

Consumer Directed Services Option
NURSING SHIFT
NOTE/LOG

Patient Name:		Physician:		Pharmacy:				
Medicaid #:		Phone number:		Pharmacy #:				
INTAKE: Type: <input type="checkbox"/> GT <input type="checkbox"/> Other ORAL				OUTPUT				
Time given or Time started/stop	Type of Fluids	Rate/ cc/hr	Total Amount	Time	Urine Voided	Urine Cath	Urine Color & Consistency	Stool

URINE CODES: Color: Y-yellow B-bloody A-amber **Consistency:** C-clear Cld- cloudy S-sediment

STOOL CODES: SL-semi-liquid LQ-liquid S-soft F-formed

Size: Sm-small M-medium L-large XL-Ex-large

Digital stimulation performed Yes No

Fleets enema administered No Yes, Time: _____

INTAKE: FLUIDS W/MEDS & BOLUS FEEDINGS

Time	Type of Fluids	Rate: B-Bolus F- Fluids w/ Med	Total Amount	Time	Type of Fluids	Rate: B-Bolus F- Fluids w/ Med	Total Amount

RESPIRATORY CARE RECORD

SUCTIONING [] NONE REQUIRED Nasal- w/10fr cath-lubricate w/jelly prior to nasal suction Oral- w/tonsil tip applicator					RESPIRATORY SUPPLEMENTS Notify MD: if O2 Sats O2 ADMINISTERED VIA @ LPM						
Type	Time	Time	Time	Time		Time	Reading	Time	Reading	Time	Reading
					O2 sats %						
						Time On	Time Off	Time On	Time Off	Time On	Time Off
					TX: { } NOT REQUIRED						

RESPIRATORY TREATMENT RECORD

Time	Aerosol	Breath Sounds before IPV	Breath Sounds after IPV	Cough	Secretions	Comments

REPOSITIONING RECORD

Time	Position Rotated to	Time	Position Rotated to
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Printed Name:	Title: [] RN [] LVN	
Nurse Signature:	Title:	Date: