MARVIX AI

NURSING NOTES

CLINICAL NURSING DOCUMENTATION

Questions? Visit us at
www.marvix.ai

1 Patient Information

1 PATIENT DETAILS

Name: ____________ Date / Time: ____________

DOB / Age: ____________ Unit / Room: ____________

MRN: ____________ Nurse: ____________

S Subjective

2 CHIEF CONCERN

Primary reason for nursing assessment — presenting complaint in patient words or as reported...

3 PATIENT-REPORTED SYMPTOMS

Describe symptoms as reported — onset, location, quality, duration, and associated symptoms...

Pain level (0-10 scale): ____________

Additional concerns or complaints expressed by patient or family...

O Objective

4 VITAL SIGNS

BP: ____________ Temperature: ____________

HR: ____________ O2 Saturation: ____________

RR: ____________ Weight / BMI: ____________

5 PHYSICAL OBSERVATIONS

Skin color, turgor, edema, wound appearance, LOC, gait, respiratory effort, behavior...

6 INTAKE & OUTPUT

Oral intake: ____________ Urine output: ____________

IV fluids: ____________ Other output: ____________

Other intake: ____________ Net balance: ____________

A Assessment

7 NURSING ASSESSMENT

Nursing interpretation of patient status — clinical impression, changes from baseline, response patterns, and identified concerns...

8 CHANGES FROM BASELINE

Any deterioration, improvement, or new findings compared to previous nursing assessment or admission baseline...

I Interventions

9a MEDICATIONS ADMINISTERED

Medications given — name, dose, route, time, indication. Note any PRN medications and clinical rationale...

9b PROCEDURES PERFORMED

Wound dressing, catheter care, IV insertion, specimen collection, suctioning, repositioning, or other nursing procedures...

9c PATIENT POSITIONING & CARE

Repositioning frequency, fall prevention, skin care, oral hygiene, ambulation assistance, comfort measures provided...

R Response to Care

10a PATIENT TOLERANCE

How the patient tolerated interventions — adverse reactions, complaints, refusals, or need for modification...

10b SYMPTOM RESPONSE

Whether symptoms improved, declined, or remained unchanged following nursing interventions...

P Plan

11a ONGOING MONITORING

Monitoring parameters, frequency of reassessment, vital sign check intervals, and clinical triggers for escalation...

11b ESCALATION CRITERIA

Conditions under which the nurse will contact the provider — specific values, symptom changes, or patient deterioration thresholds...