# **NURSING REPORT SHEET**

Date:		
Preceptor:		
Student Name:		

Rm#	Name:		Rm#	Name:	
Age:		Age:			
Allergies:		Allergies:			
Doctor/Consults:		Doctor/Consults:			
Admitting date and diagnosis, events leading to hospitalization, what has happened since hospitalization		Admitting date and diagnosis, events leading to hospitalization, what has happened since hospitalization			
Past Medical History:		Past Medical History:			
Diet:	Accu: AC &HS Other:	I/O:	Diet:	Accu: AC &HS Other:	I/O;
Activity:	Code Status:	vs:	Activity:	Code Status:	vs:
Resp Tx:	Monitor:	wt	Resp Tx:	Monitor:	Wt:
IVs (solution, site, tbg, drsg, caps):		IVs (solution, site, tbg. drsg. caps):			
Wound/Tube Care: NG Foley CT JP Penrose Trach		Wound/Tube Care: NG Foley CT JP Penrose Trach			
Meds:		Meds:			
Report: Labs/Diagnostics/Procedures to be done this shift		Report: Labs/Diagnostics/Procedures to be done this shift			

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