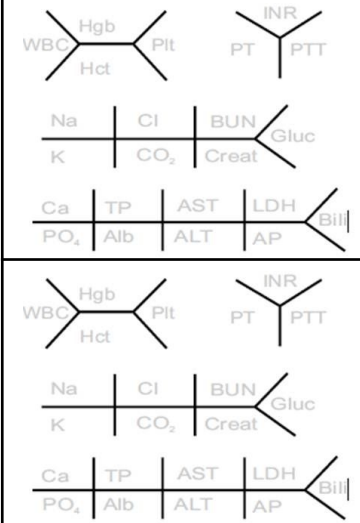
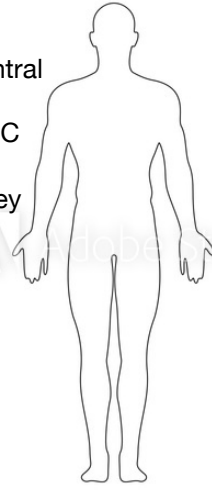


Name / Rm#		Age	Weight	Code Status	Allergies	Diagnosis	PMH						
Neuro, Resp, Cardiac		GI, GU, Musculoskeletal			DBT, Skin, Other			Labs Q _____			Lines / Fluids		
A/O ____ Activity _____ PERRLA _____, ____ mm LS _____ Secretions _____ O2 ____% by _____ Devices _____ Tele _____ Pulses _____ BP limits _____ Edema _____ _____		Diet _____ BS _____ Last BM _____ NGT _____ Devices _____ Foley _____ Amb / urinal / comm / bedpan Dialysis: M Tu W Th F Sa Su Weakness _____ Numbness _____ DVT _____			BGL Q ____ _____ Skin (wounds/dressings) _____ Other devices _____ Scheduled Procedures _____ Consults _____ Discharge _____						<input type="checkbox"/> PIV <input type="checkbox"/> Central <input type="checkbox"/> PICC <input type="checkbox"/> Foley 		
Admit/Last VS etc.	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900
Notes:													

