

CLINICAL RECORD

Directions for Use

Complete all applicable fields on all inpatients. Identify non-applicable fields with "N/A".

Legend: For **temperature:** per ora (PO); tympanic (TM); temporal (TP); rectal (R). For **pulse:** regular (reg); irregular (irreg); apical (A). Blood Glucose = BG. Chest X-ray = CXR; Abdominal X-ray = ABX; Ultrasound = U/S; Computerized Tomography Scan = CT; Occult Blood = OB; Culture & Sensitivity = C&S; Litres/min. = LPM; NP = nasal prongs; FM = face mask; OXY = oxymask; NRB = non-rebreathe mask; Room Air = RA

DATE		29 Jan 2022			30 Jan. 2022			31 Jan. 2022			01 Feb 2022		
HOSP. DAY		Admission			1			2			3		
POST OP DAY					OR			1			2		
HOUR	0200												
	0400												
TEMP.	36.8												
	See FMR												
PULSE	80												
RESP.	20												
SPO ₂ & O ₂ Therapy	90% 3LPM NP												
B.P.	100/60												
BLOOD GLUCOSE	TIME	0400											
	BG	5.3											
WEIGHT (KG)		60 kg			62.5 kg								
INTAKE		200	2000	1000	200	2000	1000						
OUTPUT		700	1000	1000	750	1000	1000						
24 hr FLUID BALANCE +/-		+500			+450								
CUMULATIVE FLUID BALANCE					+950								
DIAGNOSTICS		CXR, CT, Stool C&S, Stool OBx1, UA, INR			Group & Match								
TIME AND INITIALS	NIGHTS	0200 AB 0400 CD			0300 CD 0615 AB								
	DAYS	1100 EF 1500 GH			1100 EF 1500 EF								
	EVENING	1800 IJ 2130 MN			1800 EF 2130 MN								

Directions for Use:

- Complete all applicable fields on all inpatients on all units.
- Identify not-applicable fields with "N/A"
- Record the date, hospital day, and post-op day if applicable (see example above).
- Record vital signs and include descriptors identified in in the legend above.
- Enter SpO₂, oxygen flow rate and method of delivery for O₂ therapy (see example).
 - When using the *Frequent Monitoring Record* (CLI.4510.PR.002.FORM.002), enter "see FMR" in the vital signs section.
- Transfer the 24-hr fluid balance and calculate the cumulative fluid balance. The purpose of this duplication of charting is to provide a complete patient summary in one place.
- Within the diagnostic row, enter tests completed, such as ECG, any diagnostic imaging (e.g. CXR, AXR, U/S, CT) and any specimen collected (e.g. stool OBx1, Stool C&S). Also track INR results if applicable.
- Time and initial each assessment within the respective boxes designating the shift (see example).
- More than one provider can sign during each shift. Each provider enters the time and initials within the applicable shift.



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