ADULT CLINICAL PREP FORM

Student's name _____ Date of Care _____
Instructor: _____

CLIENT'S DEMOGRAPHIC DATA AND HISTORY
Room No. _____ Age _____ DOB _____ Male ☐ Female ☐
Admission date _____ Repeat admission for same condition ☐ Yes ☐ No

Allergies: ☐Yes (list allergy & reaction below) ☐ None
_____ _____
_____ _____

REASON FOR THIS HOSPITALIZATION (Include date of onset, presenting signs and symptoms, treatment prior to hospitalization, and medications used at home to treat this condition)
_____
_____
_____
_____
_____
_____

USE OF ALTERNATIVE or OTC MEDICINE ☐ **No** ☐ **Yes**, specify what is used and purpose:
_____
_____

PAST MEDICAL HISTORY

CONDITION	RESOLVED	CURRENT TREATMENT
_____	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	_____

PAST SURGICAL HISTORY

PROCEDURE	DATE	PROCEDURE	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_ _____

ADMITTING MEDICAL DIAGNOSIS _____

SECONDARY DIAGNOSIS _____

DESCRIPTION OF CONDITION (PRIMARY DIAGNOSIS) (Based on literature / research)

DESCRIPTION OF SECONDARY DIAGNOSIS (Based on literature/research)

CLINICAL MANIFESTATIONS (Based on literature / research)

DIAGNOSTIC EVALUATIONS, LAB TEST, AND USUAL FINDINGS (Based on literature / research)

MEDICAL MANAGEMENT (Based on literature)

NURSING MANAGEMENT (Based on literature / research)

Intervention	Rationale

REFERENCES for information on this page (Author, text, year of publication, page numbers)

Procedures Reviewed in preparation for clinical (author, text, year of publication, page numbers)

REQUIRED ADULT IMMUNIZATIONS FOR AGE (from textbook)

(√ **all immunizations adult should have according to age**)

TD Booster every 10 years ☐
Rubella serology / vaccination (childbearing age females) ☐
Influenza annuall ☐
Pneumococcal ☐
PPD (on admission) 1 ☐ 2 ☐
Other _____ ☐

Immunizations up to date ☐ Yes ☐ No
If no, which ones are needed?
_____
_____

Interventions to update immunization status:
☐ None needed ☐ Yes, specify

HEALTH PROMOTION/PREVENTION PRACTICES

Breast self-examination	☐ Yes	☐ No	☐ N/A	Cigarette / tobacco	☐ No	☐ Yes, specify	_____
Mammogram	☐ Yes	☐ No	☐ N/A	Alcohol	☐ No	☐ Yes, specify	_____
Prostate exam	☐ Yes	☐ No	☐ N/A	Illicit drugs	☐ No	☐ Yes, specify	_____

Health Care Management Variances Noted (include findings from pg 1)

Nursing Diagnosis (complete diagnostic sentence)

Goal

Interventions

Evaluation

NURSING PROCESS DOCUMENTATION

Vital Signs: 0800 T _____ P _____ R _____ B/P _____
1200 T _____ P _____ R _____ B/P _____

Monitors: ☐ Cardiac, rhythm _____ ☐ Other, specify _____

NEURO/SENSORY

Subjective Data: (check any positive findings and elaborate below)

☐H/A ☐dizziness ☐seizures ☐tremors ☐incoordination ☐numbness
☐tingling ☐difficulty swallowing ☐difficulty speaking ☐ Denies Difficulty

Specific Data:_____

Sensory Deficits: ☐ No ☐ Yes, specify: _____

Pain: No ☐ Yes, Pain Rating_____ Scale: ☐ Numbers 1-5 ☐ Numbers 1-10 ☐ Other_____
Location _____
Quality_____

Objective Data:

Level of Consciousness: ☐ Alert ☐ Lethargic ☐ Obtunded ☐ Stuporous
☐ Unresponsive to painful stimuli

Best Motor Response: ☐ Obeys commands ☐ Localizes pain ☐ flexion – withdrawal
☐ flexion – abnormal (decorticate rigidity) ☐ Extension – abnormal (decerebrate rigidity)
☐ No response

Best Verbal Response: ☐ Oriented X3 ☐ Conversation-confused ☐ Speech inappropriate
☐ Sounds incomprehensible ☐ No response

Memory: ☐ Short Term intact ☐ Not intact, specify_____
☐ Long Term intact ☐ Not intact, specify: _____

Judgment Appropriate ☐ Yes ☐ No, specify: _____

PERLA ☐ Yes ☐ No, specify: _____

☐ Neuro/Sensory assessment within normal limits
☐ Neuro/Sensory variances noted (Describe variances below)

Neuro/Sensory Variances Noted

Nursing Diagnosis (complete diagnostic sentence)

Goal

Interventions

Evaluation

OXYGENATION – CARDIOPULMONARY

Subjective Data: (check any positive findings and elaborate below)

☐ Cough ☐ SOB ☐ Orthopnea ☐ Fatigue ☐ Leg cramps
☐ Sinus problems ☐ Chest pain with breathing ☐ Denies Difficulty
Specific Data:_____
_____

Objective Data:

Color: ☐ Normal ☐ Pale ☐ Ashen ☐ Cyanotic ☐ Jaundiced ☐ Other _____
Respirations: ☐ Unlabored ☐ Labored ☐ DOE ☐ Other (describe) _____
Breath sounds:_____
O_2 Sats _____ ☐ RA ☐ on O_2 Delivery Method _____ O_2 Rate _____

Cough ☐ Yes ☐ No Productive ☐ No ☐ Yes Amt/Color:/Consistancy: _____

All Pulses regular & equal: ☐ Yes ☐ No, specify_____
S_1, S_2: ☐ Yes ☐ No Other Sounds: ☐ No ☐ Yes (specify)_____
Edema: ☐No ☐Yes, specify location: _____

Circle:
- 1+ Mild pitting, slight indentation, no perceptible swelling of the leg
- 2+ Moderate pitting, indentation subsides rapidly
- 3+ Deep pitting, indentation remains for a short time, leg looks swollen
- 4+ Very deep pitting, indentation lasts a long time, leg is very swollen

Vein distention ☐Yes ☐ No
Homan's sign: ☐ Negative ☐Positive
Cardiopulmonary Labs normal ☐ Yes ☐ No ☐ N/A

☐ Oxygenation assessment within normal limits
☐ Oxygenation variances noted (describe variances below)

Oxygenation Variances Noted

Nursing Diagnosis (complete diagnostic sentence)

Goal

Interventions

Evaluation

NUTRITION

Subjective Data:

Appetite: ☐Good ☐Fair ☐Poor ☐Recent wgt changes, specify: _____
☐ Change in Taste ☐ Heartburn ☐Nausea/Vomiting Specify:_____
☐ Denies Difficulty

Specific Data:_____

Objective Data: Height _____ Weight _____
Diet _____Route: ☐ PO ☐GT ☐ JT ☐NG ☐ NPO
% of meals eaten _____
If GT/JT: ☐ Intermittent ☐ Continuous Rate _____cc/hr Residual _____ Placement _____
TPN: ☐ Yes ☐ No (If yes, list additives @ end) ☐ Cyclic ☐ Continuous Rate _____cc/hr
Reason for TPN: _____ Lipids: ☐ Yes ☐No Rate ____cc/hr

IV Fluids (Type): _____ Prescribed Rate: _____cc/hr IV Additives: _____
Diabetic: ☐ Yes ☐ No If yes, diabetes controlled? ☐ Yes ☐ No

Insulin Type	Onset	Peak	Duration of Action
_____	_____	_____	_____
_____	_____	_____	_____

AccuCheck: Time_____ Amt _____ Time _____ Amt _____ Time _____ Amt _____
Nutrition labs normal ☐ Yes ☐ No ☐ N/A

☐ Nutritional assessment within normal limits
☐ Nutritional variances noted (Describe variances below)

Nutrition Variances Noted

Nursing Diagnosis (complete diagnostic sentence)

Goal

Interventions

Evaluation

ELIMINATION

Subjective Data:

☐Nocturia ☐Frequency ☐Urgency ☐Incontinence ☐Hesitancy/Straining ☐Dysuria
LBM _____ ☐ c/o constipation ☐ c/o diarrhea
Usual bowel routine _____
☐Change in bowel routine ☐ Rectal Bleeding ☐ Denies Difficulty
Specific Data:_____
_____

