

NURSING NOTES TEMPLATES

7 Professional Clinical Documentation Templates

SOAP | SBAR | Head-to-Toe | SOAPIE | ICU Flow Sheet | DAP Handoff | Mental Health

#	TEMPLATE	BEST USED FOR	COLOUR CODE
1	SOAP Note	Shift progress notes, treatment response, admission notes — all settings	Teal
2	SBAR Communication	Physician calls, shift handoffs, RRT activation, patient transfers	Purple
3	Head-to-Toe Assessment	Systematic physical exam at admission and start of each shift	Crimson
4	SOAPIE Care Plan Note	Full nursing process documentation, care plans, complex patients	Green
5	ICU Critical Care Sheet	Intensive care: hourly monitoring, ventilator settings, fluid balance, infusions	Navy
6	DAP Shift Handoff	End-of-shift handoff with bedside checklist — all ward settings	Amber
7	Mental Health Assessment	Psychiatric evaluation, MSE, risk assessment, safety planning	Slate Blue

How to use: Each template begins on a new page. Print individually or as a bundle. All fields are editable in Microsoft Word. Replace placeholder text with patient data and complete blank lines.

Important: These templates are documentation aids. Always follow your institution's charting policies and documentation standards. Nursing notes are legal documents — complete them accurately and in real time.

SOAP PROGRESS NOTE

Nursing Documentation Template

PROGRESS NOTE

Patient Name: _____ MRN: _____
DOB: _____
Ward / Unit: _____ Nurse: _____
Date / Time: _____

S SUBJECTIVE	<i>Chief complaint in patient's own words. Use direct quotes. Onset, character, severity, associated symptoms, relevant history volunteered by patient.</i> _____
O OBJECTIVE	<i>Vital signs, physical exam findings, lab values, wound appearance, I&O, medication administered. Measurable facts ONLY — no interpretation.</i> _____
A ASSESSMENT	<i>Clinical interpretation: nursing diagnoses (NANDA-I), trends, changes from baseline, risks identified, response to treatment.</i> _____
P PLAN	<i>Specific interventions: medication (dose/route/time), dressings applied, education, physician notifications, next reassessment time.</i> _____

NURSE SIGNATURE

PIN / REGISTRATION NO.

TIME OF ASSESSMENT

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SBAR COMMUNICATION TEMPLATE

Clinical Handoff & Escalation Tool

ESCALATION / HANDOFF	Patient Name: _____ MRN: _____
	_____ DOB: _____
	Ward / Unit: _____ Nurse: _____
	Date / Time: _____

S	SITUATION — <i>Who are you? Who is the patient? What is the PROBLEM — right now?</i>
	I am: _____ (Name / Role / Ward)
	I am calling about: _____ (Patient name, MRN, Bed no.)
	I am calling because: _____

B	BACKGROUND — <i>What is the relevant clinical context? (3-4 sentences max)</i>
	Admitted: ___ days ago with: _____
	Past medical history (relevant): _____
	Recent treatment / response to date: _____

A	ASSESSMENT — <i>What are the current findings? What do YOU think is happening?</i>
	Current vitals: T ___ BP ___ / ___ HR ___ RR ___ SpO2 ___% on ___
	Key findings on assessment: _____
	I believe / I am concerned that: _____

R	RECOMMENDATION — <i>What specific action are you requesting? What have you already done?</i>
	I am requesting: _____
	Interventions already taken: _____
	Can you come now? YES / NO Agreed plan: _____

CALLED PHYSICIAN	TIME OF CALL	READ-BACK COMPLETED	NURSE SIGNATURE
		YES / NO	

HEAD-TO-TOE ASSESSMENT

Systematic Shift Assessment Template

SHIFT ASSESSMENT	Patient Name: _____ MRN: _____
	_____ DOB: _____
	Ward / Unit: _____ Nurse: _____
	Date / Time: _____

GENERAL APPEARANCE	Level of consciousness: Alert / Confused / Lethargic / Obtunded / Unresponsive Distress: None / Mild / Moderate / Severe — describe: _____ Appearance: Well / Cachectic / Diaphoretic / Flushed / Pale / Jaundiced
VITAL SIGNS	T: ___ °C BP: ___/___ mmHg HR: ___ bpm (Reg / Irreg) RR: ___/min SpO2: ___% on: RA / NC ___L / FM ___L / HFNC / NIV / Vent Pain: ___/10 BGL: ___ mmol/L Weight: ___ kg Height: ___ cm
NEUROLOGICAL	GCS: Eyes___ Verbal___ Motor___ = ___/15 AVPU: A / V / P / U Pupils: PERRLA YES / NO — Size: ___mm Reaction: Brisk / Sluggish / Fixed Orientation: Person ✓/X Place ✓/X Time ✓/X Event ✓/X UE Strength: ___/5 bilateral LE Strength: ___/5 bilateral Gait: Steady / Unsteady / Non-ambulant
RESPIRATORY	Effort: Unlaboured / Laboured Depth: Adequate / Shallow Rhythm: Regular / Irregular Accessory muscles: No / Yes Pursed lip breathing: No / Yes Nasal flaring: No / Yes Breath sounds: Clear / Wheeze / Crackles / Rhonchi / Absent — Location: _____ Cough: None / Dry / Productive Sputum: Colour ___ Consistency ___ Amount ___
CARDIOVASCULAR	S1 / S2: Present Regular / Irregular Murmur: None / Grade ___ Rub: No / Yes Peripheral pulses: Strong / Weak / Absent — Equal bilateral: Yes / No CRT: < 2 sec / > 2 sec Skin temp: Warm / Cool / Cold Colour: Pink / Pale / Mottled / Cyanotic Oedema: None / Pitting ___ (site: _____) JVD: Absent / Present Telemetry: _____
GASTROINTESTINAL	Abdomen: Soft / Rigid / Distended / Scaphoid BS: Present x4 / Hypoactive / Absent Tenderness: None / Localised (site: _____) Guarding: No / Yes Rebound: No / Yes Nausea: No / Yes Vomiting: No / Yes (frequency: ___) Last BM: _____ Diet: Tolerating / Partial / NPO Enteral feeds: N/A / Running at ___mL/hr (type: _____)
GENITOURINARY	Voiding: Independently / IDC (type/size: _____) inserted: _____ care given: Yes/No Urine: Clear / Cloudy / Haematuria / Dark Colour: _____ Odour: Normal / Offensive Output last hour: ___ mL Output last 8 hrs: ___ mL Balance: _____ Complaints of dysuria: No / Yes Frequency: No / Yes Incontinence: No / Yes
MUSCULOSKELETAL	ROM: Full / Limited (site: _____) Contractures: None / Present (site: _____) Mobility: Independent / Assisted (device: _____) / Dependent / Bed-bound Falls Risk Score: ___ (tool: _____) Braden Score: ___ Restraints: None / Type: _____ PT involved: Yes / No OT involved: Yes / No Mobility aid: _____

INTEGUMENTARY	<p>Skin integrity: Intact / Impaired Turgor: Elastic / Tenting Moisture: Dry / Moist / Diaphoretic</p> <p>Wounds: None / Present — site: _____ size: ___ cm stage: ___ drainage: ___ dressing: _____</p> <p>Pressure areas inspected: Yes / No Braden: ___ Redness / Breakdown (site): _____</p> <p>IV site: PIV / PICC / CVL — site: _____ condition: Patent / Phlebitis / Infiltrated Date: _____</p>
LINES, TUBES & DRAINS	<p>NGT: N/A / Present — position confirmed: Yes / No (method: _____) pH: ___ Secured: Yes/No</p> <p>Drains: N/A / Type: _____ site: _____ output: ___ mL colour: _____ character: _____</p> <p>Urinary catheter: N/A / IDC — urine output: ___ mL/hr Catheter care given: Yes / No</p> <p>ETT: N/A / Size: ___ cm at lip: ___ Cuff pressure: ___ cmH2O Trach: N/A / Type: _____</p>
PSYCHOSOCIAL	<p>Mood: Appropriate / Anxious / Depressed / Agitated / Flat / Elevated</p> <p>Communication barrier: None / Language (interpreter required: Yes/No) / Hearing / Cognitive</p> <p>Support system: Family present / Absent / By phone Next of kin notified: Yes / No</p> <p>Education provided: No / Yes — topic: _____ Patient understanding: Yes / Partial / No</p> <p>Discharge planning: Not indicated / Initiated / Family meeting: _____</p>

