PRESSURE & NON-PRESSURE MANAGEMENT RECORD
VERNON HEALTHCARE CENTER

RESIDENT NAME ROOM# SITE	DATE NOTED				DATE WHEN MEASURED	SIZE & DEPTH	STAGES OR WOUND TYPE	DATE TX ORDERED	PROGRESS (YES/NO)	DATE REGRESSION (IN-HOUSE)	DATE RESOLVED	TREATMENT ORDER	MEAL %	SUPP. YES OR NO
	ADMIT	IN-HOUSE	RE-ADMIT	REGRESSION OF READMISSION (YES OR NO)										
RESIDENT NAME ROOM# SITE:														
RESIDENT NAME ROOM# SITE:														
RESIDENT NAME ROOM# SITE:														

DATE: _____ GIVEN TO ADMINISTRATOR ( ) DON ( ) DIETARY ( ) MEDICAL RECORDS ( )

BRADEN SCALE – For Predicting Pressure Sore Risk

SEVERE RISK: Total score ≤ 9 HIGH RISK: Total score 10-12
MODERATE RISK: Total score 13-14 MILD RISK: Total score 15-18

RISK FACTOR	SCORE/DESCRIPTION				DATE OF ASSESS ➡ 1	2	3	4
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	1. COMPLETELY LIMITED – Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation, OR limited ability to feel pain over most of body surface.	2. VERY LIMITED – Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	3. SLIGHTLY LIMITED – Responds to verbal commands but cannot always communicate discomfort or need to be turned, OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	4. NO IMPAIRMENT – Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE Degree to which skin is exposed to moisture	1. CONSTANTLY MOIST– Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. OFTEN MOIST – Skin is often but not always moist. Linen must be changed at least once a shift.	3. OCCASIONALLY MOIST – Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. RARELY MOIST – Skin is usually dry; linen only requires changing at routine intervals.				
ACTIVITY Degree of physical activity	1. BEDFAST – Confined to bed.	2. CHAIRFAST – Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. WALKS OCCASIONALLY – Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. WALKS FREQUENTLY– Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.				
MOBILITY Ability to change and control body position	1. COMPLETELY IMMOBILE – Does not make even slight changes in body or extremity position without assistance.	2. VERY LIMITED – Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. SLIGHTLY LIMITED – Makes frequent though slight changes in body or extremity position independently.	4. NO LIMITATIONS – Makes major and frequent changes in position without assistance.				
NUTRITION Usual food intake pattern [1]NPO: Nothing by mouth. [2]IV: Intravenously. [3]TPN: Total parenteral nutrition.	1. VERY POOR – Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, OR is NPO[1] and/or maintained on clear liquids or IV[2] for more than 5 days.	2. PROBABLY INADEQUATE – Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	3. ADEQUATE – Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally refuses a meal, but will usually take a supplement if offered, OR Is on a tube feeding or TPN[3] regimen, which probably meets most of nutritional needs.	4. EXCELLENT – Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION AND SHEAR	1. PROBLEM- Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	2. POTENTIAL PROBLEM– Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. NO APPARENT PROBLEM – Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.					
TOTAL SCORE	Total score of 12 or less represents HIGH RISK							

ASSESS	DATE	EVALUATOR SIGNATURE/TITLE	ASSESS.	DATE	EVALUATOR SIGNATURE/TITLE
1	/ /		3	/ /	
2	/ /		4	/ /	

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed

Form B
Policy No. SK - 01

BRADEN SCALE – For Predicting Pressure Sore Risk

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ASSESS	DATE	EVALUATOR SIGNATURE/TITLE	ASSESS.	DATE	EVALUATOR SIGNATURE/TITLE
1	/ /		3	/ /	
2	/ /		4	/ /	

NAME-Last First Middle	Attending Physician	Record No.	Room/Bed

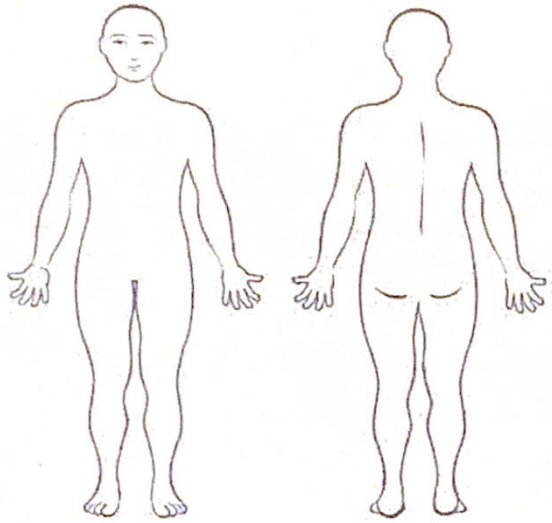
Form B
Policy No. SK - 01

XX. Skin Integrity

Directions: Document and stage pressure and circulatory ulcers. The unit of measure is centimeters.

Code (*detail in grid below*)

1 = Rash	2 = Reddened Area ◆	3 = Pressure Sore ◆	4 = HX of Pressure Sore ◆	5 = Scar
6 = Skin Tear	7 = Abrasion	8 = Laceration	9 = Lesion	10 = Burn
11 = Incision	12 = Stasis Ulcer ◆	13 = Mottled	14 = Skin Discoloration	15 = Other



STAGE I: Nonblanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, mushy, induralton or harness may also be indicators.

STAGE II: Partial thickness skin loss involving epidermis, dermis, or both.

STAGE III: Full thickness skin loss involving damage to or necrosis or subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining adjacent tissue.

STAGE IV: Full thickness loss with extensive destruction, tissue, necrosis, or damage to muscle, bone or supporting structures (e.g., tendon or joint capsule).

UNSTAGEABLE (UTD): Eschar until debrided

SUSPECTED DEEP TISSUE INJURY (SDTI): Purple maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Moisture:	☐ Dry/Flaking	☐ Oily	☐ Clammy	Turgor:	☐ Normal	☐ Fair	☐ Poor ◆
Color:	☐ Pink	☐ Pale	☐ Flushed	Temperature:	☐ Cool	☐ Warm	

1. Pressure Ulcer

Site	Type	Length	Width	Depth	Stage
1.					
2.					
3.					
4.					
5.					
6.					

2. Other (*document all other ulcers, wounds, and skin problems including scars over bony prominences.*)

Site	Type	Length	Width	Depth	Stage
1.					
2.					
3.					
4.					
5.					
6.					

XXI. Feet

1. General:
☐ Corns ☐ Calluses

2. Skin Integrity:
☐ Good/Intact ☐ Heels Spongy ◆

3. DX or HX of:
☐ Diabetes ◆ ☐ Pressure Ulcers ◆
☐ PVD ◆ ☐ Neuropathy ◆
☐ Other: _____

4. Footwear Needs: _____

Resident Name:	Physician:	Room Number:	Medical Record Number:

XXII. Additional Comments

Licensed Nurse (Print Name) | Signature/Title: | Sections Completed: | Date:

Resident Name:	Physician:	Room Number:	Medical Record Number:

TREATMENT RECORD

Treatments	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature

Physician/Alt. Physician	Phone No.		Pharmacy

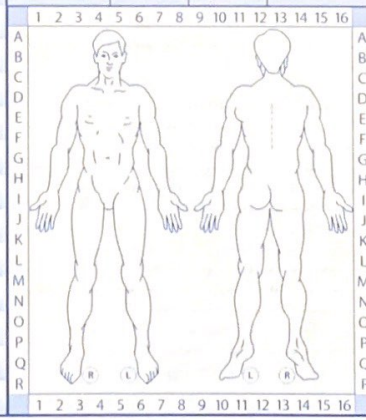
Resident	Station/Room/Bed	Admission Number/Date	Sex	Date of Birth	Allergies/Notes	Current Month/Year	Page No.

Nurse's Treatment Notes

Vital Signs	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Temperature																															
Pulse																															
Respiration																															
Blood Pressure																															
Blood Pressure																															
Weight																															

Date	Time	Initials	Treatment	Reason / Remarks

Date	Time	Initials	Treatment	Reason / Remarks



(Code for highest stage of pressure ulcer)
0. No pressure ulcer
Stage 1. Observable pressure-related alteration of intact skin whose indicators as compared to adjacent or opposite area on the body may include changes in: skin temperature, tissue consistency and/or sensation. Ulcer appears as defined area of persistent redness in lightly pigmented skin and persistent red, blue or purple hues in darker skin tones.
Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
Stage 3. A full thickness of skin is lost, exposing the subcutane-ous tissues - presents as a deep crater with or without under-mining adjacent tissue.
Stage 4. A full thick-ness of skin and sub-cutaneous tissue is lost, exposing muscle and/or bone.

