

PATIENT PROGRESS NOTES

<p>Nurses Notes (VAR) (1500-2300) V = Variance A = Action R = Response</p>	<p align="center">2300-0700</p> <p>Assessment Completed _____ Time _____</p> <p>SIGNATURE _____</p> <p>ORIENTED TO: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Lethargic <input type="checkbox"/> Restless <input type="checkbox"/> Unresponsive</p> <p>SPEECH: <input type="checkbox"/> Clear <input type="checkbox"/> Slurred <input type="checkbox"/> Garbled <input type="checkbox"/> Rambling <input type="checkbox"/> Mute</p> <p>COMMANDS: <input type="checkbox"/> Follows consistently <input type="checkbox"/> Occasionally <input type="checkbox"/> Does not follow</p> <p>Comments: _____</p> <p>Purposful Action: <input type="checkbox"/> Always <input type="checkbox"/> Some <input type="checkbox"/> None Strength: RUE <input type="checkbox"/> Strong <input type="checkbox"/> Moderate <input type="checkbox"/> Weak LUE <input type="checkbox"/> Strong <input type="checkbox"/> Moderate <input type="checkbox"/> Weak RLE <input type="checkbox"/> Strong <input type="checkbox"/> Moderate <input type="checkbox"/> Weak LLE <input type="checkbox"/> Strong <input type="checkbox"/> Moderate <input type="checkbox"/> Weak</p> <p>Gait: <input type="checkbox"/> Normal <input type="checkbox"/> Slow/Steady <input type="checkbox"/> Unsteady <input type="checkbox"/> Not Walking Gait: RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE</p> <p>Comments: _____</p> <p><input type="checkbox"/> Calm <input type="checkbox"/> Cooperative <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> Forgetful <input type="checkbox"/> Agitated <input type="checkbox"/> Hallucinating</p> <p>Comments: _____</p> <p>HEART SOUNDS: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular EDEMA: <input type="checkbox"/> None site <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ site <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+</p> <p>RADIAL PULSE: Left <input type="checkbox"/> ϕ <input type="checkbox"/> Weak <input type="checkbox"/> Strong Right <input type="checkbox"/> ϕ <input type="checkbox"/> Weak <input type="checkbox"/> Strong</p> <p>PEDAL PULSE: Left <input type="checkbox"/> ϕ <input type="checkbox"/> Weak <input type="checkbox"/> Strong Right <input type="checkbox"/> ϕ <input type="checkbox"/> Weak <input type="checkbox"/> Strong</p> <p>Skin: <input type="checkbox"/> Warm <input type="checkbox"/> Cold <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundice</p> <p>Comments: _____</p> <p>RESP. <input type="checkbox"/> Reg <input type="checkbox"/> Ireg <input type="checkbox"/> Easy <input type="checkbox"/> Labored Clear <input type="checkbox"/> RUL <input type="checkbox"/> RML <input type="checkbox"/> RLL <input type="checkbox"/> LU <input type="checkbox"/> LLL Crackles <input type="checkbox"/> RUL <input type="checkbox"/> RML <input type="checkbox"/> RLL <input type="checkbox"/> LU <input type="checkbox"/> LLL Rhonchi <input type="checkbox"/> RUL <input type="checkbox"/> RML <input type="checkbox"/> RLL <input type="checkbox"/> LU <input type="checkbox"/> LLL Wheezes <input type="checkbox"/> RUL <input type="checkbox"/> RML <input type="checkbox"/> RLL <input type="checkbox"/> LU <input type="checkbox"/> LLL <input type="checkbox"/> Cough: <input type="checkbox"/> Strong <input type="checkbox"/> Weak Trach <input type="checkbox"/></p> <p>Secretions: _____ O2 Therapy: _____ /SpO2 _____</p> <p><input type="checkbox"/> CHEST TUBE <input type="checkbox"/> Suction _____ cm <input type="checkbox"/> Gravity <input type="checkbox"/> Fluctuation <input type="checkbox"/> Air Leak</p> <p>Comments: _____</p> <p>ABD: <input type="checkbox"/> Soft <input type="checkbox"/> Non Tender <input type="checkbox"/> Distended <input type="checkbox"/> Tender <input type="checkbox"/> NAUSEA/VOMITING</p> <p>BOWEL SOUNDS: <input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Hypoactive <input type="checkbox"/> Hyperactive</p> <p>BM: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> None <input type="checkbox"/> Formed <input type="checkbox"/> Liquid</p> <p>COLOR: _____</p> <p>TUBES <input type="checkbox"/> NG <input type="checkbox"/> GT <input type="checkbox"/> JT <input type="checkbox"/> Feeding tube <input type="checkbox"/> Suction <input type="checkbox"/> Placement <input type="checkbox"/> Residual _____ ml</p> <p>DRAINS: <input type="checkbox"/> T-Tube <input type="checkbox"/> JP <input type="checkbox"/> Hemovac <input type="checkbox"/> Tenchoff Cahetar Ostomy Type: _____ <input type="checkbox"/> Red(normal) <input type="checkbox"/> Dusky <input type="checkbox"/> Edematous</p> <p>Comments: _____</p> <p><input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Voiding <input type="checkbox"/> Foley <input type="checkbox"/> Suprapubic <input type="checkbox"/> Nephrostomy <input type="checkbox"/> Urostomy <input type="checkbox"/> External Cath <input type="checkbox"/> 3-way Irrigation <input type="checkbox"/> Clear <input type="checkbox"/> Cloudy <input type="checkbox"/> Sediment <input type="checkbox"/> Clots <input type="checkbox"/> Yellow <input type="checkbox"/> Amber <input type="checkbox"/> Red <input type="checkbox"/> Pink <input type="checkbox"/> Vaginal Drainage <input type="checkbox"/> Bladder Distention</p> <p>Comments: _____ AV Graft Location: _____ Thrill <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Absent Bruit <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Absent</p>	<p>Nurses Notes (VAR) (2300-0700) V = Variance A = Action R = Response</p>
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