

Nursing II Clinical Assignment and Nursing Process Paper – Assessment Form

DATE: Click here to enter a date.

Pt. Initials:

RM# Click here to enter text.

Student: Click here to enter text.

Allergies: Click here to enter text.

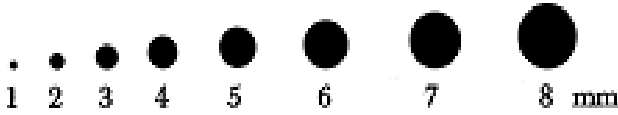
Check your assessment data. When you see ** you need to document in a narrative note for the patient's chart further details of the assessment or problem identified, the treatment and the patient's response to that treatment.

Physiologic needs: Oxygenation

Glasgow Coma Scale (GCS)

Neurological assessment

(3-8 Coma severe TBI)(9-12 mod. Disability TBI) (13-15 mild TBI)



Pupil Reaction	B-brisk <input type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> S-Sluggish <input type="checkbox"/> NR - no reaction <input type="checkbox"/> C-eye closed by swelling <input type="checkbox"/>
Pupil size (mm)	Right Click here to enter text. Left Click here to enter text.
Mentation	4-Alert <input type="checkbox"/> 3-lethargic <input type="checkbox"/> 2-Stuporous <input type="checkbox"/> 1-Comatose <input type="checkbox"/>
Emotional state	CA-Calm <input type="checkbox"/> AN-Anxious <input type="checkbox"/> CO-Combative <input type="checkbox"/> AG-agitated <input type="checkbox"/>

Eye Opening Response	Spontaneous--open with blinking at baseline	4 points <input type="checkbox"/>
	Opens to verbal command, speech, or shout	3 points <input type="checkbox"/>
	Opens to pain, not applied to face	2 points <input type="checkbox"/>
	None	1 point <input type="checkbox"/>
Verbal Response	Oriented	5 points <input type="checkbox"/>
	Confused conversation, but able to answer questions	4 points <input type="checkbox"/>
	Inappropriate responses, words discernible	3 points <input type="checkbox"/>
	Incomprehensible speech	2 points <input type="checkbox"/>
Motor Response Usually record best arm response	None	1 point <input type="checkbox"/>
	Obeys commands for movement	6 points <input type="checkbox"/>
	Purposeful movement to painful stimulus	5 points <input type="checkbox"/>
	Withdraws from pain	4 points <input type="checkbox"/>
	Abnormal (spastic) flexion, decorticate posture	3 points <input type="checkbox"/>
	Extensor (rigid) response, decerebrate posture	2 points <input type="checkbox"/>
None	1 point <input type="checkbox"/>	

Total of each section

GCS Total Click here to enter text.

2.) Cardio Vascular Assessment

Temp site – record with temp measurement O-oral R-rectal A-axillary T-Tympanic	BP SITE – record where taken RUA-right upper arm LUA-left upper arm RLA-right lower arm LLA-left lower arm RLL-right lower leg LLL-left lower leg		SKIN COLOR N-Normal for ethnicity F-Flushed P-Pale C-Cyanotic M-Mottled J-Jaundice	SKIN TEMP H-Hot W-warm C-Cool O-Cold	SKIN PALPATION D-Dry M-Moist C-Clammy/Diaphoretic	
	PULSE SITE – record where taken R-Radial B-Brachial F-femoral A-Apical O-other (location)					
TIME	Temp	BP/Site	Pulse rate/site	Skin color	Skin Temp	Skin palpation
PULSE SITES – record which pulse sites assessed for pulse strength on each extremity Upper : R-radial U-ulnar B-brachial Lower: F-femoral P-popliteal DP-dorsalis pedis PT-posterior tibial		PULSE STRENGTH 3+Bounding 2+Normal 1+ Weak D-Doppler A-Absent	EDEMA 0-None TR-Trace 1+ 3+ 2+ 4+ G-Generalized W-** Skin Weeping **Requires further documentation		CAPILLARY REFILL B- Brisk (< 3 sec) M- Moderate (>3 sec, <5 sec) S – Sluggish (>5 sec)	
Right upper		Click here to enter text.	Click here to enter text.		Click here to enter text.	
Left upper		Click here to enter text.	Click here to enter text.		Click here to enter text.	
Right lower		Click here to enter text.	Click here to enter text.		Click here to enter text.	
Left lower		Click here to enter text.	Click here to enter text.		Click here to enter text.	

