INTRAVENOUS THERAPY

DATE ORDERED	PERIPHERAL ☐ CVP ☐ PIC ☐ SL ☐ PORT ☐
	BLOOD PRODUCTS:

TPN:	LIPIDS:	CHEMO/SPECIAL IV THERAPY:

FLUID RESTRICTIONS:
Total _____ 1st _____cc
Trays _____ 2nd _____cc
3rd _____cc

DIET:

TUBE FEEDING:

ACTIVITY:

TRAVEL: Bed ☐ Wheelchair ☐ Stretcher ☐ O_2 ☐

BATH:

POSITION:

B.M.

DATE:

V.S.

Neuro

I&O

O_2

DAILY WT.

SPECIAL PROGRAMS:

DATE ORDERED		TIME
	P.T.	
	O.T.	
	SPEECH	
	RADIATION	
	TEACHING	

DATE ORDERED	RESPIRATORY THERAPY

DATE ORDERED	CONSULTS	NOTIFY	HERE	DATE	SPECIAL COMMENTS & INFORMATION

ADVANCE DIRECTIVES:

Durable Power of Attorney:

Legal Guardian:

Next of Kin:

In Case of Emergency:

CODE STATUS:

DISCHARGE PLANS DATE NOTIFIE

Discharge Plan Referral:

Social Work Referral:

SIGNIFICANT PAST MEDICAL HISTORY:

DRG/LOS:

BRADEN SCALE:

DIAGNOSIS:

POST DIAGNOSIS OR SURGERY:

ALLERGIES

MEDICAL RECORD NO	PATIENT	ROOM NO	DOCTOR	AGE	ADM. DATE

McLAREN FLINT

NURSING CARE CARD

Use Pencil Only

DATE ORDERED	TREATMENTS & DRESSINGS

DRAINS & PACKING

DATE ORDERED	EQUIPMENT

Ht.

Wt.

CODE STATUS

DATE ORDERED	X-RAY	DATE SCHEDULED

FALL RISK

DATE ORDERED	EKG

DATE ORDERED	DAILY LAB WORK

DATE ORDERED	LABORATORY

DATE ORDERED	DIAGNOSTIC TESTS/SPECIMENS