

Assessment sheet for the critical ill or injured patient

Patient's name :..... Age..... Gender.....

Diagnosis..... Date admission...../...../.....

Unit :..... Bed number:..... Family notification:.....

Student's name Date of assessment/...../.....

Primary assessment (at the patient arrival)

Airway :

- Chest rising and falling ☐ foreign material ☐
- Nasal flaring ☐ Stridor ☐
- Intercostal retraction ☐ Central cyanosis ☐

Cervical spine injuries :

- Neck pain ☐ numbness ☐
- Loss of sensation ☐ loss of movement ☐

Breathing :

- Exhaled air felt from :
Nose ☐ Mouth ☐ Stoma ☐
- Bilateral chest expansion ☐
- Respiration :
Rhythm : Regular ☐ Irregular ☐
Pattern : Bradypnea ☐ Tachypnea ☐
Shallow ☐ Deep ☐
Cheney stokes ☐ Kussmaul's ☐
Dyspnea : At rest ☐ With movement ☐
Use of accessory muscles (Effort) ☐

Circulation :

- Carotid pulse ☐ Dysrhythmia ☐ Peripheral cyanosis ☐
- Skin : cold ☐ Hot ☐ Dry ☐ Wet ☐
- Bleeding ☐
Site.....
Severity : Mild ☐ Moderate ☐ Severe ☐

Disability :

- Alert ☐ Respond to voice ☐
- Respond to painful stimulus ☐ Unresponsive ☐
- Eye pupil : Equal ☐ Unequal ☐
Size RT dilated ☐ pinpoint ☐
LT dilated ☐ Pinpoint ☐
Reaction : RT fixed ☐ LT fixed ☐

- Subjective data : concurrently done with resuscitation
- Allergies :
- Medication(s) :
- Past history of immunization (toxoid)
- Last meal :
- Event prior to injury / disease

Nursing diagnosis

secondary assessment

1. Subjective Data

Present Medical History

Chief Complaints

Duration

Description (in patient words).....

Mechanism of injury (trauma):

Blunt trauma ☐ fall ☐

Penetrating trauma ☐ motor vehicle crash ☐

History of present illnesses (complete , clear and chronologic account of the problems) :.....

.....

.....

Characteristics of Pain :

Precipitating factors

Quality : Stabbing ☐ Burning ☐ Prickling ☐ Aching ☐

Cramping ☐ Pressing ☐ squeezing ☐ throbbing ☐

Region / radiation :

Relieving and aggravating factors :

Severity : Mild ☐ Moderate ☐ Severe ☐

Timing : Onsetduration.....

Frequencycontinuous ☐ intermittent ☐

Associated Manifestations.....

Past Medical / Surgical History

Childhood illnesses:

Adult illnesses :

- Medical:
- Surgical :
- Obstetric /gynecologic :
- Psychiatric :

Health maintenance practices such as :

- Immunizations :.....
- Screening tests (such as tuberculin test , Papillomavirus , Mammograms , stools for occult blood and cholesterol tests).....

Medication History : all prescribed and over- the counter medications

- With dose
- Allergies

Family History :

D.M ☐ Hypertension ☐ Heart Diseases ☐ T.B ☐

Cancer ☐ Kidney Diseases ☐ Blood disorders ☐ B. Asthma ☐

Personal and Social History:

Marital status : M ☐ W ☐ S ☐ D ☐ Occupation

Socioeconomic status , Insurance & Ability to afford health care

Lifestyle Habits that promote health or create risk.....

Availability of : Family ☐ Surrogate Decision Makers ☐ Emergency

contacts ☐ Tobacco , Alcohol & IV drugs use.....

