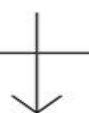
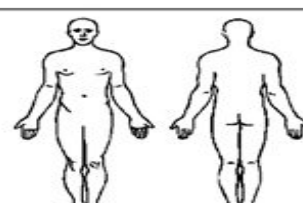


Gastrointestinal	<p><input type="checkbox"/> See Critical Care Flow Chart for Rate/Type of Enteral Feeding and TPN</p> <p><b>Abdomen:</b>    <input type="checkbox"/> Soft    <input type="checkbox"/> Firm    <input type="checkbox"/> Flat    <input type="checkbox"/> Rounded  <input type="checkbox"/> Obese    <input type="checkbox"/> Distended    <input type="checkbox"/> Guarding    <input type="checkbox"/> Rebound Tenderness</p> <p><b>Bowel Sounds:</b>    <input type="checkbox"/> Absent    <input type="checkbox"/> Present  <input type="checkbox"/> Normal    <input type="checkbox"/> Increased    <input type="checkbox"/> Decreased</p> <p><b>Diet:</b>    <input type="checkbox"/> NBM    <input type="checkbox"/> CF    <input type="checkbox"/> FF    <input type="checkbox"/> Diet    <input type="checkbox"/> Diabetic    <input type="checkbox"/> Cardiac    <input type="checkbox"/> Tube feeds  <input type="checkbox"/> Special Consistency: _____    <input type="checkbox"/> Other*</p> <p><b>Feeding Tube:</b>    Type: _____    Insitu to: _____ ( L/R nare, mouth etc.)  <input type="checkbox"/> Gastric    <input type="checkbox"/> Duodenal    <input type="checkbox"/> Jejunal  <b>Insertion site:</b>    <input type="checkbox"/> Intact    <input type="checkbox"/> Other*    <input type="checkbox"/> Placement verified by: _____  <input type="checkbox"/> Administering Feeds    <input type="checkbox"/> Clamped    <input type="checkbox"/> Aspirated q4h    <input type="checkbox"/> Straight drainage  Description of aspirate: _____  *Other (description) _____</p> <p><b>Stool:</b>    Last BM: ____/____/____    <input type="checkbox"/> Prior to admission  Stool colour: _____    Stool characteristic: _____</p> <p><b>Ostomy:</b>    <input type="checkbox"/> Type: _____    Appearance of Stoma: _____</p> <p><b>Abdominal Drain:</b>    <input type="checkbox"/> Type: _____    Location: _____  Drainage (describe): _____</p> <div style="text-align: right;"> <p>+++ Incision  X Drain  /// Bruising  &gt; Stab Site  O Ostomy</p>  </div>																
Genitourinary	<p><input type="checkbox"/> See Critical Care Flow Chart for Urine Output, Fluid Balance, &amp; CRRT Monitoring</p> <p><b>Catheter:</b>    <input type="checkbox"/> Type: _____    Size: _____    Urine (description) _____</p> <p><b>Urethral/vaginal discharge:</b>    <input type="checkbox"/> Describe: _____    <input type="checkbox"/> Menstruating</p>																
Vascular Access	<p><input type="checkbox"/> See Critical Care Flow Chart for Drugs, Infusions, Concentrations, &amp; Rates</p> <table border="0" style="width:100%;"> <tr> <td style="width:50%; vertical-align:top;"> <p><input type="checkbox"/> <b>CVC:</b>  # Lumens _____    Location: _____  <b>Lumen's:</b>    <input type="checkbox"/> Patent    <input type="checkbox"/> Heparin lock    <input type="checkbox"/> Other*  <b>Flush Bag:</b>    <input type="checkbox"/> Normal saline  <input type="checkbox"/> Pressurised and adequate fluid  <input type="checkbox"/> Flushed and line transduced</p> <p><b>Site:</b>    <input type="checkbox"/> No redness/swelling    <input type="checkbox"/> Other*  <b>Dressing:</b>    <input type="checkbox"/> D&amp;I *(describe) _____</p> <p><input type="checkbox"/> <b>PIV #1:</b>  Location: _____  <b>Site:</b>    <input type="checkbox"/> No redness/swelling    <input type="checkbox"/> Other*  <b>Dressing:</b>    <input type="checkbox"/> D&amp;I  *(describe) _____</p> </td> <td style="width:50%; vertical-align:top;"> <p><input type="checkbox"/> <b>Arterial Line/ PICCO:</b>  Location: _____</p> <p><b>Flush Bag:</b>    <input type="checkbox"/> Normal saline  <input type="checkbox"/> Pressurised and adequate fluid  <input type="checkbox"/> Flushed and line transduced</p> <p><b>Site:</b>    <input type="checkbox"/> No redness/swelling    <input type="checkbox"/> Other*  <b>Dressing:</b>    <input type="checkbox"/> D&amp;I *(describe) _____</p> <p><input type="checkbox"/> <b>Other line</b>  Type: _____    Location: _____  <b>Site:</b>    <input type="checkbox"/> No redness/swelling    <input type="checkbox"/> Other*  <b>Dressing:</b>    <input type="checkbox"/> D&amp;I  *(describe) _____</p> </td> </tr> </table>	<p><input type="checkbox"/> <b>CVC:</b>  # Lumens _____    Location: _____  <b>Lumen's:</b>    <input type="checkbox"/> Patent    <input type="checkbox"/> Heparin lock    <input type="checkbox"/> Other*  <b>Flush Bag:</b>    <input type="checkbox"/> Normal saline  <input type="checkbox"/> Pressurised and adequate fluid  <input type="checkbox"/> Flushed and line transduced</p> <p><b>Site:</b>    <input type="checkbox"/> No redness/swelling    <input type="checkbox"/> Other*  <b>Dressing:</b>    <input type="checkbox"/> D&amp;I *(describe) _____</p> <p><input type="checkbox"/> <b>PIV #1:</b>  Location: _____  <b>Site:</b>    <input type="checkbox"/> No redness/swelling    <input type="checkbox"/> Other*  <b>Dressing:</b>    <input type="checkbox"/> D&amp;I  *(describe) _____</p>	<p><input type="checkbox"/> <b>Arterial Line/ PICCO:</b>  Location: _____</p> <p><b>Flush Bag:</b>    <input type="checkbox"/> Normal saline  <input type="checkbox"/> Pressurised and adequate fluid  <input type="checkbox"/> Flushed and line transduced</p> <p><b>Site:</b>    <input type="checkbox"/> No redness/swelling    <input type="checkbox"/> Other*  <b>Dressing:</b>    <input type="checkbox"/> D&amp;I *(describe) _____</p> <p><input type="checkbox"/> <b>Other line</b>  Type: _____    Location: _____  <b>Site:</b>    <input type="checkbox"/> No redness/swelling    <input type="checkbox"/> Other*  <b>Dressing:</b>    <input type="checkbox"/> D&amp;I  *(describe) _____</p>														
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