

Nursing Brain Sheet

Patient information															
Date:		Name:		Age:		Gender:		Sex:							
Admitted:		Diagnosis:		Allergies:		Isolation:		Consults:							
Room #:		Attending:		Code status: Full code DNR TOSA+											
Situation		Assessment													
		Date:		IV:		Site:		Central:		IVF:		Drips:			
		Vital signs		Pain (Level, location, medication, frequency, etc.)				Genitourinary		Musculoskeletal					
		Heart rate:						Voiding Foley Incontinence Diarrhea Clear Cloudy Yellow Bloody Amber		Weakness:		Numbness:			
		Blood pressure:													
		O2:													
Background		O2:													
PMH:		Tests:		Temperature:		Respiratory rate:									
DM CHF HTN CAD PCI HLD PVD GERD COPD Asthma CKD ESRD Smoker Drug abuse Psych CVA Dementia Hypothyroid CA Other:		MRI CT X-ray Endo US Cath Other:		Neuro				Respiratory							
				A&O x _____ I		Confused		O2:							
				Activity:		Notes:		Breath sounds:		Notes:					
								Cough:							
								Treatments:							
								Notes:							
												Dialysis:			
								Others							
				Cardiovascular				Gastrointestinal							
				Rhythm:				Diet:							
				Edema:				BM:				Recommendation			
				Pulses:				Notes:				Scheduled procedures:			
				Notes:								Consults:		Discharge to:	
												Others:			