Nursing diagnosis

2. Objective Data :

General appearance

Weight : Normal ☐ Emaciated ☐ Obese ☐

Position : Lying Down ☐ fowlers ☐ Leaning Forward ☐

Odor (body & breath) : Alcohol ☐ Acetone ☐ urine ☐ stool ☐

Dress , Grooming & personal Hygiene : Acceptable ☐ Poor ☐

Skin :

Color : Pale ☐ Cyanosis ☐ Rash ☐ Abnormal pigmentation ☐

Turgor : Normal ☐ Poor ☐ **Moisture :** Moist ☐ Dry ☐

Nails : Color..... InfectionsCapillary Refill Time

Presence of	site	Presence of	site
Swelling		Decubitus Ulcer	
Edema :local		Contusion	
General		Ecchymosis	
Redness		Hematoma	
Hotness		Abrasion	
Rash		Bruises	
Tenderness		Laceration	
Previous Scar		Puncture	
Surgical Wound		Avulsion	
Implanted Object		Others	

Mental status : LOC (a wakeness):

A wake or conscious ☐

Drowsy or Lethargy

☐

Stupors

☐

Comatosed

☐

Awareness : Oriented or aware

☐

Confused

☐

Delirious

☐

Glasgow Coma Scale (GCS).....

Eye Opening	Open spontaneously	4
	Open to verbal command (to voice)	3
	Open to pain	2
	No response	1
Verbal Response	Oriented and converses	5
	Confused (disoriented & converses)	4
	Inappropriate words	3
	Incomprehensible sounds	2
	No response	1
Motor Response	Obeys command	6
	Localizes pain to painful stimulus	5
	Withdrawal (flexion)	4
	Abnormal flexion (decorticate rigidity)	3
	Abnormal extension (decerebrate rigidity)	2
	No response	1

13 - 15 = normal or slight injury

9 - 12 = moderate injury

≤ 8 = severe injury

Nursing diagnosis

Vital signs :

Temperature :Oral ☐ Axillary ☐ Rectal ☐
RR:.....Tachypnea ☐ Bradypnea ☐ odor.....
Rhythm : Cheney stokes ☐ kussmaul's ☐
Depth : Shallow ☐ Normal ☐ Deep ☐

Pulse Rate: Apical

Peripheral :Carotid ☐ Radial ☐ Brachial ☐ Femoral ☐

Rhythm : Regular ☐ Irregular ☐

Force : Thready or weak ☐ normal ☐ Bounding ☐

BP.....

CVP.....

Head to Toe Assessment

Head - Deformity ☐ Open wounds ☐ Tenderness ☐ Swelling ☐

Others

Eyes :

Pain ☐ Redness ☐ jaundice ☐ sunken ☐ Raccoon Eye ☐

Discharge ☐ vision changes : loss of vision ☐ double vision ☐

Blurred vision ☐ spots ☐ flashing ☐ others.....

Nose : Rhinorrhea (CSF) ☐ Epistaxis ☐ Discharges ☐

Deformity ☐ Tenderness ☐ Pain ☐ Obstruction ☐ Others

Ears : Battles sign ☐ Otto rhea (CSF) ☐ Bleeding ☐ Discharge ☐

Foreign body ☐ Earache ☐ Infection ☐ Vertigo ☐ Tinnitus ☐

Decreased hearing acuity ☐ Others.....

Throat (or mouth and pharynx):

Fracture jaw ☐ bleeding ☐ Dry ☐ Ulcers ☐ Sore tongue ☐

Foul odor ☐ Toothache ☐ Enlarged tonsils ☐ Hoarseness ☐

Abnormal coding – speech disturbances :

Unable ☐ slurred ☐ Aphasia ☐ Others

Neck : deformity ☐ open wound ☐ cervical spine tenderness ☐

Swelling ☐ pain ☐ Bruising ☐ Numbness or Tingling ☐

Enlarged thyroid ☐ enlarged lymph nodes ☐ Distended neck veins ☐

Deviated trachea ☐

Chest : Inspection :

Movement : Asymmetry ☐ Unilateral expansion ☐ Paradoxical ☐

Scars ☐ Open wound ☐ Swelling inflammation ☐ Dilated veins ☐

Shape : Normal ☐ Barrel ☐ Others deformity.....

