

POST HOSPITALIZATION/ER/PROCEDURE ASSESSMENT

Subjective Data:

Allergies: _____

Discharge Diagnosis: _____

Current problems: _____

Procedures/Treatments: _____

Current Medications: _____

Objective Data:

BP _____ Pulse _____ Resp. _____ Temp. _____ Wt. _____ FSBS _____ O2 sats. _____

Respirations:	<input type="checkbox"/> WNL	<input type="checkbox"/> Uneven	<input type="checkbox"/> Labored	<input type="checkbox"/> Unlabored	<input type="checkbox"/> Shallow	<input type="checkbox"/> Deep
Lung sounds:	<input type="checkbox"/> WNL	<input type="checkbox"/> Crackles (L / R)	<input type="checkbox"/> Wheezing (L / R)	<input type="checkbox"/> Rhonchi (L / R)	<input type="checkbox"/> Diminished (L / R)	
Skin:	<input type="checkbox"/> WNL	<input type="checkbox"/> Cool	<input type="checkbox"/> Pale	<input type="checkbox"/> Cyanotic	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Diaphoretic
Gastrointestinal:	<input type="checkbox"/> WNL	<input type="checkbox"/>	<input type="checkbox"/> Vomiting Describe: _____		<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation
Abdomen:	<input type="checkbox"/> WNL	<input type="checkbox"/>	<input type="checkbox"/> Firm	<input type="checkbox"/> Distended		
Genitourinary:	<input type="checkbox"/> WNL	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Dysuria			
Wounds:	Location, size, drainage: _____					
	Location, size, drainage: _____					
Ulcers:	Stage, size, drainage: _____					
	Stage, size, drainage: _____					
LOC:	<input type="checkbox"/> WNL	<input type="checkbox"/> Oriented X _____	<input type="checkbox"/> Confused	<input type="checkbox"/> Lethargic		
Functional Status:	<input type="checkbox"/> WNL	<input type="checkbox"/> Partial/Moderate assist	<input type="checkbox"/> Substantial/Maximal assist	<input type="checkbox"/> Dependent		
Medical Devices:	<input type="checkbox"/> Ostomy	<input type="checkbox"/> Indwelling catheter	<input type="checkbox"/> Infusion port	<input type="checkbox"/> PICC line	<input type="checkbox"/> Fistula (dialysis)	
	<input type="checkbox"/> Peg tube	<input type="checkbox"/> Tracheal tube	<input type="checkbox"/> Oxygen (Liters)	<input type="checkbox"/> JP drain	<input type="checkbox"/> Wound vac	
	<input type="checkbox"/> Other: _____					
Supported Devices:	<input type="checkbox"/> Walker	<input type="checkbox"/> Cane	<input type="checkbox"/> Brace:		<input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Crutches	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Splint:		<input type="checkbox"/> Other: _____	
Appearance:	<input type="checkbox"/> No distress	<input type="checkbox"/> Mild distress	<input type="checkbox"/> Moderate distress	<input type="checkbox"/> Severe distress		

Nursing Protocol must be signed by the Medical Provider if offender displays any of the below s/s or any additional treatment/ medication required)

NOTIFY MEDICAL PROVIDER IMMEDIATELY.

- Severe exacerbation Unstable VS S/S of infection, fever > 101 degree F Increase or severe pain
 Call 911 if altered mental status change
 Emergency department notification time: _____ Transport time: _____

Medical Provider Notified: Date: _____ **Time:** _____ **Orders Received for Treatment:** Yes No

Assessment:

- Knowledge deficit related to: Surgical procedure Postoperative care
 Alteration in comfort related to: Surgical procedure Disease process

Plan: Nursing Intervention Routine: (check only those that apply)

- Check in assessment only for medical providers visit.
 Monitor for S/S of infection
 Monitor offenders VS
 Monitor for presence of pain
 Encourage relaxation with slow deep breaths to minimize pain and nausea
 Arrange for dressing change, wound check, suture removal
 Follow-up sick call if pain persists more than 2 days or becomes more severe
 Medical lay-in / restrictions
 Schedule medical provider appointment for **NEXT WORKING DAY**
 Education/Intervention: Instructed on nutrition and fluids, s/s of infection, follow-up sick call if no improvement. Offender verbalizes understanding of instructions.

Progress Note: _____

Medical Provider Signature/Credentials: _____ **Date:** _____ **Time:** _____

QHCP Signature/credentials: _____ **Date:** _____ **Time:** _____

Offender Name
(Last, First)

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