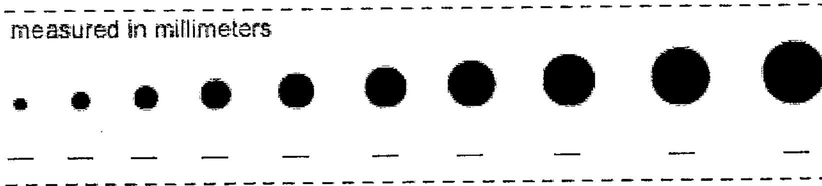
KAPLAN COLLEGE

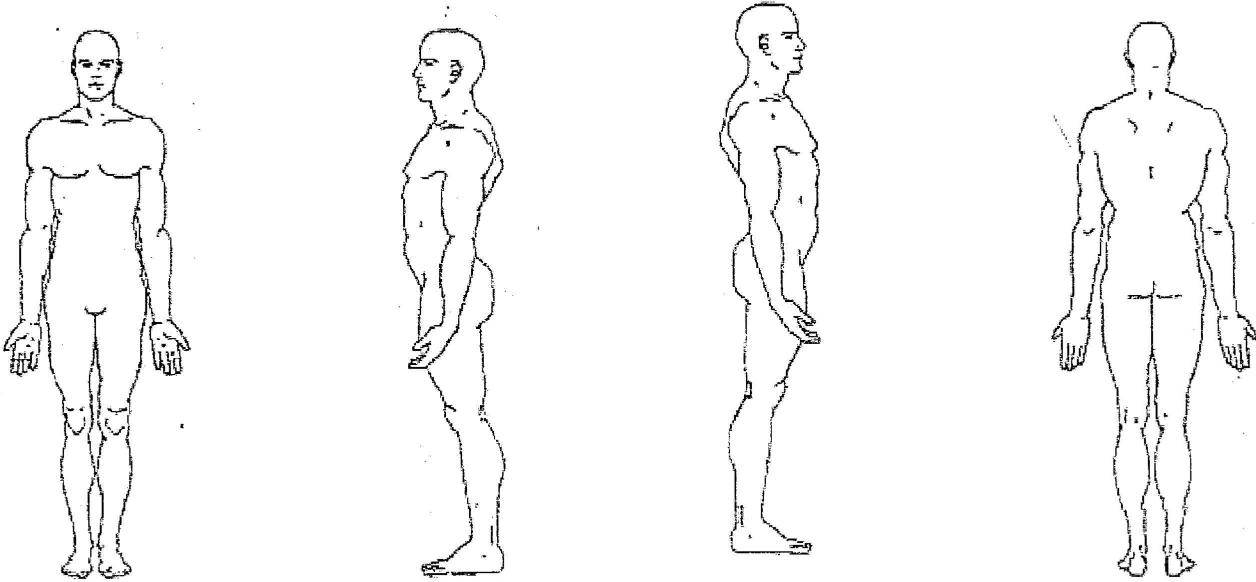
VOCATIONAL NURSING ASSESSMENT / CHRONOLOGICAL CHARTING

Student Name: Pt. Initials: HIPPA Room #: Date:		
NEURO / BEHAVIOR / COMFORT	TIME	ASSESSMENT
LOC: Alert, oriented to time, place person; confused, lethargic, stupor, unresponsive		
Behavior / Affect: Cooperative, calm, cheerful, anxious, agitated, flat affect, tearful		
HEAD & NECK		
Vision: good / fair / poor / blind		
Hearing: HOH		
Speech: clear, slurred, dysphasia, aphasia		
CARDIOVASCULAR		
Apical Pulse: Pacemaker		
Pulses: Radial, pedal, femoral, carotid		
Heart Rate: Reg/Irregular, strong, bounding, weak, thready		
Edema: Location: 1+ 2+ 3+ 4+		
Capillary Refill < 3 seconds:		
RESPIRATORY		
Chest: Symmetrical / asymmetrical		
Rhythm: Regular/irregular, labored/unlabored		
Lung Sounds: Clear, congested, noisy		
Anterior, posterior, lateral		
Cough: dry, wet, productive, non-productive		
Color of Secretions: Clear, yellow, green, pink, brown, bright red, frothy		
O2: Liters/min O2 Sats: Type:		
Trach: Y or N Secretions:		
Suctioning: Oral, nasal, trach		
GASTROINTESTINAL		
Teeth/Gums: dentures, partial		
Abdomen: soft, firm, flat, distended, tender, non-tender		
Tubes: NG, J-tube, G-tube, others		
Bowel Sounds: Active, hyper, hypo, flatus		
LUQ, LLQ, RUQ, RLQ		
Last BM: Continent/Incontinent		
BM: Sm, med, lg, soft, firm, hard, liquid, odor		
GENITOURINARY		
Bladder: Continent/Incontinent		
Urine: Clear, cloudy, color		
Foley Catheter: Size Patent		
SKIN / WOUND ASSESSMENT		
Skin: Hot, warm cool, dry, moist, intact		
Tissue Integrity: Turgor: Good, Poor		
Color: Pink, pale, jaundice, cyanotic, nailbeds		
Mucous Membranes: Moist, dry		
Incisions / Location: Dry, intact, staples, sutures, drainage, odor, redness		
Pressure Ulcers: Y or N. Location: Stage:		

