

NURSING NOTES TEMPLATE

Patient Assessment & Care Record

PATIENT INFORMATION

Patient Name: _____

MRN #: _____

DOB: _____

Room/Bed: _____

Attending MD: _____

Date: _____ Shift: Day Evening
 Night

Admitting Diagnosis: _____

Code Status: Full DNR DNI Comfort

VITAL SIGNS

Time	BP (mmHg)	HR (bpm)	RR (/min)	Temp (°C/°F)	SpO2 (%)	Pain (0-10)	Initials

NEUROLOGICAL ASSESSMENT

LOC: Alert Confused Lethargic Obtunded Unresponsive

Orientation: Person Place Time Event

GCS: Eye: ___ Verbal: ___ Motor: ___ Total: ___/15

Pupils: R: ___ mm Reactive Sluggish Fixed L: ___ mm Reactive Sluggish Fixed

Strength: Equal bilaterally Weakness — Location: _____

Neuro notes:

RESPIRATORY ASSESSMENT

Breath Sounds: Clear Crackles Wheezes Diminished Absent

O2 Delivery: RA NC ___L Mask ___L Vent

Rhythm: Regular Irregular Labored Shallow

Cough: None Productive Non-productive

Secretions: None Color: _____ Amount: Scant Mod Large

Chest Expansion: Equal Unequal

Respiratory notes:

CARDIOVASCULAR ASSESSMENT

Heart Rhythm: Regular Irregular
Paced

Heart Sounds: S1 S2 S3 S4
Murmur

Peripheral Pulses: 2+ equal
Diminished Absent

Edema: None +1 +2 +3 +4
Location: _____

Capillary Refill: <2s 2-3s >3s

Skin Color: Normal Pale
Cyanotic Jaundiced

Cardiovascular notes:

LABORATORY VALUES

Lab Test	Result	Normal Range	H/L/C	Action Taken
Sodium (Na+)		135–145 mEq/L		
Potassium (K+)		3.5–5.0 mEq/L		
Glucose		70–100 mg/dL		
Hemoglobin		12–17.5 g/dL		
WBC		4,500–11,000/μL		
Creatinine		0.6–1.2 mg/dL		
BUN		10–20 mg/dL		
INR/PT		0.8–1.1 (INR)		

IV ACCESS / LINES

Type	Location / Size	Inserted	Site Condition	Fluids Running	Rate (mL/hr)
PIV					
PICC					
Central					
Arterial					

NURSING INTERVENTIONS / CARE PROVIDED

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Repositioned | <input type="checkbox"/> Oral care | <input type="checkbox"/> Skin care | <input type="checkbox"/> ROM exercises |
| <input type="checkbox"/> Ambulated | <input type="checkbox"/> Fall precautions reinforced | <input type="checkbox"/> Restraints checked | <input type="checkbox"/> DVT prophylaxis |
| <input type="checkbox"/> Foley care | <input type="checkbox"/> Wound care/dressing change | <input type="checkbox"/> Incentive spirometry | <input type="checkbox"/> Education provided |
| <input type="checkbox"/> Family updated | <input type="checkbox"/> Interpreter used | <input type="checkbox"/> Safety rounds | <input type="checkbox"/> Call light in reach |

Additional interventions / notes:

PAIN ASSESSMENT

Pain Scale: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

(Circle current level)

Location: _____	Quality: <input type="checkbox"/> Aching <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Pressure <input type="checkbox"/> Throbbing	Radiates? <input type="checkbox"/> No <input type="checkbox"/> Yes → _____
Onset: _____	Aggravating factors: _____	Relieving factors: _____ _____
Non-pharm interventions: <input type="checkbox"/> Position <input type="checkbox"/> Ice <input type="checkbox"/> Heat <input type="checkbox"/> Distraction <input type="checkbox"/> Other: _____	Re-assess score after intervention: _____	Goal pain level: _____

SAFETY / ALERTS

<input type="checkbox"/> ALLERGY BAND on patient	<input type="checkbox"/> Fall precautions in place	<input type="checkbox"/> Seizure precautions in place	<input type="checkbox"/> Isolation precautions active
<input type="checkbox"/> Bed in lowest position	<input type="checkbox"/> Side rails up (x2 or x4)	<input type="checkbox"/> IV pump alarm on	<input type="checkbox"/> Restraint order obtained

NURSING NARRATIVE / SHIFT NOTES (SBAR)

S — SITUATION

B — BACKGROUND

A — ASSESSMENT

R — RECOMMENDATION

HANDOFF COMMUNICATION / SIGNATURE

Report given to: _____ RN **Time:** _____ **Method:** Bedside Phone Written

Nurse Signature:

Credentials:

Date/Time:

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