Florida Parishes Campus
PRACTICAL NURSING PROGRAM

PATIENT DATABASE

Pre-clinical General Patient Information

Student's name ____ Dates of Care ________________________________

Client's initials ____________ Rm# ____________ Admit Date __________________ MD ___________________________

Admitting Sx or Dx ____

Surg. since admit? Y N Type ____ Date ____________________

Age_____ Sex ____ Ht______ Wt______ BMI_____ Mar. Status______ Occupation (when working) ___________________

Religion ____

Medical Hx (all active diagnoses) ____

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Surgical Hx (previous surgeries) ____

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<u>Allergies</u> (RED) ____

<u>DNR</u> - Y N (Circle in RED)

Advanced Directives on chart Y N

<u>NOTE:</u> Other Treatments, Needs, Precautions) ____

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NURSING CARE RESPONSIBILITIES (Information from chart, flow sheets, med sheets etc.)
Fill in all blanks that apply to your patient.

VS orders _________________ **Neuro Vital Sign orders** ______________________________

Nutritional Needs: Diet __________________ **Assist. needed Y N Snacks: AM** _____ **PM** _____

Dysphagia: Y N Suctioning needed? Y N Devices: NGT, G-Tube, PEG, PEJ

Tube Feeding Schedule: Bolus or Pump: Formula _____________________ Rate ____________

Elimination: Continent: Y N Foley: Y N Colostomy: Y N Incontinent of: stool, urine.

Last BM________ Usual bowel schedule_______________BSC, attends, EUD I&O: Y N

ADLs: Bath Day _______ Self, Assist, Bed Chair, Shower, Partial, Oral Care: Self, Assist

Dressing: Self, Assist, Total Care # of nurses required to dress/transfer/ambulate pt ______

Activity: Up ad lib, Bed rest, Dangle, Chair, Amb with assist: Y N uses: Walker, W/C

Safety Risk: Y N Type _____ Device(s) needed/used _____________________________________

Therapy: Y N Type (PT, Speech, etc)(Time) ____

Special Mattress: Y N Type ____

Glucometer Checks: Y N, Times _______________ Last Reading _______ Date/Time ___________

Special Tx**:** Drsg. changes, Wound care (type) ____

Special Resp. Tx: O2, Rate/Route _____________, HHN, Trach care, Suctioning, Spirometry

Special Orthopedic Equip:. (traction, CPM, OHFT,. other) __________________________________

Parenteral infusion information**:** IV, CL, PICC, hep lock, saline lock Site: __________________

Soln. (IV, TPN, additives, etc.) __________________________________ Rate ________________

Nursing Hx: **(pertinent information to share)-** ____
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Diet ____________________________ Diet Change ____
Reason for change: ____ Date ____________________

DIET RATIONALE (Consider: Medical Diag., Meds, BMI, Lab Values, include Foods &/or Fluids the pt needs to increase or avoid.) ____
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