUAL:			C P M:						
UROSTOMY:			TRAPEZE:						
RESPIRATORY THERAP	Y:		WHEELCHAIR:						
O 2: LITERS	: NC:	MASK:	WALKER:						
INCENTIVE SPIROMETE	R:		RECLINER CHAIR:						
PULSE OXIMETRY Q:			SUPPORT SURFACE:						
SUCTION:			PROSTHESIS:						
PRECAUTIONS:			DENTURES:		☐ UPPER	LOWER			
CONTACT:			HEARING AIDE:						
DROPLET:			GLASSES:						
AIRBORNE:			CONTACTS:		LEFT	RIGHT			
BLOOD GLUC MONITOR	RING:		BRACE:						
FREQUENCY:			SPLINT:						
NUTRITION:			MENTAL STATUS:						
DIET:	☐ DIET CHANGE	D	ALERT:						
TUBE FEEDING:	GT:	JT:	CONFUSED:						
BOLUS:	CONTINUOUS:		AGITATED:						
CALORIE COUNT:		/ DAYS	MEMORY IMPAIRMENT	T:					
SUPPLEMENT:			LETHARGIC:	COMAT	TOSE:				
ROOM #:	NAME	AGE	FALLS SKIN PROTOCOL PROTOCOL	PHYSICIAN	l:	CODE STATUS			
	DAD	T OF THE	MEDICAL REC	CORD					
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