Telemetry Flowsheet

Date: _______________ Room #: ______ ACP level: ______ Diagnosis: ______________________ Pack #: _______ Start Date/Time: _____________

Time														
Heart Rate														
Rhythm* Analysis (+/- ectopics)														
SpO_2 (%) Only if ordered														
√ If Strip mounted														
Nurse Initials														

*Correlate patient symptoms with any changes in rhythm analysis and notify physician if warranted

Comments	Shift Report

Initials	Signature	Initials	Signature	Initials	Signature