

Head To Toe Assessment C

Wash Hands

() Completed - Standard Precautions

Introduction

() Completed - Introduce self & purpose of assessment to relieve anxiety and role function identification.

Vital Signs

Pulse _____ Rate, Strength, Regularity

Temperature _____ Oral, Rectal, Tympanic

B / P _____ Respiration _____

Orientation

(Oriented x 4)

What year is this ? _____

Tell me your name ? _____

Tell me where you are ? _____

Tell me why you are here? _____

Pupil Check

(PERRLA) Pupils, Equal, Round, React to light, Accommodate

Sluggish () No Change () Brisk () Normal ()

Accommodation Yes () No ()

Neck Veins

Patient at 45o angle ()

Neck Veins Flat () Distended ()

Heart Tones

Apical Pulse with Stethoscope

Rate ? _____ Rhythm ? _____

Clarity of Sounds ? _____ Abnormal? ()

Explain ! _____

Bilateral Checks

(Radial Pulses) - Rate, Strength, Regularity

Right _____ Left _____

(Hand Strength) - 2 fingers only

Right Stronger () Left Stronger () Equal ()

(Pedal Pulses) - Top of Foot

Right Foot _____ Left Foot _____

(Capillary Refill) -On fingers or toes 3 seconds or less

Right Fingers () sec. Left Fingers () sec.

Right Toes () sec. Left Toes () sec. Delay or abnormal refill return ? Yes () ie., _____

Skin

Skin Turgor - 1 to 3 second return, on Sternum

Return was () sec. Abnormal () sec.

Skin Color - Check on inside of Lip or

Conjunctiva

Lip () Conjunctiva ()

Pink () Pale () Jaundice () Cyanotic ()

Skin Temperature - Use back of hand to check

Hot () Warm () Cool ()

Breath Sounds

Assess anterior and posterior and :
take deep breaths, do not move sta
patients part.

Clear Bilaterally () Left only () Rig

Both poor bilaterally () ie., _____

Good air flow () Poor air flow ()

Bowel Sounds

Assess all 4 quadrants, do not touc
disrupt normal sounds. If irregular,
Umbilicus is
midpoint.

(Stomach) - Check for condition

Soft () Hard () Distended () Other

RUQ Active () Absent () Hyperact

RLQ Active () Absent () Hyperacti

LUQ Active () Absent () Hyperacti

LLQ Active () Absent () Hyperactr

Peripheral Edema

Edema is found in dependent area
finger by pressing down. Observe t

Feet Yes () No () Pitting () R () L

Hands Yes () No () Pitting () R ()

Sacrum Yes () No () Pitting () Ind

Assessing For Pain

Where is the pain ? _____

How long has it lasted ? _____

Does the pain travel anywhere ? _____

What makes it feel better ? _____

What makes pain worse ? _____

Descrip. of pain ? Sharp () Stabbin

On a scale of 1 - 10, 10 being the v

Skin Breakdown Check

Check entire body for redness or s

Normal () Abnormal () Explain cor

affected. _____

Homan's Sign

Ask patient to dorsiflex both feet.

Pain in right calf Yes () No ()

Pain in both calves Yes () No ()

Closure

Let the patient know you are finish

Bedrails up () Bed in low position ()

SAMPLE CHARTING ENTRY

Sample Nursing Documentation Head Toe Assessment

Michal Rosen-Zvi



Sample Nursing Documentation Head Toe Assessment:

The book delves into Sample Nursing Documentation Head Toe Assessment. Sample Nursing Documentation Head Toe Assessment is a crucial topic that must be grasped by everyone, from students and scholars to the general public. The book will furnish comprehensive and in-depth insights into Sample Nursing Documentation Head Toe Assessment, encompassing both the fundamentals and more intricate discussions.

1. The book is structured into several chapters, namely:
 - Chapter 1: Introduction to Sample Nursing Documentation Head Toe Assessment
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 - Chapter 3: Sample Nursing Documentation Head Toe Assessment in Everyday Life
 - Chapter 4: Sample Nursing Documentation Head Toe Assessment in Specific Contexts
 - Chapter 5: Conclusion
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- This book is crafted in an easy-to-understand language and is complemented by engaging illustrations. This book is highly recommended for anyone seeking to gain a comprehensive understanding of Sample Nursing Documentation Head Toe Assessment.

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