3.) Pulmonary Assessment

AIRWAY CODE N-No Artificial Airway TR-Tracheostomy L-Laryngectomy ETT – Endotracheal tube Trach/ET Tube size. Click here to enter text. ET tube placement Click here to enter text.cm @ lip line			OXYGEN THERAPY: NV-Non-Invasive ventilator TC-Trach Collar NC-Nasal Cannula VM-Venti-Mask NRB-Non-Rebreather Mask RA-Room Air O-Other (requires comment) V – Vent (If vent complete below) Mode Click here to enter text. Rate. Click here to enter text. Tidal volume Click here to enter text. Peep/pressure support Click here to enter text.			SECRETIONS: S-Small W-White M-Moderate Y-Yellow C-Copious G-Green TN-Thin T-Tan TK-Thick F-Foul BT-Blood-Tinged N-None		Breath Sounds** CL-Clear CR Crackles W-Wheeze R-Rhonchi D-Diminished ** Note required to describe breath sounds if other than clear	INTERVENTION CPT-Chest Physiotherapy IS-Incentive Spirometry S-Suction TC - Trach care (requires note)	Chest Tube Lt <input type="checkbox"/> RT <input type="checkbox"/> Chest tube to suction: <input type="checkbox"/> No <input type="checkbox"/> Yes Click here to enter text.cm H2O Drainage: Color: Click here to enter text.
TIME	RR	Airway	O2 therapy	O2 Flow	Pulse Ox	Cough	Secretions	Breath Sounds	Intervention	Hx. of SMOKING
						<input type="checkbox"/> No <input type="checkbox"/> Yes				<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes				Packs per day Click here to enter text.

4.) Fluid and Electrolytes Assessment

Skin Turgor: N-Normal P-Poor		MUCOUS MEMBRANES TD-Tongue Dry LD- Lips Dry/Cracked TM – Tongue Moist LM - Lips Moist		Fluid Intake Thirst-Presence of thirst Yes <input type="checkbox"/> No <input type="checkbox"/> Nausea/ Vomiting** Yes <input type="checkbox"/> No <input type="checkbox"/> NPO Yes <input type="checkbox"/> No <input type="checkbox"/> Fluid Intake previous 24 hrs. Click here to enter text. **Requires note		Fluid Restriction Previous 24 hrs. Yes <input type="checkbox"/> No <input type="checkbox"/> Fluid Restriction amt. for 24 hrs. and distribution every shift. Total mL Click here to enter text. Day shift Click here to enter text. Night shift Click here to enter text.		IV Infusion Yes <input type="checkbox"/> No <input type="checkbox"/> Site Flush Yes <input type="checkbox"/> No <input type="checkbox"/> IV D/C ** Yes <input type="checkbox"/> No <input type="checkbox"/> ** Note needed Continuous medication drip** Yes <input type="checkbox"/> No <input type="checkbox"/> ** Note needed		
Time	Skin Turgor	Mucous Membranes	Fluid Intake for shift	Fluid allowed for shift	IV site location/ Condition/ Pain** Note needed	IV Solution and rate				

5.) Nutrition Assessment

Ordered Nutrition R-Regular T-TPN/PPN S-soft P-Pureed CL-Clear liquid NPO-Nothing by mouth E-Enteral feeding (type) O-other (specify)		Dentures U-Upper L- Lower B- Both O-Own N-None p-Partial	Nutrition Problems E-Eating S-Swallowing H-Heartburn T-Taste C-chewing N-None	Change in Weight Yes** <input type="checkbox"/> No <input type="checkbox"/> ** Note needed	Other information if needed: Click here to enter text.	Dietary Supplement type Click here to enter text.
% of meal consumed	Ordered nutrition	Dentures	Problems	Weight	Height	Dietary Supplement (Amount taken)

