PREMIER CARE NURSES OF AMERICA

NURSE'S CLINICAL NOTE AND TIME SHEET

Client's Name_____ Date: ___/___/___ Day of Week:_____

Days of Week	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Date	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Time In	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

IF YOU WORK TWO SHIFTS A DAY FOR ONE PATIENT, PUT *SECOND SHIFT ONLY BELOW*

Time In	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

Vital Signs
Temp_____ Site____
Pulse_____ Site____ Reg/Irreg
Resp_____ Reg/Irreg
O2 Sat_____
BP_____ Site_____
Comment: _____
_____
_____
_____
_____
_____

Physical Assessment
Mental Status_____
Skin Integrity: Temp._____
Color_____
Edema_____
Breath Sounds: Cl/Wh/Cr/Ra/ Abs
Bowel Sounds/ GI_____
LBM _____ # for shift_____
Diet_____
Intake_____ Output_____
Other_____
_____

Pain Assessment
Numerical assessment

0 1 2 3 4 5 6 7 8 9 10

Site_____
Measure to relieve_____
OR
Observation Assessment
Is the patient: Grimacing_____
Frowning_____
Moaning_____

Foley Catheter/Treatment
Condom Cath/ Indwelling Cath
Catheter size_____
Output_____
Color_____

Wound Care and Treatment
Site: _____
Size: Length: _____
Width: _____
Depth: _____
Treatment: _____
_____

Trach Care and Treatment
O2: _____L/minute

Trach/ Mask/ Nasal cannula/ Room Air

Frequency Ordered_____
Treatment_____
_____
Trach Type:_____ Size:_____
Suction: _____
Tracheal/ Oral

Color:_____

NGT/ GT Care and Treatment
Type: PEG/ Nasogastric
Site Status:_____
_____
Treatment: _____
_____
_____

Supplement: _____
Amount Given: _____ml
Flush Amount: _____ml

Change in Patient's Status
Change: _____
_____
Notified:_____

CLIENT CARE AND NURSING INTERVENTIONS:

_____
_____
_____
_____

Client Signature: X_____ **Caregiver Signature: X_____**