Objective Data: Expected urinary output (8 hrs) _____cc

Urinary Output (8hrs) _____cc Color _____ Clarity_____
Foley Catheter: ☐ Yes ☐No
Urinary Diversion Device: ☐ No ☐ Yes Type: _____
Assessment of stoma: _____
Peritoneal Dialysis: ☐ Yes ☐ No Hemodialysis: ☐ Yes ☐ No
Assessment of site(s) _____
Fecal Diversion Device: ☐No Yes, type: _____
Assessment of stoma: _____
Bowel sounds: ☐ Normal ☐ Hyperactive ☐ Hypoactive ☐ Absent
Abdomen ☐ Tender ☐ Non-tender
☐ Distended ☐Round ☐ Concave ☐ Soft ☐ Firm
Bowel Movement: Amt _____ Color _____ Consistency _____
Other Output (ie drains, NG) _____ Amt _____ Color _____ Consistency _____

Elimination labs normal ☐ Yes ☐ No ☐ N/A

☐ Elimination assessment within normal limits
☐ Elimination variances noted (Describe variances below)

Elimination Variances Noted (further describe any abnormal findings)

Nursing Diagnosis (complete diagnostic sentence)

Goal

Interventions

Evaluation

SKIN INTEGRITY

Subjective Data: : (check any positive findings and elaborate below)

☐Pruritus ☐Rash ☐Bruising ☐Lesion ☐Mole ☐Hair loss ☐ Denies Difficulty
Specify:_____
_____
Usual care of skin/hair/nails/teeth: (specify): _____
_____

Objective Data:

Skin temp: ☐ warm ☐ cool ☐ hot ☐ cold
Skin Intact: ☐ Yes ☐ No
Skin tears: ☐ No ☐Yes, describe: _____
Pressure Ulcers present: ☐ No ☐ Yes, describe: _____
_____
Surgical Wounds:☐ No ☐Yes, describe (REDA/COCA/Location)_____
_____
Dressings present: ☐ No ☐Yes,Type/Location/Assessment: _____
Last Changed: _____
Drains/Tubes: ☐ Penrose ☐ J-P ☐ Hemovac ☐ PEG ☐Other _____
Site Assessment: _____
IV Lines: ☐ Peripheral ☐ CVL, specify type: _____ Location: _____
Assessment:_____
Hygiene/ADL's: ☐ Self ☐ Student ☐ Other, specify _____
☐ Complete ☐Partial ☐Set up ☐Independent
Self-care deficits present: ☐No ☐ Yes, specify_____

☐ Skin Integrity assessment within normal limits
☐ Skin Integrity variances noted (describe variances below)

☐ Hygiene variances noted (describe variances below)

Skin Integrity Variances Noted

Nursing Diagnosis (complete diagnostic sentence)

Goal

Interventions

Evaluation

MOBILITY / SAFETY

Subjective Data: : (check any positive findings and elaborate below)

☐Stiffness ☐Weakness ☐Hx falls ☐ Denies difficulties

Specific Data:_____

Objective Data:

Activity Level: ☐ Bedrest ☐ BRP ☐ Up with assistance ☐ Up ad lib

Abel to sit without support: ☐ Yes ☐ No, specify: _____

Abel to move from sitting to standing independently: ☐Yes ☐No, specify_____

Able to Bear Full Weight: ☐Yes ☐ No, specify: _____

Gait: ☐ Stable ☐ Unstable, specify _____

Ambulatory assistive devices: ☐ No ☐ Yes, type/reason_____

Traction: ☐ Yes ☐ No Type: _____

Assessment _____

Cast: ☐ Yes ☐No If yes, location: _____

Assessment _____

Range of motion ☐ Full range in all major joints

☐ Limited ROM in 1 or more joints

(specify limit vs contracture) _____

Muscle strength (indicate strength of each extremity using scale below):

= & strong against resistance	Grade 5
= & strong against gravity & some resistance	Grade 4
Able to move against gravity	Grade 3
Weak with difficulty moving against gravity.	Grade 2
Unable to move. Flaccid.	Grade 1

Hand Grips	Right _____	Left _____
Upper Extremities	Right _____	Left _____
Lower Extremities	Right _____	Left _____

Bed in low position: ☐ Yes ☐ No

Call light at hand: ☐ Yes ☐ No

Able to use call light ☐Yes ☐No
Restraints: ☐ No ☐ Yes, type and location _____
Environment free of hazards: ☐ Ye ☐ No
Patient poses danger to self/others ☐ Yes ☐ No

