Women's Health Clinical Assignment and Nursing Process Paper – Assessment Form

DATE:Click here to enter a date. Client. Initials: AgeClick here to enter text. RM#

Student:Click here to enter text. Allergies:Click here to enter text. Admitting Dx.Click here to enter text.

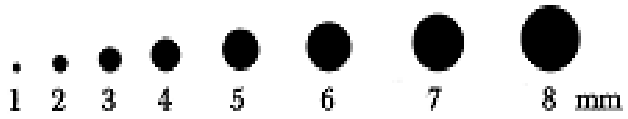
EDC:#Click here to enter text. Gravida# Click here to enter text. Para:#Click here to enter text. PP day #Click here to enter text.

Status: Hepatitis ☐ Rubella☐ HIV☐ GBS☐ Term ☐ Post-term☐ Pre-term☐ Gestation☐

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

Neurological assessment



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

Glasgow Coma Scale (GCS)

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

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

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 **PULSE SITE – record where taken** R-Radial B-Brachial F-femoral A-Apical O-other (location)		**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
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 **Location** TR-Trace H-Hand 1+ 3+ A-Arm 2+ 4+ F-Foot G-Generalized A-Ankle W-** Skin Weeping T-Thigh **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	OXYGEN THERAPY:	SECRETIONS:	Breath Sounds••	INTERVENTION	Chest Tube
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**	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.	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	CL-Clear CR Crackles W-Wheeze R-Rhonchi D-Diminished •• Note required to describe breath sounds if other than clear	CPT-Chest Physiotherapy IS-Incentive Spirometry S-Suction TC – Trach care (requires note)	**Lt** ☐ **RT** ☐ Chest tube to suction: ☐No ☐Yes Click here to enter text.cm H20 Drainage: Color:Click here to enter text.

TIME	RR	Air-way	O2 therapy	O2 Flow	Pulse Ox	Cough	Secretions	Breath Sounds	Intervention	Hx. of SMOKING
						☐No ☐Yes				☐No ☐Yes
						☐No ☐Yes				Packs per day Click here to enter text.

4.) Fluid and Electrolytes Assessment

Skin Turgor: MUCOUS MEMBRANES	Fluid Intake	Fluid Restriction Previous 24 hrs.	IV Infusion
N-Normal P-Poor Dry/Cracked TD-Tongue Dry LD- Lips TM – Tongue Moist LM - Lips Moist	Thirst-Presence of thirst Yes ☐No ☐ Nausea/ Vomiting** Yes ☐No ☐ NPO Yes ☐No ☐ Fluid Intake previous 24 hrs. Click here to enter text. **Requires note	Yes ☐ No ☐ **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.	**Yes ☐ No ☐** **Site Flush** **Yes ☐ No ☐** **IV D/C ••** **Yes ☐ No ☐** •• Note needed **Continuous medication drip••** **Yes ☐ No ☐** •• 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	Dentures	Nutrition Problems	Change in Weight	Other information if needed:	Dietary Supplement type
R-Regular T-TPN/PPN S-soft P-Pureed CL-Clear liquid NPO-Nothing by mouth E-Enteral feeding (type) O-other (specify)	U-Upper L- Lower B- Both O-Own N-None p-Partial	E-Eating S-Swallowing H-Heartburn T-Taste C-chewing N☐-None	Yes** ☐ No ☐ ** Note needed	**Click here to enter text.**	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:	BOWEL SOUNDS	PALPATION	Bowel movement Size	DRAINAGE COLOR:	Nasogastric Tube type:	TUBE SUCTION:
F-Flat D-Distended O-Obese C-Concave **Colostomy** ☐ Yes** requires note ☐ No	3+ Hyperactive 2+ Normal 1+ Hypoactive 0-Absent	S-Soft F-Firm R-Rigid N-Guarding NT-Non-Tender T-Tender	S-small M-medium L-large Formed Diarrhea☐ ** Bedpan☐ Commode☐	G-Green BR-Brown BL-Black Y-Yellow R-Red CG-Coffee Ground N/A-Not applicable	Salem sump ☐ Feeding tube ☐PEG ☐ J-Tube ☐ **Placement confirmation method:** Aspiration ☐ Air bolus☐ X-ray☐ Date Click here to enter text.	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	URINE COLOR:	CLARITY:	SEDIMENT	TOILETING
I-Indwelling S-Straight SP-Suprapubic N-Nephrostomy N/A-not applicable	Y-Yellow A-Amber N-Colorless B-Brown O-Orange R-Red P-Pale D-Dark **Time First void:** Click here to enter text. **Second Void** Click here to enter text.	C-Clear T-Turbid	P-Present 0- None	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 **Homan's sign:** Click here to enter text.	REPOSITIONING: R-Right Side L-Left Side S-Supine P-Prone O-OOB to chair BRP- bathroom privileges. Ad Lib	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
				Homan's: Click here to enter text.		