SHIFT	ASSESSED BY (PRINT + SIGN)	TIME
AM / PM / NOC		

SOAPIE NURSING NOTE

Full Nursing Process Documentation Template

CARE PLAN NOTE	Patient Name: _____ MRN: _____
	_____ DOB: _____
	Ward / Unit: _____ Nurse: _____
	Date / Time: _____

NURSING DIAGNOSIS	Diagnosis: _____ Priority: _____
	High / Medium / Low
	Related to (R/T): _____

SUBJECTIVE	S	<i>Patient's reported symptoms, concerns, history in their own words (use quotes)</i>

OBJECTIVE	O	<i>Measurable data: vitals, labs, physical findings, I&O — facts only</i>

ASSESSMENT	A	<i>Nursing diagnosis (NANDA-I) + clinical interpretation of S and O data</i>

PLAN	P	<i>Planned nursing interventions — specific, measurable, time-bound</i>

IMPLEMENTATION	I	<i>What was actually carried out: medications given (dose/route/time), procedures, education delivered</i>

EVALUATION	E	<i>Patient's response to interventions. Was the plan effective? Goal met / partially met / not met?</i>

GOAL STATUS	NEXT REVIEW DATE/TIME	NURSE SIGNATURE & PIN
MET / PARTIALLY MET / NOT MET		

ICU CRITICAL CARE FLOW SHEET

Intensive Care Nursing Documentation

CRITICAL CARE	Patient Name: _____ MRN: _____
	DOB: _____
	Ward / Unit: _____ Nurse: _____
	Date / Time: _____

VENTILATOR / RESPIRATORY SUPPORT

MODE	FIO2 (%)	TV (ML)	PEEP (CMH2O)	RR SET	PEAK PRESS.

HOURLY HAEMODYNAMIC MONITORING

Time	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00
HR (bpm)								
BP (mmHg)								
MAP (mmHg)								
SpO2 (%)								
RR (/min)								
Temp (°C)								

FLUID BALANCE — INTAKE & OUTPUT

FLUID / DRUG	ROUTE	RATE	VOLUME IN (ML)	VOLUME OUT (ML)	BALANCE

TOTALS					
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SEDATION / ANALGESIA / INFUSIONS				
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DRUG / INFUSION	CONCENTRATION	RATE (ML/HR)	RASS / PAIN SCORE	NOTES

DAP SHIFT HANDOFF NOTE

Data · Assessment · Plan

SHIFT HANDOFF	Patient Name: _____ MRN: _____
	_____ DOB: _____
	Ward / Unit: _____ Nurse: _____
	Date / Time: _____

ADMITTING DIAGNOSIS	CODE STATUS	ALLERGIES	ISOLATION PRECAUTIONS
	Full / DNR / DNI / Comfort		Standard / Contact / Droplet / Airborne

D DATA	<p><i>Include: current vitals, significant assessment findings, labs/imaging results, I&O, wound/line status, relevant events during shift.</i></p> <hr/>
A ASSESSMENT	<p><i>Clinical interpretation: active problems, changes from previous shift, concerns, risks identified (falls, pressure injury, DVT, sepsis).</i></p> <hr/>
P PLAN	<p><i>Outstanding tasks, pending orders, escalation thresholds, family communication needed, discharge planning, next reassessment time.</i></p> <hr/>

BEDSIDE HANDOFF CHECKLIST — OUTGOING NURSE CONFIRMS			
<input type="checkbox"/>	IV access/lines checked & documented	<input type="checkbox"/>	Medication reconciliation completed
<input type="checkbox"/>	Safety: rails up, call bell in reach, brakes locked	<input type="checkbox"/>	Outstanding labs/imaging results reviewed
<input type="checkbox"/>	Pain/comfort assessed & managed	<input type="checkbox"/>	Physician/team notified of concerns
<input type="checkbox"/>	Patient/family education provided	<input type="checkbox"/>	Discharge plan discussed with patient

