

**Weekly report**

**(To be submitted every other week)**

**Student Name:** \_\_\_\_\_ **area** \_\_\_\_\_ **Room/bed No.** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **WEEK#** \_\_\_\_\_



	Marks	Student Marks
1. Physical assessment sheet	2	
2. Laboratory and Diagnostic Tests	1	
3. Nursing care plan	4	
4. Medication	3	
<b>TOTAL</b>	<b>10</b>	



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Physical assessment

RM #	Area critical \ ER ---- bed# ----- sex: M\F Age:	Admission day :	Unit : Triage level in ER dep. :		Wt : Height: BMI:			
DX:		ISOLATION:		Allergies:				
Lines : art lines PA caths IV Site: PICC: CVC: note: location, the condition of them, and when the dressings were last changed <b>Orders to flush central/hep</b>		CVP:  PA pressure :	V/S	0800	0900	1000	1100	1200
			T					
			HR					
			BP					
			SPO2					
			FSBS					
NEURO: Mental : Speech: PUPILS: R ____ L ____		Cardio: Heart sound:  Tele (ECG) :  Edema -----  Location of edema :		O2      RA ..... NC .....L Lung Sounds Cough TRACH suction Ventilation      mood                      setting				



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GCS ----\-----		Peripheral pulse: ( Strength/regularity) UR                      LR  UL                      LL		Chest tube:  ABG :  PH :              HCO3 :              PCO2:  Interpretation :-----	
GI Diet: PO. NPO NPO w/Meds NGT Fluid Restrictions Last BM:	GU Urine color Intake: Output:-- ml\kg\hr Balance: FOLEY <input type="checkbox"/> 24/HR <input type="checkbox"/> Strict I/O 's  DIALYSIS	Skin  Color  Condition  Wound  Dressing Drain                      output.....			
M/S → (Strong , week , par thesis , paralysis ) RU      RL      LU      LL  Brace    Cane    Walker    Wheelchair		ACITVITY PT		PAIN (PQRSTU)	



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ECG strip                      HR: ----- PR interval ----- QSR duration-----

Interpretation -----



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\_\_\_\_\_ Area \_\_\_\_\_ Date Submitted \_\_\_\_\_

Laboratory and Diagnostic studies

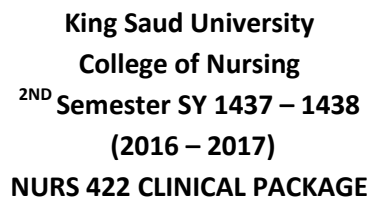
I – Laboratory Test	Normal Value	Result	Significance
II – Diagnostic Test	DATE	FINDING	



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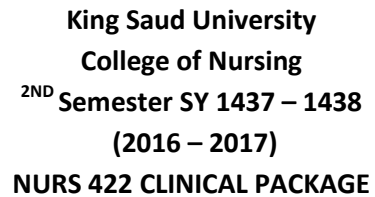
**List of actual nursing diagnosis :**

- 1-
- 2-
- 3-
- 4-
- 5-



**Patent Name:** \_\_\_\_\_ **Room/Bed NO:** \_\_\_\_\_ **Diagnosis:** \_\_\_\_\_

*NUR 422 Medical-Surgical Dept.*



**Patent Name:** \_\_\_\_\_ **Room/Bed NO:** \_\_\_\_\_ **Diagnosis:** \_\_\_\_\_

*NUR 422 Medical-Surgical Dept.*



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### Nursing Care Plan 3

Patent Name: \_\_\_\_\_ Room/Bed NO: \_\_\_\_\_ Diagnosis

List of patient medication:

- 1-
- 2-
- 3-
- 4-
- 5-
- 6-
- 7-



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Medication sheet 1

Patent Name &ID: ..... Room/bed NO: ..... Diagnosis: .....

Name of Drug Dose Route Frequency	Classification / Action of the Drug	Indication	Side effects Observed in the client	Nursing role	Evaluation



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Medication sheet 2

Patent Name &ID: ..... Room/bed NO: ..... Diagnosis: .....

Name of Drug Dose Route Frequency	Classification / Action of the Drug	Indication	Side effects Observed in the client	Nursing role	Evaluation

Medication sheet 3



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Patent Name &ID: ..... Room/bed NO: ..... Diagnosis: .....

Name of Drug Dose Route Frequency	Classification / Action of the Drug	Indication	Side effects Observed in the client	Nursing role	Evaluation