*Describe type of **problem** indicated in diagram.*

TREATMENT ADMINISTRATION RECORD

SKIN TREAT[illegible] ORDER PAGE 1

DESCRIPTION	TIME CODES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	28	29	30
Date: _____ ( ) Monitor pain pre, during, post wound treatments ( ) DAILY 7-3 ( ) BID 7-3 & 3-11 SHIFTS ( ) TID 7-3, 3-11, & 11-7 SHIFTS	7-3 SHIFT																													
	PAIN PRE																													
	PAIN DURING																													
	PAIN POST																													
	3-11 SHIFT																													
	PAIN PRE																													
	PAIN DURING																													
	PAIN POST																													
	11-7 SHIFT																													
	PAIN PRE																													
	PAIN DURING																													
	PAIN POST																													
Date: _____ ( ) _____mattress Dx: ( ) Wound prevention ( ) Wound Management																														
	FYI																													
Date: _____ ( ) Wound consult & ff up with ( )Ameriound Wound MD ( ) Wound MD _____																														
	FYI																													
Date: _____ Site/Type: _____ _____ ( ) Cleanse with NS ( ) Apply _____ (med) & cover with _____ (drsg) _____ (times) X_____ ( )days ( ) month																														

RESIDENT NAME	ROOM #	PRIMARY MD	PHONE NUMBER	ALLERGIES	MONTH

INITIALS	NURSE'S SIGNATURE	INITIALS	NURSE'S SIGNATURE	INITIALS	NURSE'S SIGNATURE	INITIALS	NURSE'S SIGNATURE	INITIALS	NURSE'S SIGNATURE
1		4		7		10		13	
2		5		8		11		14	
3		6		9		12		15	

DATE	HOUR AM / PM	INITIALS	MEDICATION	REASON	HOUR AM / PM	INITIALS	RESULT

INJECTION SITE CODES: 1. BUTTOCK (GLUTEUS) LEFT 2. BUTTOCK (GLUTEUS) RIGHT 3. ARM (DELTOID) LEFT 4. ARM (DELTOID) RIGHT 5. THIGH (QUADRICEPS) LEFT 6. THIGH (QUADRICEPS) RIGHT 7. ILIAC CREST LEFT 8. ILIAC CREST RIGHT 9. ABD LEFT 10. ABD RIGHT 11. OTHER (SPECIFY) 12. _____

Resident Care Plan
Skin – Short Term Non-Pressure Ulcer

Date	Problem/Need	Goal	Goal Date	Approach	Start Date	Discipline	Re-Eval Date	Initial
	□ Skin tear, laceration, abrasion □ Bruise, discoloration □ Surgical wound Stasis ulcer □ Venous □ Arterial □ Excoriations Related to: □ Thin, fragile skin □ Incompliant with treatment □ Poor nutritional status □ Aggressive behavior □ Edema □ Diabetes Mellitus □ Peripheral vascular disease □ Medication: _____ _____ □ Diagnosis: _____ _____ Site of skin condition: _____ _____ _____ □ Other (Specify):	□ Skin condition will heal within ____days □ Resident will be free of signs and symptoms of infection □ Resident will be free from further skin breakdown □ Resident will reach pain relief goal of (1-10): _____ □ Other (Specify):		□ Administer medication and treatment as ordered and monitor for effectiveness □ Keep affected area clean and dry □ Turning and repositioning as scheduled □ Refer resident for dietary consult □ Encourage use of assistive device □ Provide good skin care □ Obtain lab tests as ordered □ Monitor and assess for pain □ Provide education to resident, responsible party, and staff regarding special care needs □ Other (Specify):				

Initial	Signature	Initial	Signature

Resident Name_____
Room No._____ Medical Record No._____
Physician_____

Weekly Pressure Injury/Ulcer Progress Report

Nursing Manual – Skin

CONTINUATION PAGE

Date	Site	Stage	Size/Depth	Necrosis	Slough	Granulation	Epithelialization	Drainage/Odor	Pain Scale	Tunneling Undermining
		1 2 3 4 Unstageable / Necrosis Unstageable / DTI	L= W= D=	Color= %	Color= %	Color= %	Color= %			

Preventative Measures: ☐Alternating Pressure ☐Low Air-loss ☐Float heels ☐Gel cushion ☐Heel protector ☐Elbow protector ☐Other_____

☐Nutritional support ☐Trapeze ☐Mechanical lift ☐Other_____

☐Indwelling catheter ☐Foot cradle ☐Geri sleeves ☐Skin barrier cream

Response to Treatment/Level of Patient Cooperation

Physician notified ☐Yes ☐No Family notified ☐Yes ☐No ☐N/A Nurse's Signature:

Patient Name: _____ Physician: _____ Room No.: _____ MR No.: _____

Date	Site	Stage	Size/Depth	Necrosis	Slough	Granulation	Epithelialization	Drainage/Odor	Pain Scale	Tunneling Undermining
		1 2 3 4 Unstageable / Necrosis Unstageable / DTI	L= W= D=	Color= %	Color= %	Color= %	Color= %			

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☐Nutritional support ☐Trapeze ☐Mechanical lift ☐Other_____

☐Indwelling catheter ☐Foot cradle ☐Geri sleeves ☐Skin barrier cream

Response to Treatment/Level of Patient Cooperation

Physician notified ☐Yes ☐No Family notified ☐Yes ☐No ☐N/A Nurse's Signature:

Patient Name: _____ Physician: _____ Room No.: _____ MR No.: _____

W[illegible] Pressure Injury/Ulcer Progress [illegible]ort

Nursing Ma[illegible]al – Skin

Date of onset_____ Site_____ Stage_____

Present on Admission ☐Yes ☐No Size in cm L=_____ W=_____ D=_____

Necrosis/Eschar ☐Yes ☐No If yes, Color = _____ % of necrotic tissue=_____%

Slough ☐Yes ☐No If yes, Color = _____ % of slough tissue=_____%

Granulation ☐Yes ☐No If yes, Color = _____ % of granulated tissue=_____%

Epithelialization ☐Yes ☐No If yes, Color = _____ % of epithelialized tissue=_____%

Drainage ☐Yes ☐No Odor ☐Yes ☐No

Pain Scale on wound site_____ Undermining/Tunneling_____

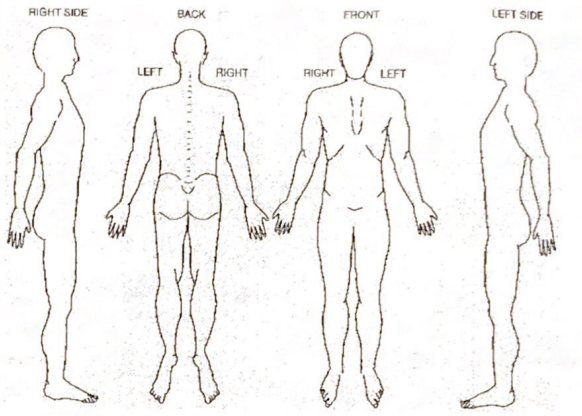
Physician notified ☐Yes ☐No Family notified ☐Yes ☐No ☐N/A

Comments:_____

Preventative Measures: ☐Alternating pressure ☐Low air-loss ☐Float heels ☐Gel Cushion

☐Heel protectors ☐Elbow Protectors ☐Nutritional support ☐Trapeze ☐Mechanical lift

☐Indwelling catheter ☐Foot cradle ☐Skin barrier cream ☐Other_____



DO NOT PHOTOGRAPH PRESSURE INJURY/ULCER

Nurse's Signature:_____ Date:_____ Time:_____

Nurse's Signature:_____ Date:_____ Time:_____

WEEKLY PRESSURE INJURY/ULCER PROGRESS REPORT

Date	Site	Stage	Size/Depth	Necrosis	Slough	Granulation	Epithelialization	Drainage/Odor	Pain Scale	Tunneling Undermining
		1 2 3 4 Unstageable / Necrosis Unstageable / DTI	L= W= D=	Color= %	Color= %	Color= %	Color= %			

Preventative Measures: ☐Alternating Pressure ☐Low Air-loss ☐Float heels ☐Gel cushion ☐Heel protector ☐Elbow protector ☐Other_____

☐Nutritional support ☐Trapeze ☐Mechanical lift ☐Other_____

☐Indwelling catheter ☐Foot cradle ☐Geri sleeves ☐Skin barrier cream

Response to Treatment/Level of Patient Cooperation

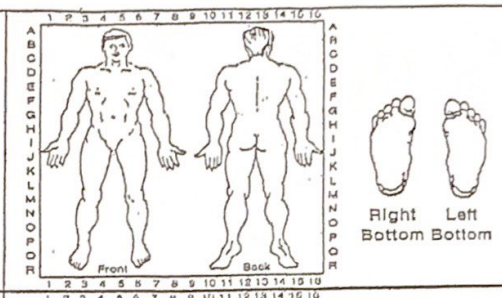
Physician notified ☐Yes ☐No Family notified ☐Yes ☐No ☐N/A Nurse's Signature:

Patient Name:_____ Physician:_____ Room No.:_____ MR No.:_____

Weekly Skin Evalutation

Date: ______________ **Shift:** ☐ AM ☐ PM ☐ Noc
Skin Condition:
☐ Intact
☐ Dry ☐ Ecchymosis ☐ Rash ☐ Redness
☐ Other ______________________________
☐ Open Area: ☐ New ☐ Old
If open area, proceed to appropriate skin condition record.

Signature/Title:



Date: ______________ **Shift:** ☐ AM ☐ PM ☐ Noc
Skin Condition:
☐ Intact
☐ Dry ☐ Ecchymosis ☐ Rash ☐ Redness
☐ Other ______________________________
☐ Open Area: ☐ New ☐ Old
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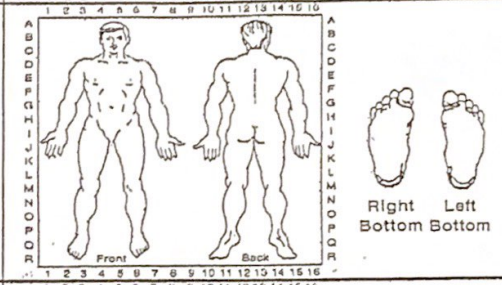
Signature/Title:



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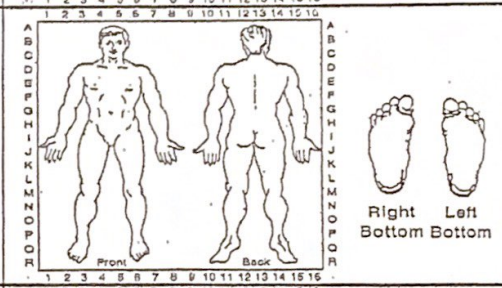

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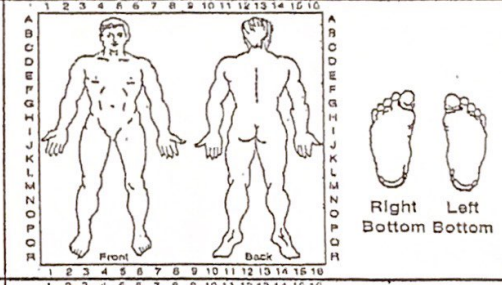

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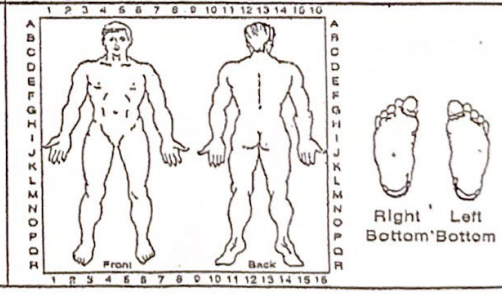

Resident Name: Physician: Room/Bed #:

Form C
Policy No. - SK - 04

SPECIAL TREATMENTS/PROCEDURES:

S/P BLOOD TRANSFUSION: ____ YES ____ NO ADVERSE REACTIONS: ____ YES ____ NO

PARENTERAL/ IV FEEDING OR THERAPY: ____ YES ____ NO ADVERSE REACTIONS; ____ YES ____ NO

____ CENTRAL LINE ____ PICC LINE ____ PERIPHERAL LINE ____ OTHER, SPECIFY _____

IV SITE: _____ S/S OF COMPLICATIONS FROM IV SITE: ____ YES ____ NO

IV MEDICATION: _____ REASON FOR USE _____

IV/TPN THERAPY: _____ FOR _____

CHEMOTHERAPY/RADIATION TXS: ____ YES ____ NO ADVERSE REACTIONS: ____ YES ____ NO

TX FOR: _____

DIALYSIS TREATMENTS: ____ YES ____ NO ____ AV SHUNT ____ VASCATH

S/S INFECTION FROM DIALYSIS SITE: ____ YES ____ NO

ISOLATION PRECAUTIONS: ____ STANDARD ____ CONTACT ____ DROPLET ____ AIRBORNE ____ N/A

REASON FOR ISOLATION: _____ SITE: _____

____ SYMPTOMATIC ____ ASYMPTOMATIC ____ ALONE IN ROOM ____ TX, ACTIVITIES, DINING DONE IN ROOM

PACEMAKER ____ YES ____ NO

ANTIBIOTIC THERAPY: ____ YES ____ NO

MEDICATION _____ REASON FOR USE _____

MEDICATION _____ REASON FOR USE _____

ADVERSE REACTIONS: ____ YES ____ NO EFFECTIVE: ____ YES ____ NO

INSULIN THERAPY: ____ YES ____ NO RECEIVED INSULIN ____ YES ____ NO TIME(S): _____

ADVERSE REACTIONS: ____ YES ____ NO ANY INSULIN ORDER CHANGES: ____ YES ____ NO

ANY ORDER CHANGES: ____ YES ____ NO

MD VISITS: ____ YES ____ NO MD APPOINTMENTS: ____ YES ____ NO

PAIN MANAGEMENT: ____ YES ____ NO ____ ROUTINE PAIN MED ____ PRN PAIN MED

____ NON-PHARMACOLOGICAL INTERVENTIONS TYPE: _____

EFFECTIVE: ____ YES ____ NO

REHABILITATION ____ N/A

____ PT SPECIFY ACTIVITY: _____ ASSISTANCE: _____

____ OT SPECIFY ACTIVITY: _____ ASSISTANCE: _____

____ ST SWALLOWING PROBLEM: ____ YES ____ NO COGNITIVE DEFICITS: ____ YES ____ NO

ADDITIONAL INFORMATION: _____

____ REFUSES THERAPY REASON: _____

____ RNA ADDITIONAL INFORMATION: _____

ADL LEVELS: Note: DOCUMENT ADL ACTIVITY ON THE NURSING UNIT.

ACTIVITY	INDEPENDENT	SUPERVISED	LIMITED	EXTENSIVE	DEPENDENT	ACTIVITY DID NOT OCCUR	# OF STAFF SUPPORT
BED MOBILITY							
TRANSFER							
FEEDING							
TOILETING							

DATE/TIME	NOTES

LICENSED NURSE'S SIGNATURE : _____ DATE: _____

RESIDENT NAME	MED. REC. #	ROOM #	PHYSICIAN

SKILLED NURSING NOTES

DATE: _____ SHIFT: _____

VITAL SIGNS: T _____ P _____ R _____ BP _____ PAIN _____

COGNITION: _____ ALERT _____ ORIENTED x ( ) _____ CONFUSED _____ LETHARGIC _____ UNRESPONSIVE

COMMUNICATION: _____ VERBALLY RESPONSIVE _____ UNABLE TO UNDERSTAND
_____ ABLE TO VERBALIZE OR EXPRESS NEEDS _____ UNABLE TO VERBALIZE OR EXPRESS NEEDS

HEARING: _____ ADEQUATE _____ PROBLEM _____ USES HEARING APPLIANCE SPECIFY _____
_____ RIGHT _____ LEFT _____ BOTH

SPEECH: _____ CLEAR _____ APHASIC _____ SLURRED _____ UNINTELLIGIBLE _____ INAPPROPRIATE

RESPIRATORY FUNCTION: _____ N/A

RESPIRATION: _____ NORMAL _____ LABORED _____ DEEP _____ SHALLOW
LUNG SOUNDS: _____ CLEAR _____ DIMINISHED _____ RALES _____ RHONCHI _____ WHEEZING
COUGH: _____ PRODUCTIVE; SPUTUM COLOR _____ _____ NON-PRODUCTIVE
OXYGEN: ( ) YES ( ) NO _____ O2 SAT. ___-___ % ( ) RA ( ) WITH O2 S/S OF SOB: _____ YES _____ NO
BREATHING TX/HHN TX: ( ) YES ( ) NO RESPONSE TO TX: _____
TRACHEOSTOMY: _____ YES _____ NO TRACH CARE: _____ YES _____ NO SUCTIONING: _____ YES _____ NO
VENTILATOR: _____ YES _____ NO CPAP/BIPAP _____ YES _____ NO

GI/GU FUNCTIONS: _____ N/A

ABDOMEN: _____ SOFT _____ HARD _____ DISTENDED _____ NON-DISTENDED _____ VOMITING
BOWEL SOUNDS: _____ (+) _____ (-)
URINE: _____ CONTINENT _____ INCONTINENT COLOR: _____ S/S UTI: _____ YES _____ NO
APPLIANCE: _____ YES _____ NO _____ FOLEY CATH _____ CONDOM CATH _____ UROSTOMY _____ SUPRAPUBIC
BM: _____ CONTINENT _____ INCONTINENT CONSISTENCY: _____ SOFT _____ HARD _____ LOOSE
APPLIANCE: _____ YES _____ NO _____ ILEOSTOMY _____ COLOSTOMY _____ RECTAL CATH
TOILETING PROGRAM: _____ YES _____ NO SPECIFY: _____
EFFECTIVE: _____ YES _____ NO

NUTRITION: _____ N/A

DIET: _____ COMPLIANT: _____ YES _____ NO NOURISHMENTS: _____ YES _____ NO
FLUID RESTRICTION: _____ YES _____ NO COMPLIANT: _____ YES _____ NO
APPETITE: _____ REFUSED _____ POOR (<50%) _____ FAIR (>50% to <75%) _____ GOOD (75% to 100%) _____ N/A
NGT( ) GT( ) JT( ): _____ TOLERATED: _____ YES _____ NO STOMA _____
ON A WEIGHT REGIMEN: _____ YES _____ NO ( ) LOSS ( ) GAIN

SKIN CONDITION: _____ N/A

PRESSURE INJURY PRESENT: _____ YES _____ NO
ULCER: _____ ARTERIAL _____ VENOUS _____ DIABETIC
_____ OTHER SPECIFY: _____
_____ FOOT INFECTION _____ OPEN LESION ON FOOT _____ OTHER LESIONS
_____ SURGICAL WOUND LOCATION/TYPE: _____
_____ DRAINS SPECIFY _____
_____ EDEMA LOCATION: _____ ELEVATED: _____ YES _____ NO
DRESSING CHANGES: _____ YES _____ NO TX EFFECTIVE: _____ YES _____ NO
OINTMENTS/MEDICATIONS: _____ YES _____ NO ANY TX ORDER CHANGES: _____ YES _____ NO
ADDITIONAL INFORMATION: _____

RESIDENT NAME	MED. REC. #	ROOM #	PHYSICIAN

FACILITY

Resident Name	Attending Physician	Room No.	Admission No.

Date Discontinued	Date/Time Ordered	Code	ORDERS DIAGNOSIS FOR EACH MEDICATION	Frequency

Signature of Nurse Receiving Order	Signature of Physician

☐ Resident / Family Informed	☐ Med/Tx Sheet	☐ Date & Time	☐ Communicated
☐ Pharmacy	☐ Nurses Notes	☐ Resident Care Plan	☐ Signee

PHYSICIAN'S TELEPHONE ORDERS

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PHYSICIAN'S TELEPHONE ORDERS

FORM 206

ARTISTIC PRESS - (323) 660-3085
(800) 750-2012

PLEASE! USE BALLPOINT PEN ONLY

PHYSICIAN and TELEPHONE ORDERS