

SOUTH TEXAS COLLEGE
ASSOCIATE DEGREE NURSING PROGRAM
Student Nurses Notes/Assessment

P.Y. Initials

Room #

Student:	Date:	Time:
RESP.	Respirations: <input type="checkbox"/> Even <input type="checkbox"/> Uneven <input type="checkbox"/> Unlabored <input type="checkbox"/> Labored <input type="checkbox"/> Deep <input type="checkbox"/> Shallow Long Sounds Clear: <input type="checkbox"/> Left lung <input type="checkbox"/> Right lung Others: Rales: <input type="checkbox"/> Left lung <input type="checkbox"/> Right lung Rhonchi: <input type="checkbox"/> Left lung <input type="checkbox"/> Right lung Wheezes: <input type="checkbox"/> Left lung <input type="checkbox"/> Right lung Congestion: <input type="checkbox"/> Left lung <input type="checkbox"/> Right lung <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Dyspnea <input type="checkbox"/> Sibilant <input type="checkbox"/> Orthopnea <input type="checkbox"/> Anxious (explain) _____ O₂ L/M <input type="checkbox"/> per <input type="checkbox"/> NC <input type="checkbox"/> Mask <input type="checkbox"/> Reservoir <input type="checkbox"/> Catheter <input type="checkbox"/> Other _____	
	Apical Heart Rate: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular BPMs _____ Heart Sounds: <input type="checkbox"/> S ₁ S ₂ loud and distinct <input type="checkbox"/> Other _____ Cardiac Monitor: <input type="checkbox"/> Yes <input type="checkbox"/> No Pattern MM: <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ Capillary Refill: <input type="checkbox"/> 3 seconds or less <input type="checkbox"/> Delayed _____ seconds	
GI	Bowel Sounds: Present in all 4 quadrants <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ <input type="checkbox"/> Normal active <input type="checkbox"/> Hypoactive <input type="checkbox"/> Hyperactive <input type="checkbox"/> Absent (explain) _____ Abdominal Distention: <input type="checkbox"/> No <input type="checkbox"/> Yes Circumference of abdomen _____ cm. Abdominal Characteristics: <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Rigid <input type="checkbox"/> Flat <input type="checkbox"/> Rounded <input type="checkbox"/> Sunken <input type="checkbox"/> Masses Describe: _____ Emesis: <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: Color _____ Amount: _____ vs. Consistency: _____ Nausea: <input type="checkbox"/> No <input type="checkbox"/> Yes Involuntary of Stool: <input type="checkbox"/> No <input type="checkbox"/> Yes # of times _____ Stool(s): # _____ Soft <input type="checkbox"/> Hard <input type="checkbox"/> Liquid <input type="checkbox"/> Color of stool: _____ NGT Drainage: <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: Color _____ Amount _____ ml External Findings: Formula name: _____ <input type="checkbox"/> Continuous _____ ml/hr or <input type="checkbox"/> Bolus _____ ml every _____ hours Other: _____	
	Urinating: <input type="checkbox"/> No <input type="checkbox"/> Yes Retention of Urine: <input type="checkbox"/> No <input type="checkbox"/> Yes # of times _____ Urine Color: _____ Urine Clear: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____ Catheter: <input type="checkbox"/> Inserting <input type="checkbox"/> Straight Catheter Anchored to Thigh: <input type="checkbox"/> Yes <input type="checkbox"/> No Why not? _____ CBBs Type: _____ Rate: _____ ml/hr Any: <input type="checkbox"/> Burning/Itching in urethra <input type="checkbox"/> Decrease stream <input type="checkbox"/> Other _____ <input type="checkbox"/> Vaginal Discharge-Describe: _____ <input type="checkbox"/> Perineal Discharge-Describe: _____	
IV's	Fluid Type: _____ Infusion rate: _____ ml/hr Type/Gauge/Length of IV Catheter: _____ Site: _____ Repair or Saline Lock: <input type="checkbox"/> Yes <input type="checkbox"/> No IV Sites: <input type="checkbox"/> No redness <input type="checkbox"/> Swelling <input type="checkbox"/> Tenderness <input type="checkbox"/> Other _____ IV Insertion Site Changes: <input type="checkbox"/> Yes <input type="checkbox"/> No Why changed? _____ IV Tubing Changes: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Oriented: ☐ Time ☐ Place ☐ Person
Disoriented: ☐ Time ☐ Place ☐ Person
☐ Conscious ☐ Unconscious ☐ Alert
☐ Lethargic ☐ Sedated
Other: _____



Time	Pupils Size		Equal	Round	Reactive to light	Accommodation
	Right	Left				
0a	non	non	Yes No	Yes No	Yes No	Yes No
1b	non	non	Yes No	Yes No	Yes No	Yes No
1c	non	non	Yes No	Yes No	Yes No	Yes No
2d	non	non	Yes No	Yes No	Yes No	Yes No

GLASGOW COMA SCALE

	Score
Eye Open^e	
<input type="checkbox"/> Spontaneously <input type="checkbox"/> To voice command <input type="checkbox"/> To pain <input type="checkbox"/> No response	
Motor Response^m	
<input type="checkbox"/> Obeys verbal commands <input type="checkbox"/> Localizes pain <input type="checkbox"/> Flexion - withdrawal (purposeless) <input type="checkbox"/> Flexion - abnormal (decorticate) <input type="checkbox"/> Extension <input type="checkbox"/> No response	
Verbal Response^v	
<input type="checkbox"/> Oriented person <input type="checkbox"/> Oriented, but incoherent <input type="checkbox"/> Incoherent words <input type="checkbox"/> Incomprehensible sounds <input type="checkbox"/> No response	

PATIENT'S SCORE			
Time	EEG ^e	Motor ^m	Verbal ^v
0a			
1b			
1c			
2d			

MUSCULOSKELETAL ABBREVIATION CODE

Extremity movement:

V = Voluntary C = Command S = Spontaneous W = Withdrawn

D = None

B = Strong

F = Fairly

W = Weak

Chest = Chest/Thorax

D = None

B = Strong

F = Fairly

W = Weak

D = None

B = Strong

F = Fairly

W = Weak

D = None

B = Strong

F = Fairly

W = Weak

Time	Right Arm		Left Arm		Right Leg		Left Leg	
0a	non	non	non	non	non	non	non	non
1b	non	non	non	non	non	non	non	non
1c	non	non	non	non	non	non	non	non
2d	non	non	non	non	non	non	non	non

Full ROM of all Extremities Describe any Deficits:

Right Pedal Pulse: ☐ Strong ☐ Weak ☐ Distal ☐ Doppler ☐ AbsentLeft Pedal Pulse: ☐ Strong ☐ Weak ☐ Distal ☐ Doppler ☐ Absent

Describe any irregularities:

Fim Assessment Scale Cheatsheet

R Sanford



Fim Assessment Scale Cheatsheet:

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