NURSING ASSESSMENT / CHRONOLOGICAL CHARTING (Page 2)		
MOBILITY / DEVICES	TIME	ASSESSMENT
Activity: Bedrest, BRP, up-in-chair, ambulatory, up-ad-lib, independent, min. assist, max assist.		
ROM: RUE, RLE, LUE, LLE, Active or Passive		
Assistive Devices: WC, FWW, cane, splints, hand rolls, braces, restraints, hoyer lift.		
OTHER		

PUPIL GAUGE
Sizes 1 mm to 10 mm





KAPLAN COLLEGE SVN NURSING ADMISSION ASSESSMENT

Student Pt's Initials Facility Date Room

KAPLAN COLLEGE

VOCATIONAL NURSING CARE PLAN / PROCESS DATA SHEET

Student's Name: ______________________ Pt's Initials: _____ Rm #: ____ Age: ___ Sex: ___ Ht: ___ Wt: ___ Code Status: ________ Diet: _______ Allergies: ______________

Vital Signs: BP: __________ T: _____ P: _____ R: _____ O2 Sat: ______ Diagnosis: ______________________ PMH: ______________________________

Define Diagnosis: ____

CURRENT MEDICATIONS				
NAME OF MEDICATION	CLASSIFICATION / ACTION	REASON FOR MEDICATION	SIDE EFFECTS	NURSING IMPLICATIONS

CURRENT TREATMENTS	
TYPE OF TREATMENT	REASON FOR TREATMENT

ABNORMAL LABS / LABS RELATED TO PRIMARY DIAGNOSIS / DIAGNOSTIC TEST			
TEST	NORMAL LAB VALUES	PATIENT'S LAB VALUES	REASON FOR LAB OR DIAGNOSTIC TEST

KAPLAN COLLEGE

VOCATIONAL NURSING CARE PLAN / PROCESS DATA SHEET

NURSING DIAGNOSIS STATEMENT OF PROBLEMS, SUBJECTIVE AND OBJECTIVE	**GOALS** SPECIFIC EXPECTED OUTCOMES OF NURSING INTERVENTIONS	**NURSING INTERVENTION** NUMBER IN ORDER OF PRIORITY	**SCIENTIFIC RATIONALE** HOW DOES THE ACTION HELP MEET THE PATIENT'S GOAL	**EVALUATION** DID PATIENT REACH DESIRED GOAL

KAPLAN COLLEGE PATIENT MEDICATION SHEET

Room/Drug Name/Dose/Route/Time	CLASSIFICATION	ACTION/USE	REASON/DIAGNOSIS	SIDE EFFECTS	NURSING INTERVENTIONS
Room#: ____________ Brand: ____________ Generic: ____________ Dose: ____________ Route: ____________ Time(s): ____________					
Room#: ____________ Brand: ____________ Generic: ____________ Dose: ____________ Route: ____________ Time(s): ____________					
Room#: ____________ Brand: ____________ Generic: ____________ Route: ____________ Dose: ____________ Time(s): ____________					

VOCATIONAL NURSING PROGRAM
ASSIGNMENT TIME LINE

STUDENT: ____________________ WEEK OF: ____________________

	0700	0800	0900	1000	1100	1200	1300	1400	1500
Date: ______ Rm#: ______ ADL's: ______ Therapy: ______ Diet: ______ Intake/Output: ______ Assistive Devices; ______ ______ Other: ______									
Date: ______ Rm#: ______ ADL's: ______ Therapy: ______ Diet: ______ Intake/Output: ______ Assistive Devices: ______ ______ Other: ______									
Date: ______ Rm#: ______ ADL's: ______ Therapy: ______ Diet: ______ Intake/Output: ______ Assistive Devices: ______ ______ Other: ______									