

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	<input type="checkbox"/> Needs assistance	<input type="checkbox"/> Bedrest		
Code:				
<input type="checkbox"/> Full	<input type="checkbox"/> DNR	<input type="checkbox"/> Limited		
Situation:				
<input type="checkbox"/> Fall risk	<input type="checkbox"/> Restraints	<input type="checkbox"/> Confused	<input type="checkbox"/> Aspiration	<input type="checkbox"/> Suicide
Precaution:				
<input type="checkbox"/> None	<input type="checkbox"/> Contact	<input type="checkbox"/> Droplet	<input type="checkbox"/> Seizure	<input type="checkbox"/> Airborne
Diet:				
<input type="checkbox"/> Oral	<input type="checkbox"/> NPO	<input type="checkbox"/> Liquid	<input type="checkbox"/> 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:**