6.) Elimination Assessment: 6a. GI Assessment

ABDOMEN INSPECTION: F-Flat D-Distended O-Obese C-Concave Colostomy <input type="checkbox"/> Yes** requires note <input type="checkbox"/> No		BOWEL SOUNDS 3+ Hyperactive 2+ Normal 1+ Hypoactive 0-Absent	PALPATION S-Soft F-Firm R-Rigid N-Guarding NT-Non-Tender T-Tender	Bowel movement Size S-small M-medium L-large Formed Diarrhea <input type="checkbox"/> ** Bedpan <input type="checkbox"/> Commode <input type="checkbox"/>	DRAINAGE COLOR: G-Green BR-Brown BL-Black Y-Yellow R-Red CG-Coffee Ground N/A-Not applicable	Nasogastric Tube type. Salem sump <input type="checkbox"/> Feeding tube <input type="checkbox"/> PEG <input type="checkbox"/> J-Tube <input type="checkbox"/> Placement confirmation method: Aspiration <input type="checkbox"/> Air bolus <input type="checkbox"/> X-ray <input type="checkbox"/> Date Click here to enter text.		TUBE SUCTION: LIS-Low Intermittent Suction LCS-Low Continuous Suction G-Gravity Drainage C-Clamped		
Time	Inspection	Bowel Sounds	Palpation	BM (Size, Color Consistency)	Drainage Color	Tube type	Tube Location: (e.g., left nare, RUQ)	Tube suction	Residual/ amount of drainage or vomit	

6b.) GU Assessment

GU CATHETER. type I-Indwelling S-Straight SP-Suprapubic N-Nephrostomy N/A-not applicable		URINE COLOR. Y-Yellow A-Amber N-Colorless B-Brown O-Orange R-Red P-Pale D-Dark			CLARITY. C-Clear T-Turbid	SEDIMENT P-Present O- None	TOILETING S-Self U- Urinal BP- Bedpan A-BRP w/assist C-Bedside commode I-Incontinent @ times B-incontinence brief
TIME	Catheter type	Days in place	Urine Color	Amount voided/emptied	Clarity	Sediment	Toileting

7.) Mobility & Activity

ROM. RANGE OF MOTION. A-Active P-Passive	Strength 0-No movement 1-Trace 2-Movement but not against gravity 3-Movement against gravity but NOT against resistance 4-Movement against Gravity AND against some resistance 5-Full power	AMBULATION. S-Self A-Assist W-Walker CR-Crutches CA-Cane PT-Physical therapy	RVS-REDUCED VENOUS STASIS INTERVENTIONS S-Elastic Stockings on O-Elastic Stockings off A-Ace wraps M-Sequential Compression Machine F-Foot Pump On	REPOSITIONING. R-Right Side L-Left Side S-Supine P-Prone O-OOB to chair	BED POSITION. F-Flat L-Low Fowler's SF-Semi-Fowler's HF-High-Fowler's T-Trendelenburg RT-Reverse Trendelenburg	
TIME	ROM	Strength RU/LU/RL/LL	Ambulation	Reduced Venous Stasis Interventions	Repositioning & time	Bed Position

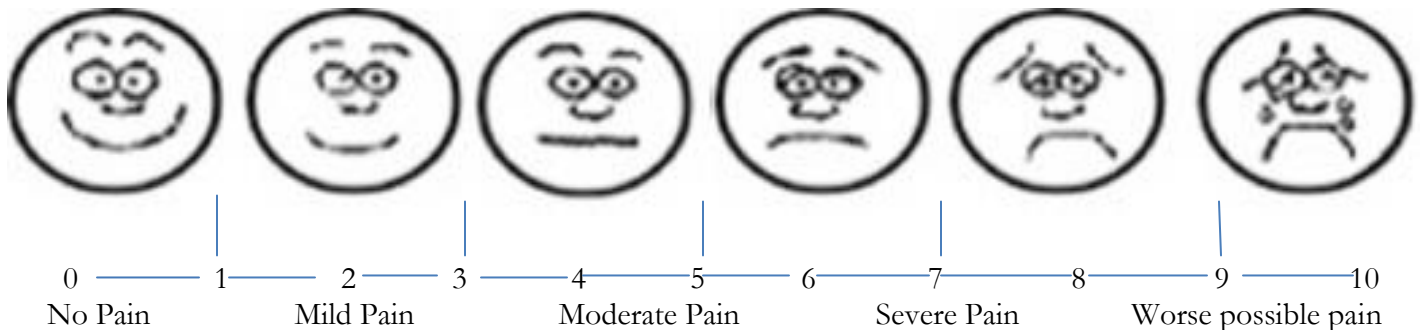
8.) Rest and Sleep (Check mark response)

