**Report**

Name, Age, Diagnosis

Allergies, code status

Relevant history (past medical problems that impact current hospital stay, ie DM, HTN, COPD)

Current problem (why are they here and are they on the appropriate unit)

**Assessment:**

Neuro (LOC, confusion)

CV (fluid issues, EKG, BP, HR)

Resp (lung sounds, oxygen amount, RR, CXR)

GI (last BM, any abnormalities, NG)

GU (voiding, BSC, foley, dialysis)

Skin (wounds, ulcers, incisions, drains)

Lines (IV, central line, PAC, fistula/shunt)

Drips/Fluids

Pain med last dose/next dose

Mobility (type of assistance needed, OOB, turn q2, fall risk)

Diet

Accuchecks (last BG, covered?)

Abnormal labs (esp K, BUN/Cr, H/H, WBC, cultures)

VTE (thromboguards, anticoagulant)

Doctors

To do’s (follow up items including labs, procedures, meds)

Plan of care

Review last 12 hours of orders