☐ Mobility/Safety assessment within normal limits
☐ Mobility/Safety variances noted (Describe variances below)

Mobility Variances Noted

Nursing Diagnosis (complete diagnostic sentence)

Goal

Interventions

Evaluation

REST/SLEEP

Usual bedtime: _____ Feels rested: ☐Yes ☐No
Usual # hrs sleep/night: _____ Naps: ☐Yes ☐No
Other: _____

☐ Sleep assessment within normal limits
☐ Sleep variances noted

Sleep Variances Noted

Nursing Diagnosis (complete diagnostic sentence)

Goal

Interventions

Evaluation

REPRODUCTIVE

Subjective Data: (check any positive findings and elaborate below)

Sexually Active: ☐No ☐Yes, specify if using protective barriers: _____

Current illness creates difficulty in sexual expression: ☐No ☐Yes, specify:

_____

Permission given to discuss sexuality: ☐Yes ☐No, rationale

_____

☐Assessment deferred, rationale:

_____

History of sexually transmitted diseases ☐ No ☐ Yes, specify: _____

Objective Data:

☐ Vaginal discharge ☐Discharge from penis ☐ No discharge

_____

☐ Sexuality assessment within normal limits

☐ Sexuality variances noted

Sexuality Variances Noted

Nursing Diagnosis (complete diagnostic sentence)

Goal

Interventions

Evaluation

FAMILY/SIGNIFICANT OTHERS:

Living Situation: _____

Marital Status: ☐Married ☐Widowed ☐Divorced ☐Other, specify: _____

Children/Grandchildren: (#, amt of contact, involvement in care):

Siblings: (#, amt of contact, involvement in care)

Spiritual/Religious supports/needs: _____

Other Support Systems: _____

Family visit during care: ☐ No ☐ Yes, specify _____

Family/patient's educational needs: _____

Family/patient education provided: ☐Yes ☐No Topic: _____

Two community or national resources available to the family/patient:

Agency_____ Phone/Web address_____

Agency_____Phone/Web address _____

☐ Family assessment within normal limits
☐ Family variances noted (Describe variances below)

Family Variances Noted

Nursing Diagnosis (complete diagnostic sentence)

Goal

Interventions

Evaluation

DEVELOPMENTAL

Highest education level: ☐ Grade School ☐High School ☐College ☐Post Graduate
☐ Other, specify: _____
Occupation:_____
Current work status: ☐Retired ☐Full-Time ☐Part-Time ☐Unemployed
Specifics: _____
Current roles: _____
_____
_____
Leisure Activities:
_____
_____
Patient Satisfied with above: ☐Yes ☐No, specify: _____
Recent stressors:
_____
_____
Coping Mechanisms:
_____
_____
Anxiety r/t hospitalization: ☐Yes ☐No
Level of anxiety: ☐Mild ☐Moderate ☐Severe
List one behavior that supports this level of anxiety in pt:
_____

Erikson's Developmental Level:

List one behavior that supports or does not support developmental level:

☐ Developmental assessment within normal limits
☐ Developmental variances noted (Describe variances below)

Developmental Variances Noted

Nursing Diagnosis (complete diagnostic sentence)

Goal

Interventions

Evaluation

LIST RECENT DIAGNOSTIC PROCEDURES, REASON FOR PROCEDURE, AND FINDINGS For example: ultrasound, X-rays, endoscopy, barium enema, CT-scan, echocardiogram

☐ None or specify below.

LABORATORY DATA (Include lab tests that relate to medications ordered for this client, treatments he/she is receiving, client's diagnosis or measures of client's response to treatment--i.e. potassium level, dig. level, hemoglobin & hematocrit, white blood cell count, prothrombin time, etc).

TEST	PATIENT VALUES	NORMAL RANGES	REASON TEST WAS PERFORMED AND RATIONALE FOR ABNORMAL VALUES

TPN ADDITIVES / ADDITIONAL COMMENTS:

BMS CPF Four Questions

1. What is the most important focus of my physical assessment and why?
2. What is the most critical medical complication that may occur/or could go wrong with the identified focus?
3. What signs and symptoms tell me this complication is developing?
4. What nursing interventions/assessments will I do to prevent and/or treat the identified complication?