1 Patient Information

1 PATIENT DETAILS

Name: ______________________ Date of Assessment: ______________________

DOB: ______________________ Time of Assessment: ______________________

Age / Sex: ______________________ MRN: ______________________

Unit / Room: ______________________ Nurse / Provider: ______________________

Reason for Assessment: ______________________

GA General Appearance

2 OVERALL CONDITION

Document overall condition — level of consciousness, apparent distress, hygiene, posture, cooperation, communication ability, and whether patient appears acutely ill, stable, uncomfortable, or in no acute distress...

N Neurological

3 NEURO STATUS

Alertness, orientation, speech, responsiveness, pupils if assessed, motor strength, sensation, focal deficits, seizure activity, confusion, dizziness, headache, or changes from baseline...

H HEENT

4 HEAD / EYES / EARS / NOSE / THROAT

Head trauma or tenderness, visual complaints, pupil response if assessed, hearing concerns, oral mucosa, dentition, swallowing ability, nasal drainage, throat discomfort, or other abnormalities...

CV Cardiovascular

5 CV STATUS

Heart rate and rhythm, peripheral pulses, capillary refill, skin perfusion, edema, chest pain, palpitations, cardiac devices, telemetry status, or abnormal heart sounds if assessed...

R Respiratory

6 RESPIRATORY STATUS

Respiratory rate and effort, oxygen delivery method, O2 saturation, breath sounds, cough, sputum, shortness of breath, accessory muscle use, wheezing, crackles, diminished sounds, or respiratory distress...

GI Gastrointestinal

7 GI STATUS

Abdominal appearance, bowel sounds, tenderness, nausea, vomiting, appetite, diet tolerance, bowel movement pattern, ostomy status if applicable, distention, or abdominal pain...

GU Genitourinary

8 GU STATUS

Voiding pattern, urine output, continence, dysuria, catheter presence and condition, urine appearance, bladder distention, or dialysis access/status if relevant...

MS Musculoskeletal / Mobility

9 MOBILITY & FUNCTION

Range of motion, strength, gait, transfers, assistive devices, fall risk, activity tolerance, weight-bearing status, and need for assistance with ambulation or repositioning...

SK Skin / Wounds

10 SKIN INTEGRITY

Skin integrity, color, temperature, moisture, bruising, rashes, pressure injury risk, wounds, surgical incisions, dressings, drains, lines, tubes, and signs of infection or breakdown...

PA Pain Assessment

11 PAIN

Location:	________	Severity (0–10):	________
Quality:	________	Duration:	________
Aggravating Factors:	________	Relieving Factors:	________
Interventions Provided:	________	Patient Response:	________

LT Lines / Drains / Tubes

12 INVASIVE DEVICES

All invasive devices — IV lines, central lines, Foley, drains, feeding tubes, tracheostomy, chest tubes, wound vacs, or other devices. Site condition, patency, output, dressing status, complications...

SF Safety / Risk Assessment

13 SAFETY MEASURES

Fall Risk Level:	________	Aspiration Precautions:	________
Seizure Precautions:	________	Skin Breakdown Risk:	________
Restraint Use:	________	Infection Precautions:	________

Mobility Restrictions: ____________________ Other Safety Measures: ____________________

AS Assessment Summary

14 CLINICAL SUMMARY

Concise narrative summary of current status, clinically significant abnormalities, changes from baseline, and priority nursing concerns...

P Plan

15 NURSING INTERVENTIONS & MONITORING PLAN

Medication administration, vital sign frequency, repositioning, wound care, intake/output monitoring, safety precautions, escalation criteria, and provider notification if indicated...

F Follow-Up / Reassessment

16 REASSESSMENT PLAN

Reassessment timeframe and parameters: ____________________

Response to interventions, changes in condition, pain control, respiratory status, neurological status, wound status, or safety concerns...

NURSE / PROVIDER NAME	CREDENTIALS	DATE	TIME