Palpation : tenderness ☐ expansion : Asymmetry ☐ Unilateral ☐

Inspection & palpation for Apical impulse or point of Maximal impulse

(PMI): Normal place ☐ (MCL at fourth to fifth intercostal)

Displaced ☐ Impaled Devices

Percussion :

Hyper-resonant = tympanic ☐ normal resonance (= lung) ☐

Dull (like Liver) ☐ Stone dullness (like bone) ☐

Auscultation for : Adventitious lung sounds :

Crackles : RT Lung ☐ LT Lung. Gurgles : RT Lung ☐ LT Lung ☐

Wheezes : RT Lung ☐ LT Lung. Rubs : RT Lung ☐ LT Lung ☐

Air Entry : RT Lung : adequate ☐ absent ☐ Diminish ☐

LT Lung : adequate ☐ absent ☐ Diminish ☐

Nursing diagnosis

Extra heart sounds :

Pericardial Rubs ☐ S3 Gallop ☐ S4 Gallop ☐ heart murmurs ☐

Respiratory Effort : Nasal Flaring ☐ Use accessory muscles ☐

Respiratory problems :

Dyspnea : on rest ☐ on effort ☐ paroxysmal nocturnal orthopnea ☐

Cough : Wet ☐ Dry ☐

Sputum – color :yellow ☐ green ☐ red ☐ black ☐

Consistency :Thick ☐ Watery ☐

Amount : Small ☐ Moderate ☐ large ☐ Hemoptysis ☐

Abdominal Inspection :

Shape – Asymmetry ☐ Dilated veins ☐ Scars ☐

Distention : Gas (from back to front) ☐ fluid (from sides) ☐

Exposed internal organsColostomy ☐

Appearant peristalsis movement ☐ others.....

Palpation:

Abdominal pain /tenderness ☐ Rigidity ☐ Mass ☐ Hernia ☐

Auscultation :

Peristaltic sound: Absent ☐ Hypoactive ☐ Hyperactive ☐

Abdominal bruit ☐ (indicating aneurysms , AV fistulas , or atherosclerosis)

Percussion : Gas content ☐ fluid content of the abdomen ☐

Nutritional intake Problems : Nausea ☐ Vomiting ☐

Hematemesis ☐ Anorexia ☐ Polydipsia ☐ Dysphagia ☐

Indigestion ☐ Delayed gastric emptying ☐ Others.....

Feeding Tube insertion site

Elimination Problems :

Bowel Elimination : Diarrhea ☐ Incontinence ☐ Constipation ☐

Fecal Impaction ☐ Melena ☐ Others.....

Urinary Elimination : Retention ☐ Incontinence ☐ Urgency ☐

Frequency ☐ Dysuria ☐ Polyuria ☐ Oliguria ☐ Dribbling ☐

Pelvis / Perineum :Hematuria ☐ Flank pain ☐ Vaginal discharges

Perineal swelling ☐ Bone deformity ☐

Extremities:

Problem	Rt. Arm	Lt. Arm	Rt. Leg	Lt. Leg
Deformity				
Crepitus				
Tenderness				
Limited ROM				
Stiffness				
Weak muscles				
Paralysis				
Los of sensation				
Numbness				
Absence periph pulse				
Capillary refill				

Function status :

Energy level : Exhausted without activity ☐ Tires Easily ☐

Activities of Daily Living : Totally Dependent ☐

Need Assistance with : Eating ☐ Dressing ☐ Bathing ☐

Nursing diagnosis

Mobility status :

Mobile with Assistance of other person ☐

Mobile with Device : Crutch ☐ Wheel chair ☐ Walker ☐

Physical Handicap ☐

Psychological status :

Anxious ☐ fearful ☐ depressed ☐ Angry ☐

Withdrawn ☐ Apprehensive ☐ Irritable ☐ Aggressive ☐

Economic Problems :

Teaching needs :

Diagnosis Data : ECG:

Radiology :

X – ray

Ultrasound

CT scan or MRI

Others :

Nursing diagnosis

Blood test	Result	Normal value	Blood test	Result	Normal value

Arterial Blood Gases (ABG)

