CNA Report Sheet

CNA INFORMATION

Name: _____ Contact information: _____

Date: _____ dd / mm / yyyy Shift: _____

PATIENT INFORMATION

Name: _____ Room number: _____

Age: _____ Gender: _____

Diagnosis:

Allergies:

Special considerations and precautions:

VITAL SIGNS

Temperature: _____ Pulse: _____

Respiratory rate: _____ Blood pressure: _____

Pain level: _____

ACTIVITY AND MOBILITY

Mobility status:

Assistance required:

Recent activity:

HYGIENE AND TOILETING

Bathing status:

Oral care:

Toileting schedule:

Incontinence care:

NUTRITION AND FLUIDS

Daily restrictions:

Food intake:

Fluid intake:

IV/tube feeding:

ELIMINATION

Bowel movements:

Bladder voiding:

Issues:

SKIN INTEGRITY

Skin assessment:

Pressure ulcer prevention:

Wound care:

MEDICATION

Medication schedule:

Recent medication administered:

Any medication reactions or changes:

Tasks or procedures for the next shift:

ADDITIONAL NOTES

Specify below:

CNA signature:

Date: _____ dd / mm / yyyy