Nurse Charting Cheat Sheet

1. Patient Information	
Name:	John Doe
Medical Record Number:	123456
Date of Birth:	01/15/1975
Allergies:	None known

2. Vital Signs		
Area:	**Format:**	**Notes:**
Temperature	*[Numeric Value] °C/°F*	37.2°C
Heart Rate (HR)	*[Numeric Value] bpm*	78 bpm
Blood Pressure (BP)	*[Numeric Value] / [Numeric Value] mmHg*	120/78 mmHg
Respiratory Rate (RR)	*[Numeric Value] breaths/min*	18 breaths/min
Oxygen Saturation (SpO2)	*[Numeric Value] %*	98%

3. Assessment	
Neurological	
Level of Consciousness (LOC):	Pupils:
☑ Alert ☐ Responsive to stimuli ☐ Verbal ☐ Pain ☐ Unresponsive	☑ Equal ☑ Reactive to light
Additional Notes:	Additional Notes:
Oriented	

Cardiovascular	
Heart Sounds:	Peripheral Pulses:
☑ Normal ☐ Abnormal	☑ Present ☐ Absent
Additional Notes:	Additional Notes:
Regular rate and rhythm	Radial and pedal pulses present
Respiratory	
Breath Sounds:	Oxygen Delivery:
☑ Clear ☐ Wheezing ☐ Crackles	☑ Room air ☐ Nasal cannula ☐ Mask
Additional Notes:	Additional Notes:
Clear bilaterally	
Gastrointestinal	
Bowel Sounds:	Abdominal Assessment:
☑ Present ☐ Absent	☑ Soft ☐ Tender ☐ Distended
Additional Notes:	Additional Notes:
Present in all quadrants	Non-tender
Musculoskeletal	
Range of Motion (ROM):	Strength *(Rate out of 5; 1 = lowest, 5 = highest)*:
☑ Full ☐ Limited	5 / 5

Additional Notes:	Additional Notes:
	5/5 in all extremities

4. Interventions

Medications

List of medications, dosage, route, and time:

Acetaminophen 500mg PO q4h PRN for pain

Normal saline 1000 mL IV over 8 hours

Procedures

Description of any procedures performed:

Wound dressing change on the right forearm

Education Provided

Topics discussed with the patient and/or family:

Reviewed discharge instructions with the patient and family

5. Fluids and Nutrition

Intake

Oral:

- [x] Fluids
- [ ] Medications

Additional Notes: Clear fluids as tolerated

IV *(Type of fluid, Rate)*: Normal saline 1000 mL

Output

Urine *(Color, Amount)*: Pale yellow, 800 mL in the last 8 hours

6. Pain Assessment	
Pain Scale	**Pain Location**
Numeric rating or descriptive scale:	*Specify the location of the pain:*
2/10	Right forearm

7. Nursing Care	
Turning and Positioning Schedule	**Skin Integrity**
Frequency of turning and repositioning:	*Assessment of any skin breakdown:*
Turned every 2 hours	No signs of skin breakdown

8. Other Observations	
Mental Health	**Infection Control**
Any observed changes in mood or behavior:	*Use of isolation precautions if applicable:*
Cooperative and in good spirits	Standard precautions followed

9. Communication
Interdisciplinary Communication
Communication with other healthcare team members:
Discussed patient care plan with the physician during rounds

Nurse's Signature
Nigel Simon
Date: January 28, 2024