

Nurse Brain Sheets

Patient Name: Date:

Room Number: Code:

Allergy:

Admission Date:

Admission Reason:

Background:

Safety	Isolation:
<input type="checkbox"/> Confused <input type="checkbox"/> Fall <input type="checkbox"/> Restraints <input type="checkbox"/> Alarm <input type="checkbox"/> Suicide	<input type="checkbox"/> None <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne <input type="checkbox"/> Neutroperic

Assessment:

Vital Signs	Diagnostic Tests:
<p>Blood Pressure:</p> <p>Heart Rate:</p> <p>Respiratory Rate:</p> <p>Temperature:</p> <p>Oxygen Saturation:</p>	<p>Pending Tests:</p> <p>Results and Interpretation:</p>

Assessment	Medications:
<p>General Appearance:</p> <p>Neurological Status:</p>	<ul style="list-style-type: none"> • List of Current Medications: <li style="margin-left: 20px;">• <li style="margin-left: 20px;">• • Dosages and Frequencies:

Respiratory Status:

- Last Administered:

Cardiovascular Status:

Gastrointestinal Status:

Genitourinary Status:

Musculoskeletal Status:

Interventions:

- Scheduled Procedures:
- Nursing Interventions:
- Patient Education:

Collaborative Care:

- Physician Rounds:
- Consultations:
- Allied Health Team Involvement:

Goals and Plan of Care:

- Short-Term Goals:
- Long-Term Goals:
- Care Plan Overview: