BRAIN NURSING REPORT SHEET

BACKGROUND

Name: _____

Room No. _____

DOB: _____

Age: _____ Gender: M ☐ F ☐

Code Status: _____

Allergies: _____

Diagnosis & Admission Reason:

_____

Fall Precautions / Safety Needs: _____

_____

Activity Level / ADL Support: _____

_____

Isolation Type / Special Precautions: _____

_____

Relevant PMH: _____

_____

REASON

Date of Admission: _____

Events leading to hospitalization:

_____

_____

_____

Acute Problem(s):

_____

_____

_____

_____

_____

ASSESSMENT

Most Recent Vitals:

HR: _____ OX: _____

BP: _____ Temp: _____

RR: _____ Pain Score: _____

Skin Status: _____ LOC: _____

Last Dose Administered: _____

H2T Highlights (Brief):

_____

_____

_____

Labs or Imaging Summary:

_____

_____

_____

INVERVENTIONS

IV / Lines:

_____

_____

Medications:

_____

_____

Wound Care:

_____

_____

Respiratory Support:

_____

_____

NEXT

Tasks for Next Shift:

_____

_____

Upcoming Procedures / Labs:

_____

_____

Discharge Planning Notes:

_____

_____

Family / Patients Concerns:

_____

_____