<input type="checkbox"/>	Wound/skin integrity documented	<input type="checkbox"/>	Incoming nurse accepted verbal handoff
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OUTGOING NURSE (PRINT)	OUTGOING NURSE SIGNATURE	INCOMING NURSE (PRINT)	INCOMING NURSE SIGNATURE

MENTAL HEALTH ASSESSMENT

Nursing Psychiatric Evaluation Template

MENTAL HEALTH	Patient Name: _____ MRN: _____
	_____ DOB: _____
	Ward / Unit: _____ Nurse: _____
	Date / Time: _____

PRESENTING CONCERN	Reason for presentation / Chief complaint (patient's words): _____ Duration of current episode: _____ Precipitating factors: _____ Previous episodes: No / Yes — how many: ____ Last episode: ____ Previous admissions: ____
MENTAL STATE EXAMINATION	Appearance: Well-kempt / Dishevelled / Unkempt / Unusual clothing Eye contact: Good / Poor / Avoided Behaviour: Calm / Agitated / Restless / Withdrawn / Hostile / Guarded / Cooperative Speech: Normal rate & volume / Pressured / Slow / Loud / Soft / Mute / Slurred Mood (patient's words): _____ Affect: Congruent / Incongruent Affect quality: Euthymic / Depressed / Elevated / Anxious / Flat / Blunted / Labile Thought form: Logical / Circumstantial / Tangential / Loose associations / Flight of ideas / Thought block Thought content: No abnormalities / Delusions (type: _____) / Obsessions / Ruminations / Suicidal ideas Perceptions: No hallucinations / Auditory / Visual / Tactile / Olfactory — Command hallucinations: No / Yes Cognition: Grossly intact / Impaired — Mini-COG score: ____ / 5 MMSE: ____/30 (if done) Insight: Full / Partial / Absent Judgement: Intact / Impaired
RISK ASSESSMENT	Suicidal ideation: None / Passive ('I wish I were dead') / Active (plan: No / Yes — describe: _____) Plan / Means: No / Yes — describe: _____ Intent: No / Yes Rehearsal behaviour: No / Yes Previous attempt(s): No / Yes (details: _____) Protective factors: _____ Homicidal / harm to others ideation: None / Present — describe: _____ Self-harm (non-suicidal): None / Present — method: _____ Frequency: _____ Risk level: LOW / MEDIUM / HIGH / VERY HIGH Rationale: _____
SUBSTANCE USE	Alcohol: None / Social / Hazardous / Dependent — last use: ____ Amount per day/week: ____ Illicit substances: None / Cannabis / Methamphetamine / Cocaine / Opioids / Other: ____ Prescription medication misuse: None / Yes — describe: _____ CAGE Score: ____/4 AUDIT Score: ____/40 (if completed)
SOCIAL & SUPPORT	Living situation: Alone / With family / Supported accommodation / Homeless / Other: ____ Support network: Adequate / Limited / Isolated — key supports: _____ Employment / Daily structure: Employed / Unemployed / Student / Retired / Unable to work Current stressors: _____ Children in care: No / Yes — child safety concerns: No / Yes (notify Child Protection: Yes / No)
PLAN &	Assessment completed by: _____ Role: _____ Time: _____

DISPOSITION	Psychiatry consulted: No / Yes — Psychiatrist: _____ Mental Health Act status: Voluntary / Involuntary (Form: ____ Expiry: ____) Disposition: Discharge with plan / Community follow-up / Admission (voluntary / involuntary) / ED obs Safety plan completed: No / Yes Copy given to patient: No / Yes Next of kin/carer notified: No / Yes — consent obtained: No / Yes
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IMMEDIATE SAFETY CONCERN?	1:1 OBSERVATIONS REQUIRED?
<p style="text-align: center;">NO — routine monitoring</p> YES — immediate action taken: _____	<p style="text-align: center;">NO / YES — Level: Intermittent / Q15min / Continuous</p>

ASSESSING NURSE (PRINT + SIGN)	REGISTRATION NO. / PIN	DATE & TIME OF ASSESSMENT