

Time-Lapse Assessment

Patient information: _____ Date of current assessment: _____ dd / mm / yyyy

Time of current assessment: _____ Date of previous assessment: _____ dd / mm / yyyy

Time of previous assessment: _____

VITAL SIGNS

Blood pressure: _____ Heart rate: _____

Respiratory rate: _____ Oxygen saturation: _____

Temperature: _____

THE PATIENT'S CURRENT HEALTH STATUS

Any changes or improvements observed since the last assessment:

Level of consciousness:

Orientation (time, place, and person):

Current mood and affect:

Patient's self-reported symptoms:

Patient's medications:

PHYSICAL ASSESSMENT

General appearance:

Skin condition, including hair and nails:

HEAD-TO-TOE INSPECTIONS

Head:

Eyes:

Nose:

Mouth and throat:

Ears:

Neck:

Chest (cardiovascular):

Chest (respiratory):

Abdomen:

Back:

Extremities:

FOCUSED ASSESSMENTS

Specify below:

FOLLOW-UP PLAN

Specify below:

NURSE'S INFORMATION

Nurse's full name: _____ Shift: _____

Signature: _____
Date: _____ dd / mm / yyyy Time: _____