

A.D.N. PATIENT ASSESSMENT

NEUROLOGICAL: ___ responds spontaneously & appropriately for age; oriented X3; pupils equal, round & reactive to light; speech clear; follows commands & moves all extremities equally; sensation normal (NIT: awake, opens eyes spontaneously, strong cry. Reflexes present, fontanels soft & flat. Developmentally appropriate for age

- Arousal/LOC/Stim: ___to sound ___to touch ___to pain ___unresponsive
- Disoriented to: ___person ___place ___time
- Speech: ___slurred ___incomprehensible ___absent ___language barrier ___inappropriate ___trach/ETT
- Pupils (PERL): ___abnormal ___ mm
- Movement/ROM: (W)Weak; (F)Flaccid; (N)Normal
 - LUE ___ RUE ___
 - LLU ___ RLE ___
- Sensation: (N)umbness, (T)ingling, (P)aresthesias; ___ Limited ROM; ___ Visual Disturbances
 - LUE ___ RUE ___
 - LLU ___ RLE ___
- Glasgow coma scale ___ (verbal, motor, and eye opening)

EENT & M: ___without Sx and no obvious deformity or problem (describe findings)

- Eye _____
- Ear _____
- Nose _____
- Throat _____
- Mouth _____

CARDIOVASCULAR: ___ Heart sounds regular & strong; peripheral pulses palpable & equal bilaterally; no peripheral edema; nail beds & mucous membranes pink; brisk capillary refill, extremities warm to touch; free of cardiac symptoms (No CP/pressure, dizziness, syncope, color, palpitations, SOB)

- Heart Rate: _____; Telemetry Rhythm _____
 - Sounds: ___regular ___irregular ___strong ___weak ___murmur
- Peripheral Pulses: (L/R) DP ___/___; PT ___/___; Radial ___/___; Fem ___/___; Pop ___/___;
 - **Peripheral Edema:** LUE ___ RUE ___ LLU ___ RLE ___ Sacral ___ Periorbital ___
- Color: nail beds ___ mucous membranes: ___ Cap refill >3sec ___
- Skin temp: ___ Periph Skin Color ___ JVD ___
- No cardiac Sx ___
- Dialysis location access: ___ Type ___: ___ Thrill; ___ Bruit

PULMONARY: ___ Respirations, regular, even & unlabored; A/P breath sounds clear & equal bilaterally (WH)eeze, (RH)onchi, (D)iminished, (R)ales, (EW)expiratory wheeze, (IW)inspiratory wheeze

- Breath sounds A/P: LUL ___ LLL ___ RUL ___ RML ___ RLL _____
- Respirations/Effort: ___irregular ___shallow ___labored ___asymmetrical
- Cough: ___Productive ___Non-Productive ___Frequent ___Hoarse ___Croupy
- Trache: Type/size _____
- Secretions: ___thick ___thin ___tenacious ___frothy ___bloody; Color _____; amount _____
- Chest Tube: location _____ Drainage _____

GASTROINTESTINAL: ___ Abdomen soft, nondistended, nontender; active bowel sounds in all 4 quadrants; bowel function within patient's normal baseline

- Abdomen: ___flat ___round ___distended ___tender ___taut ___obese ___firm ___flatus
- Bowel Sounds: ↓(hypoactive), ↑(hyperactive), (A)bsent: ___LUQ ___LLQ ___RUQ ___RLQ
- Stool: ___incontinent, ___frequent, ___liquid, ___hard, ___soft, ___diaper; Color _____
- C/O: ___nausea ___passing gas ___constipation ___diarrhea ___last BM
- Stoma: Type _____ Location _____ Assessment _____ Output Characteristics _____
- Feeding Tube: Type _____ size _____; Site Location _____ NGT/Corpak checked for placement, ___Not patent; ___intermittent/continuous suction, ___clamped, ___drainage Residual _____/_____

RENAL-URINARY: ___ Bladder nondistended, voids spontaneously (documented within last 8 hours with quantity sufficient for age & status); urine clear & yellow

- Bladder: ___distended ___foley
- Urine: ___foul odor, ___sediment, ___cloudy; Color: _____
- Voiding: ___incontinent, ___frequency, ___urgency, ___hesitancy, ___burn/pain, ___other: _____
- Diversion: Type _____ Assessment _____

REPRODUCTIVE ___ No vaginal or penile discharge; if menses, flow is within patient's usual pattern. Normal genitalia (on visual inspection).

- Genitalia: ___redness ___lesions ___edema ___pain ___itching
- Discharge: ___color ___consistency ___amount

MUSCULOSKELETAL: ___ Active full ROM in all extremities; strength equal bilaterally. Ambulatory with steady gait. (NIT: full ROM all extremities. Tone appropriate for developmental age).

- Movement/Mobility
- Tone/Strength
- Gait ___ Use of assistive device ___

SKIN/INTEGUMENT: ___skin color consistent with ethnic background; warm, dry & intact. Mucous membranes moist. Skin turgor appropriate for age.

- Color: ___pale, ___cyanotic, ___flushed, ___jaundice, ___mottled
- Condition: ___dry
- Temperature/location: ___hot, ___cool
- Texture
- Moisture
- Turgor: ___loose, ___tenting
- Mucous membranes: ___dry, ___lesions, ___thrush
- Odor
- Integrity
- Braden Score (All adults)
- Incision/Wounds: ___normal except
- Drains/Tube: Location: _____ Drainage: _____

PSYCHOSOCIAL: ___ behavior & appearance appropriate. Mood, affect & family/significant other involvement appropriate to situation.

- Behavior
- Affect
- General Appearance
- Interaction

VITAL SIGNS:

Time:	0700	1400	1500
VS:			
02 Sat:			
Pain Level:			

INTAKE:	Time	7	8	9	10	11	12	13	14	15	16	17
	PO											
	% Meal											
	IVF											
	IVPB											
	Other											
OUTPUT:	Time	7	8	9	10	11	12	13	14	15	16	17
	BM											
	Urine/foley											
	Emesis											
	Drain											

ADL:

- Activity:

MOBILITY:	Time	Activity	Level of Indep.	Duration (mins/hrs)	Distance (feet)	Tolerance

- Bath _____
- Linen Change _____

IV SITES: Gauge + Type Location Date Insertion Appearance
 _____ _____ _____ _____

IVE: #1 Solution: _____ Rate: _____ #2 Solution: _____ Rate: _____

TE: #1 Solution: _____ Rate: _____ #2 Solution: _____ Rate: _____

WOUNDS and/or ULCERS:

Time/Initials	Wound/Ulcer Location	Ulcer Stage	Measurements (cm)					Exudate			Wound Bed	Surrounding Skin	Wound Care	Comments	
			Length	Width	Depth	Tunneling (y/n)	Undermining (y/n)	Amount	Type	Odor (y/n)					

Key:

Stage # 1 = reddened area 2 = blister or skin break 3 = skin break exposing subc tissue 4 = skin break exposing subc tissue, muscle, bone E = eschar/eocrotic tissue covering wound	Type of Exudate: S = serous SG = serosanguineous P = purulent A = appropriate for dressing B = bloody	Wound Bed: G = granulation (red) SL = slough (soft eschar) ES = eschar (blackish, leather-like) EP= epithelialization	Surround Skin: N = normal, intact E = erythema I = induration Ed = edematous M = macerated	Wound Care: W = wet to dry ____ H = hydrocolloid T = transparent G = hydrogel O = other _____
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Note: On darkly pigmented skin, intact skin may not be reddened. Pt. may have pain at site, localized heat and/or edema, or history of pressure ulcer.

ENVIRONMENT OF CARE:

- Safety precautions: _____
- Fall assessment score: _____
- Isolation: type _____