

Nurse Brain Sheet

Patient information				
Name:		Date of birth:		
Room number:		Sex:		
Emergency contact:				
Contact information:		Admission date:		
Address:				
Patient background				
Chief complaint/admission reason:				
Allergies:				
Mobility:				
<input type="checkbox"/> Independent Needs assistance Bedrest				
Code:				
<input type="checkbox"/> Full DNR Limited				
Situation:				
<input type="checkbox"/> Fall risk Restraints Confused Aspiration Suicide				
Precaution:				
<input type="checkbox"/> None Contact Droplet Seizure Airborne				
Diet:				
<input type="checkbox"/> Oral NPO Liquid Tube feed				

Vital signs	
Temperature:	Blood pressure:
Heart rate:	Respiratory rate:
SPO2:	
Assessment	
Diagnosis:	
Test/procedures conducted:	
Laboratory:	
Neurological:	
Cardiovascular:	
Respiratory:	
Gastrointestinal:	

Medications and tasks	
Time	Task
Care plan	
Discharge plan	
Additional notes	
Nurse-in-charge:	
Designation:	
Signature:	
Date:	