

Date:

Room #: Name: MRN: Age: DOB: Sex:	0700/1900 0800/2000 0900/2100 1000/2200 1100/2300 1200/2400 1300/0100 1400/0200 1500/0300 1600/0400 1700/0500 1800/0600
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Diagnosis:	<input type="checkbox"/> Safety <input type="checkbox"/> Tubing <input type="checkbox"/> Bath <input type="checkbox"/> Oral	PRN Meds
Code Status:	Weight (kg):	Diet
Allergies:	IVF/Access	End-of-Shift: <input type="checkbox"/> Assessment <input type="checkbox"/> I&O <input type="checkbox"/> Care Plan <input type="checkbox"/> Education

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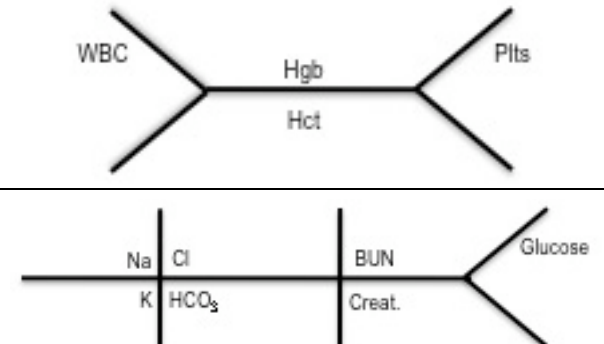
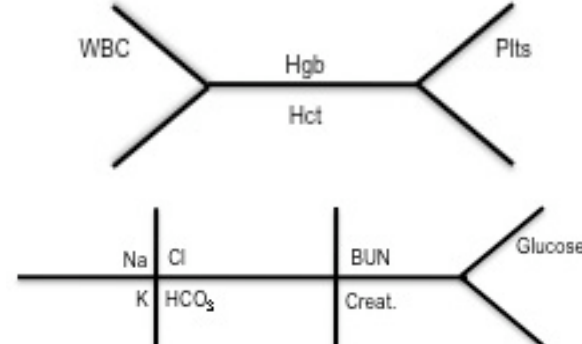
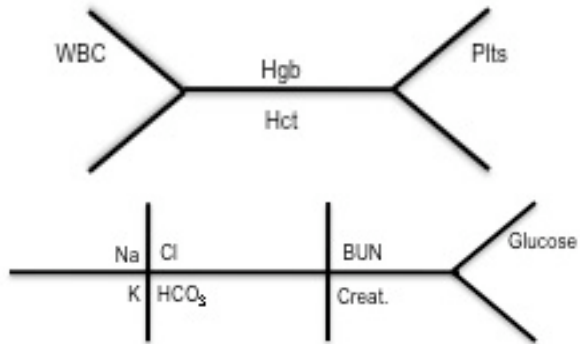
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Room #/Client:

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Room #/Client:



RBC
 Protein
 PT/INR
 Urine Dip
 Drug Levels
 Other

ANC
 Albumin
 aPTT

RBC
 Protein
 PT/INR
 Urine Dip
 Drug Levels
 Other

ANC
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RBC
 Protein
 PT/INR
 Urine Dip
 Drug Levels
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ANC
 Albumin
 aPTT

S

B

Neuro:

CV:

Resp:

A

GI/GU:

Skin:

Musculo:

R

S

B

Neuro:

CV:

Resp:

A

GI/GU:

Skin:

Musculo:

R

S

B

Neuro:

CV:

Resp:

A

GI/GU:

Skin:

Musculo:

R