Assessment of Sleep Pattern Difficulty falling asleep <input type="checkbox"/> Difficulty staying asleep longer than 4 hrs. <input type="checkbox"/> Uses a prescription sleep aide nightly <input type="checkbox"/> Drug name: Click here to enter text. Uses an OTC sleep aide, nightly <input type="checkbox"/> Drug name: Click here to enter text. Denies sleep disturbance. <input type="checkbox"/>	Sleep Aides/Methods tried with or without success. Click here to enter text.	Patient's rest, sleep goal. Click here to enter text.
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9.) Pain

DESCRIPTION of PREDOMINANT PAIN. P-Prickling SH-Sharp A-Aching ST-Stabbing B-Burning PR-Pressure T-Throbbing O-Other	Pain scale used. N-Numeric F-Faces P- PAINAD V-Verbal descriptor	FREQUENCY of Pain. C-Constant E-Episodic WM with Movement WB with breathing	What worked in the past? Click here to enter text.	INTERVENTIONS. P-Pharmacological H-Heat R -Relaxation C-Position for comfort I-Imagery E-Emotional Support D-Distraction Q-Quiet Environment M-Massage O-Other
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TIME	Location	Description	Intensity (0-10) and scale used	Frequency	Intervention ** Note required



PAINAD scale (Pain Assessment in Advanced Dementia) Use as necessary only

Item	1	2	3	Score
Breathing independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheynes-Stokes respirations	Click here to enter text.
Negative vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality	Repeated troubling calling out. Loud moaning or groaning. Crying.	Click here to enter text.
Facial expression	Smiling or inexpressive	Sad, frightened, frown	Facial grimacing	Click here to enter text.
Body language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	Click here to enter text.
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	Click here to enter text.

Total [Click here to enter text.](#)

10.) Safety and Security needs - Skin and Safety Assessments (Describe wound dressings in note)

SKIN CONDITION: I-Intact N-Non-Intact *(Requires further documentation) WOUND TYPE: P-Pressure ulcer S-Surgical wound L-Laceration A-Abrasion E-Echymosis R-Rash SURGICAL DRAINS Yes** <input type="checkbox"/> ** Note needed No <input type="checkbox"/>	DESCRIPTION B-Blanching Erythema Stage I (Non-Blanching Erythema) Stage II: (Skin open to superficial layer) Stage III (Skin open to SC tissue layer) Stage IV (Skin open to muscle or bone) U-Unstageable – Eschar present DTI-Deep tissue injury	BATH C-Complete P-Partial S-Self A-Assist	SIDE RAILS: 4-4 Rails Up 3-3 Rails Up 2-2 Rails Up 1-1 Rail Up 0- Side Rails ↓	**BRADEN SCALE SCORE# _____ HIGH <input type="checkbox"/> MED <input type="checkbox"/> LOW <input type="checkbox"/> **FALL RISK Score # _____ HIGH <input type="checkbox"/> MED <input type="checkbox"/> LOW <input type="checkbox"/> Fall risk scale used Click here to enter text.	
Wound type/Size (cm)/Location	Surgical drain type and location	Description (wound and drainage)	Bath	Side rails	
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Love and Belonging needs

11.) Psychosocial Assessment

Client report of Family/Friends: Click here to enter text.	Next of Kin (Ask) Click here to enter text.
Religious Affiliation Click here to enter text.	Indicators—Cards <input type="checkbox"/> Flowers <input type="checkbox"/> Family Photos <input type="checkbox"/>
Additional Data Click here to enter text.	

Self-Esteem needs

Family Role Click here to enter text.	Grooming equipment at bedside:
Occupation Click here to enter text.	Brush/Comb <input type="checkbox"/> Toothbrush <input type="checkbox"/> Toothpaste <input type="checkbox"/> Other Click here to enter text.
Toiletries: Click here to enter text.	Interest in appearance Click here to enter text.
Additional Data: Click here to enter text.	

Self-Actualization needs

Client report of satisfaction with life: Click here to enter text.
Independence: Click here to enter text.
Creativity: Click here to enter text.
Additional Data: Click here to enter text.

ERICKSON'S STAGE OF DEVELOPMENT: (1) State the Developmental Stage the client is exhibiting. (2) Include what part of the stage best represents the client's behavior and WHY you feel this is the part of the stage the client is exhibiting? (Make sure you explain your decision process in your explanation.) [Click here to enter text.](#)