

PATIENT BACKGROUND

ROOM	AGE	ADMIT DATE	SITUATION
NAME		ADMIT REASON	<input type="checkbox"/> FALL RISK <input type="checkbox"/> CONFUSED <input type="checkbox"/> ALARM <input type="checkbox"/> RESTRAINTS <input type="checkbox"/> SUICIDE
SEX	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
CODE	<input type="checkbox"/> FULL <input type="checkbox"/> DNR <input type="checkbox"/> LIMITED		
MD	HOSPITAL COURSE		PRECAUTIONS
PRIMARY DIAGNOSIS			<input type="checkbox"/> NONE <input type="checkbox"/> DROPLET <input type="checkbox"/> CONTACT <input type="checkbox"/> AIRBORNE
ASSESSMENTS		MEDICAL HISTORY	TESTS / PROCEDURES
NEURO			
CARDIAC	ACCU-CHECK		MEDICATIONS
	TIME	BS COVER	
	TIME	BS COVER	
RESPIRATORY	VITALS		ALLERGIES
GI / GU	LABS		PLAN OF CARE
SKIN			
MUSCULOSKELETAL			
IV SITES	NOTES		
DRIPS / FLUIDS			

