Affix patient label

Nursing Assessment Record and Care Planning Document

Preferred name: ______Admitted: ______
Ward: ______Time

Reason for admission:

Mode of admission

Emergency

Elective

Expected date of discharge:

Is the patient currently competent to self medicate? Yes □ No □
If yes complete and ask the patient to sign a "self-medication consent form"
Patient has name band Yes □ Patient property disclaimer signed yes □ no □ n/a □
Patient consent to their name on bedside board/whiteboard Yes □ No □
Infection control screening on admission (refer to Policy); MRSA Yes □ No □ CPE Yes □ No □
Other (please state)

Ward transfers Yes - No - complete SBAR transfer form

From	То	Date	Time	
		- 3 -		

Nursing Assessment contents - please sign, date and time sections you have completed

PØ.	title	Must be completed	Partially completed in POAMAUSAU by:	date & time	Completed by:	date & time
3	Social circumstances	within 6 hours				
4	2. Neuro/mental health	within 6 hours				
6	3. GI (eating, drinking & bowels)	within 24 hours				
8	4. Nutritional risk	within 24 hours		6		
10	5. GU (Micturition)	within 24 hours	TE .			8
11	6. Manual handling/mobility	within 6 hours				
12	7. Hygiene	within 6 hours				%.
13	8. Pain	within 24 hours				
14	9. Respiratory	within 24 hours				
15	10. Cardiovascular	within 24 hours				3
16	11. Pressure areas	within 6 hours				
18	12. Skin inspection	within 6 hours		N		
18	12a. Diabetic feet	within 6 hours		G		
19	13. Wound assessment	within 6 hours				
20	14. Falls	within 6 hours	65			8
22	15. Bed rails	within 6 hours				

Nursing associates, trainee nursing associates, assistant practitioners, trainee assistant practitioners, therapy students and student nurses - all entries in this document must be countersigned by a registered nurse.

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Doris L. Carnevali

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