Your Hospital's Logo Here

# MONTHLY SUMMARY

PATIENT IDENTIFICATION

DATE:

MONTH: YEAR:

**1. MOBILITY:**
☐ WHEELCHAIR ☐ WALKER ☐ AMBULATE
☐ CANE / CRUTCH ☐ AMPUTATION Site >> __ L __ R
☐ SELF O Asst: _____

**2. FALL PRECAUTIONS:** ☐ Yes ☐ No ☐ ALARM Type >> _____ ☐ LO MAX BED ☐ BLUE MAT

**3. POSITION:** ☐ EVERY 2 HOURS ☐ WHILE IN BED ☐ SELF ☐ CHAIR

**4. MENTAL STATUS:**
☐ ALERT ☐ CONFUSED ☐ CHANGES OFTEN ☐ POOR MEMORY ☐ WANDERS
☐ SEMI-COMATOSE ☐ COMATOSE ☐ ORIENTED >> Person _____ Place _____ Time _____

**5. EMOTIONAL:**
☐ FRIENDLY ☐ QUIET ☐ WITHDRAWN ☐ ANXIOUS ☐ NOISY
☐ EASILY UPSET ☐ HOSTILE ☐ COOPERATIVE ☐ INTERFERES WITH CARE
☐ EXPRESSES ACCORDING TO SITUATION

**6. PSYCHOTROPIC DRUG USE:** TYPE _____ OBSERVED BEHAVIORAL INTERVENTION _____

**7. SKIN INTEGRITY:** ☐ DRY & FRAGILE
☐ GOOD ☐ ABRASION ☐ PRESSURE ULCER >> Location _____ Stage _____
☐ FAIR ☐ DRY PEDAL PULSE: ☐ Yes ☐ No Treatment _____

**8. EDEMA:** ☐ Yes ☐ No DEGREE _____ LOCATION _____

**9. BLADDER:**
☐ CONTINENT ☐ NON-CONTINENT ☐ ASSIST TO BATHROOM ☐ CATHETER ☐ IRRIGATION
URINE COLOR _____ CONSISTENCY _____

**10. BOWEL:**
☐ REGULAR ☐ INCONTINENT ☐ LAXATIVES ☐ ENEMAS ☐ SUPPOSITORY
☐ DIARRHEA ☐ CONSTIPATION

**11. BRIEFS:**
☐ WORN DURING SLEEP ☐ WORN WHILE AWAKE ☐ NOT USED (See CARE PLAN)

**12. EATING HABITS:**
☐ GOOD APPETITE ☐ POOR APPETITE ☐ FEEDS WITH ASSIST ☐ SELF-FEED ☐ TOTAL FEED
☐ EATS IN DINING ROOM ☐ G-TUBE ☐ J-TUBE ☐ PLEASURE FOODS ☐ SWALLOW PRECAUTIONS

**13. SLEEPING PATTERN:**
☐ POOR ☐ SLEEPS AT NIGHT ☐ NEEDS NAP ☐ NEEDS REST ☐ DIFFICULTY RESTING
☐ AWAKENS FREQUENTLY ☐ REQUIRES HS MEDICATION FOR SLEEP

**14. PAIN:** ☐ Yes ☐ No (See PAIN MANAGEMENT FORM)

**15. VISION:**
☐ GOOD ☐ ADEQUATE WITH GLASSES ☐ POOR ☐ BLIND ☐ MAGNIFIER

**16. HEARING:**
☐ GOOD ☐ POOR ☐ RIGHT ☐ LEFT ☐ ADEQUATE WITH HEARING AID ☐ AMPLIFIER

**17. SPEECH:**
☐ DIFFICULTY ☐ APHASIA ☐ SLURRED ☐ CLEAR ☐ LOW TONE ☐ NORMAL ☐ NON VERBAL

**18. ORAL HYGIENE:**

☐ DENTURES ☐ NEEDS ASSIST ☐ NEEDS TOTAL STAFF CARE ☐ HAS OWN TEETH ☐ SELF-CARE

☐ TOOTHLESS ☐ CAVITIES CONDITION OF MOUTH _____

**19. SOCIAL:**

☐ GOOD FAMILY RELATIONS ☐ POOR FAMILY RELATIONS ☐ FREQUENT VISITORS ☐ FEW VISITORS

☐ NO VISITORS ☐ SOCIALIZES WITH OTHERS ☐ SPIRITUAL NEEDS ADDRESSED

**20. GROOMING:**

☐ SELF-CARE ☐ NEEDS ASSISTANCE ☐ TOTAL CARE

**21. HYGIENE:**

☐ BATH ☐ BED BATH ☐ TUB BATH ☐ SHOWER ☐ SHAMPOO HAIR

**22. NAILS:**

☐ Finger Nail SELF-CARE ☐ Finger Nail STAFF ASSIST ☐ Toe Nail SELF-CARE ☐ Toe Nail STAFF ASSIST

**23. CONTRACTURES:** ☐ Yes ☐ No ☐ HANDS ☐ LEGS ☐ ARMS ☐ FOOT __ L __ R

**24. SPLINTS:** ☐ PALMAR GRIP ☐ BRACE TYPE _____ OTHER Assistive Devices _____

| **25. VITAL SIGNS:** | TEMP | PULSE | RESP | WEIGHT |
|---|---|---|---|---|
| | | | | |

**26. HEMODIALYSIS:** ☐ MWF ☐ TTHS FREQUENCY _____

**LAST SUMMARY WEIGHT**

**27. OXYGEN:** ADMINISTRATION RATE _____ OTHER _____

**28. GLUCOSE FINGERSTICK:** Results Range (below)

Resident's Symptoms _____

_____

Frequency of SSRI _____

## COMMENTS

NURSE'S SIGNATURE / TITLE:

DATE: