Nurse Brain Sheet

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Room number: _____ Sex: _____

Emergency contact: _____ Contact information: _____

Address: _____ Admission date: _____ dd / mm / yyyy

PATIENT BACKGROUND

Chief complaint/admission reason:

Allergies:

Mobility:

◯ Independent ◯ Needs assistance ◯ Bedrest

Code:

◯ Full ◯ DNR ◯ Limited

Situation:

☐ Fall risk
☐ Restraints
☐ Confused
☐ Aspiration
☐ Suicide

Precaution:

◯ None
◯ Contact
◯ Droplet
◯ Seizure
◯ Airborne

Diet:

◯ Oral ◯ NPO ◯ Liquid ◯ Tube feed

VITAL SIGNS

Temperature: _____ Blood pressure: _____

Heart rate: _____ Respiratory rate: _____

SPO: _____

ASSESSMENT

Diagnosis: _____

Test/procedures conducted:

Laboratory:

Neurological:

Cardiovascular:

Respiratory:

Gastrointestinal:

MEDICATIONS AND TASKS

1. Time: _____

Task:

2. Time: _____

Task:

3. Time: _____

Task:

4. Time: _____

Task:

5. Time: _____

Task:

CARE PLAN

Specify below:

DISCHARGE PLAN

Specify below:

ADDITIONAL NOTES

Specify below:

Nurse-in-charge: _____ Designation: _____

Signature:
Date: _____ dd / mm / yyyy