MED - SURG KARDEX

CODE STATUS

ADVANCE DIRECTIVE
YES ☐
NO ☐

DIET TYPE: _____

TUBE FEEDING:

FEED ☐
ASSIST ☐
SELF ☐

FLUID RESTRICTION
D _____
E _____
N _____

VITAL SIGNS
q4h _____
q8h _____
OTHER _____
CVP _____

WEIGHT

INTAKE / OUTPUT
YES ☐ NO ☐
DRAINS:
FOLEY _____
NGT _____ SUCTION _____
JP _____
CT _____ SUCTION _____
HEMOVAC _____
GT _____
OSTOMY _____
OTHER

SAFETY
FALL PRECAUTIONS _____
SIDE RAILS X 2 _____
SIDE RAILS X 4 _____
RESTRAINTS

	ORDER DATE	EXP DATE
POSEY VEST		
2 POINT		
4 POINT		
OTHER		

PAST MEDICAL HISTORY:

BATH
COMPLETE _____
ASSIST _____
SELF _____
TUB _____
SHOWER

ACTIVITY
BEDREST _____
BRP _____
OOB CHAIR _____
AMBULATORY _____

USUAL MOBILITY
BED / CHAIR CONFINED _____
TRANSFERS WITH ASSIST _____
AMBULATES WITH ASSIST _____
AMBULATORY _____
ASSISTIVE DEVICE _____

SPECIAL NOTICE:

OXYGEN

POSITION
☐ SPECIALTY BED _____
☐ SOF. CARE MATTRESS

MENTAL STATUS / BEHAVIOR

TYPE OF IV: _____
LOCATION: _____
DATE OF INSERTION: _____
BY: _____
DATE OF DC: _____

TYPE OF IV: _____
LOCATION: _____
DATE OF INSERTION: _____
BY: _____
DATE OF DC: _____

TEACHING NON TEACHING _____

ALLERGIES

RELIGION

CONDITION

SURGICAL PROCEDURE

PART OF THE MEDICAL RECORD

DATE ORD.	DAILY TESTS	DATE DONE
	☐ ACCUCHECKS	
	☐ OTHER	

DATE ORD.	DATE TO BE DONE	ROUTINE ORDERS & STAT TESTS	

DATE ORDERED	TREATMENTS
	RESPIRATORY THERAPY ORDERS:
	WOUND CARE / DRESSING CHANGES:
	PT / OT:
	SKIN CARE TREATMENTS:
	MISCELLANEOUS:

PART OF THE MEDICAL RECORD

DISCHARGE PLANNING

ANTICIPATED DISPOSITION:

HOME _____ **HOME WITH HOME CARE** _____ **SPECIFY** _____

NH RETURN _____ **NH PLACEMENT** _____ **OTHER** _____

HOME CARE AGENCY _____

CARETAKER / PERSON AVAILABLE p̄ DISCHARGE _____

PHONE NO _____ **RELATIONSHIP** _____

LEGAL GUARDIAN / NEXT OF KIN _____

HOME PHONE _____ **WORK PHONE** _____

CONSULTS	REASON	Date Requested	Date Done
☐ SOCIAL SERVICES			
☐ HOME CARE			
☐ DIETARY			
☐ PT / OT			
☐ SPEECH			
☐ GERIATRIC			
☐ SKIN CARE			
☐ OTHER:			
☐			

COMMUNITY SUPPORT PROGRAM REFERRALS: _____

PATIENT / FAMILY TEACHING NEEDS:

MEDICATIONS _____ **WOUND CARE** _____ **NGT / GT FEEDING** _____

OTHER: _____

DATE REQUESTED	D/C ROUNDS - ISSUES FOR FOLLOW UP	INITIALS / DATE DONE

ROOM	NAME	AGE	DIAGNOSIS	PHYSICIAN	SERVICE	ADM DATE

PART OF THE MEDICAL RECORD

DATE REQUESTED	D/C ROUNDS - ISSUES FOR FOLLOW UP	INITIALS / DATE DONE

PART OF THE MEDICAL RECORD