Parameter	8 am	9 am	10am	11am	12am	1 pm	2pm
PH (7.35 – 7.45)							
PaO ₂ (80 – 100 mmHg)							
PaCO ₂ (35 – 45 mmHg)							
HCO ₃ (22 – 26 mmol/L)							
SaO ₂ (>95 – 100%)							
Base Excess (± 2mmol/L)							
Conclusion							

Nursing process

[illegible]

Nursing process

[illegible]

Nursing process

[illegible]

جامعة 21 سبتمبر للعلوم الطبية والتطبيقية

كلية التمريض العالي

الدائرة السريرية



DAILY NURSING RECORD

Student's name : _____ Date / time (today) : / /

Patient's name: Age: Gender:

Unit : Room / Bed Number: Family Notification:

O₂ Therapy : ☐ Presence of Tubes :

Method Concentration Gastric Tube ☐ Site of insertion

Date of application / / Duration Date of insertion / / Duration

Artificial Airway : ☐ Chest Tube : ☐

Type Size Date of insertion / / Duration

Mechanical Ventilation : ☐ Other Tube :

Date of application Duration Invasive Lines (catheters)

Urinary Catheters : ☐ Central Venous Catheter : ☐

Date of insertion / / Duration Site Date of insertion / /

Other Devices : Arterial Catheter : ☐

Date of insertion / / Duration

Vital signs and CVP Readings

Sign	8 am	9 am	10 am	11 am	12 am	1 pm	2 pm
Temperature (C) site.....							
Pulse :Radial (b/m)							
Apical							
BP : Non – invasive (mmHg)							
Invasive (mmHg)							
CVP (cmH ₂ O)							
Respiratory Rate (breath /m)							
Saturation (SpO ₂)							

Glasgow Coma Scale (GCS)

Eye Opening	Open spontaneously	4
	Open to verbal command (to voice)	3
	Open to pain	2
	No response	1
Verbal Response	Oriented and converses	5
	Confused (disoriented & converses)	4
	Inappropriate words	3
	Incomprehensible sounds	2
	No response	1
Motor Response	Obeys command	6
	Localizes pain to painful stimulus	5
	Withdrawal (flexion)	4
	Abnormal flexion (decorticate rigidity)	3
	Abnormal extension (decerebrate rigidity)	2
	No response	1

Mechanical ventilation monitoring

Parameter	8 am	9 am	10 am	11 am	12 am	1 pm	2 pm
Time							
Muscle Relaxant Intake							
Settings							
FIO ₂ (%)							
Mode							
Tidal Volume (ml)							
Inspiratory Pressure (cmH ₂ O)							
Frequency (breath / min)							
I:E Ratio							
Flow Rate (L / min)							
PEEP (cmH ₂ O)							
PSV (cmH ₂ O)							
Sensitivity (cmH ₂ O or L / min)							
Measurements (values)							
Spontaneous Rate							
Total Rate (breath / min)							
Spontaneous Expired Tidal Volume(ml)							
Expired Tidal Volume(ml)							
Spontaneous Minute ventilation (L / min)							
Total Minute ventilation (L / min)							
Airway pressures <ul style="list-style-type: none"> Peak (cmH₂O) Plateau (cmH₂O) Mean (cmH₂O) 							
Humidifier Temp.							
Nebulizer on or off							
Arterial Blood Gases (ABG)							
PH (7.35 – 7.45)							
PaO ₂ (80 – 100 mmHg)							
PaCO ₂ (35 – 45 mmHg)							
HCO ₃ (22 – 26 mmol/L)							
SaO ₂ (>95 – 100%)							
Base Excess (± 2mmol/L)							
Conclusion							

Fluid Intake and output

Time	fluid intake			Fluid output		
	Amount (ml)	Type	Route	Amount (ml)	Type	Route
8 am						
2 pm						
	Shift Total intake =			Shift Total output =		
	Shift Balance = Total intake - Total output =					

Drug Administration

Time	Drug	Dose	Route	Site	Remarks	Signature

Nursing Notes

[illegible]

Nursing process

[illegible]

Nursing process

[illegible]

Nursing process

[illegible]

جامعة 21 سبتمبر للعلوم الطبية والتطبيقية

كلية التمريض العالي

الدائرة السريرية