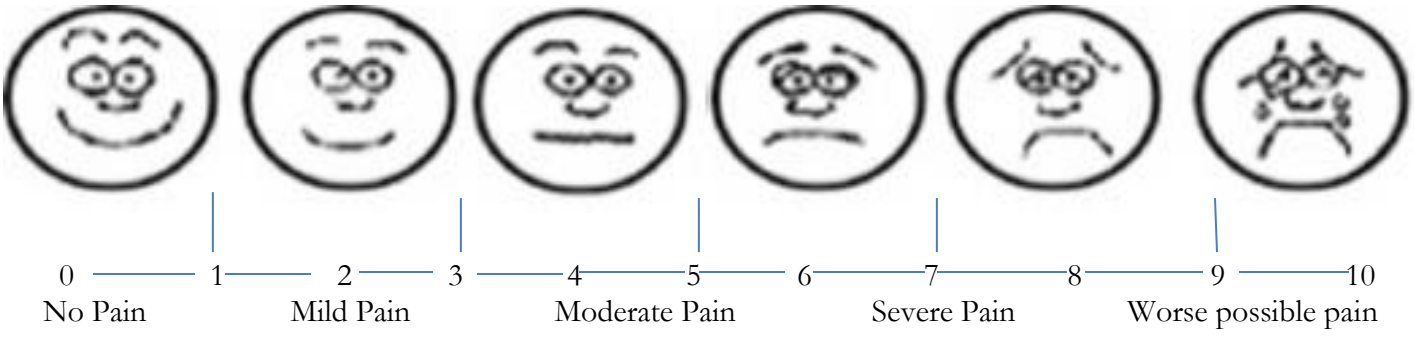
8.) Rest and Sleep (Check mark response)

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

9.) Pain

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

TIME	Location	Description	Intensity (0-10) and scale used	Frequency	Intervention ** Note required



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-Ecchymosis R-Rash SURGICAL DRAINS Yes** ☐ ** Note needed No ☐		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 ☐ MED ☐ LOW ☐ ••FALL RISK Score # _____ HIGH ☐ MED ☐ LOW ☐ 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.

Episiotomy: Midline: ☐ Medio lateral: ☐ Edges approximate: ☐ Hematoma:☐

C-section Incision: Click here to enter text. **Approximate size in cm:** Click here to enter text.

***Incision treatment:** Click here to enter text.

Hemorrhoids: ☐ Perineal Swelling: ☐ Ice:☐ Sitz bath: ☐

Fundus: Firm: ☐ Boggy:☐ Midline: Yes ☐ No ☐ Height#Click here to enter text.

Lochia: Enter amount: Click here to enter text.**Color:**Click here to enter text.

Condition of Breast/Nipples: Click here to enter text.

Love and Belonging needs

11.) Psychosocial Assessment

Feelings on first sight of baby: Click here to enter text.**Feelings about labor and delivery:** Click here to enter text.

Main focus of attention: Click here to enter text.

Family reaction to birth: Click here to enter text. **Next of Kin (Ask)_**Click here to enter text.

Religious Affiliation_ Click here to enter text. **Indicators—Cards ☐ Flowers ☐ Family Photos☐**

Additional Data Click here to enter text. **Help at home:**

Thoughts about how baby is progressing: Click here to enter text.

Mother's knowledge of baby care: (safety, feeding, bathing) Click here to enter text.

Concerns about taking baby home: Click here to enter text.

Self-Esteem needs

Family Role_ Click here to enter text. **Grooming equipment at bedside:**Click here to enter text.

OccupationClick here to enter text. **Brush/Comb ☐ Toothbrush ☐ Toothpaste☐ 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. **Knowledge of self-care:** Click here to enter text.

Reactions/communication with infant (body contact, security): Click here to enter text.

Infant's reaction to mother: Click here to enter text. **Role fulfillment vs conflict:**Click here to enter text.

Self-Actualization needs

Client report of satisfaction with life: Click here to enter text. **Pregnancy planned:** Click here to enter text.

Independence: Click here to enter text. **Contraception planned:** Click here to enter text.

Creativity: Click here to enter text. **Comments:**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? Degree of dependency/independency in caring for self and newborn: (Make sure you explain your decision process in your explanation.)_Click here to enter text.