

PATIENT PROFILE DATABASE

Date: 8/27/18Student Name: Nshan NshanyanFaculty Name: Angelina, Thallorir*Angelina*
8/27/18

1. ADMISSION INFORMATION

Date of Care: <u>8/27</u>	Pt. Name: <u>KM</u>	Admission Date:	Age:	Gender: <u>F</u>	Growth and Development (Erikson):	Ethnicity: <u>Caucasian</u>	Occupation:	Spiritual Beliefs:
Reason for Hospitalization/Chief Complaint (in pt's own words): <u>Pneumonia, fever.</u>		Surgical Procedures/Date: <u>Bone marrow, transplant.</u>		Medical Diagnoses History: (Present and past diagnoses, Physician's History and Physical notes in the chart, nursing intake assessment, with length of history if possible) <u>Pneumonia, Sepsis, Fever, HTN, DM2 altered mental status, accidental fall, Resp. failure w/ hypoxia</u>				
Admitting Medical Diagnosis: <u>Pneumonia</u>		History of Present Illness: <u>Pneumonia, streptococcus infection, acute renal failure</u>						

ADVANCE DIRECTIVES (Nursing Admission Assessment):

Living Will: ☒ Yes ☐ No	Durable Power of Attorney: ☐ Yes ☒ No	Code status: ☒ Full Code ☐ DNR (Do Not Resuscitate)
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2. MEDICATIONS

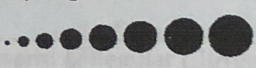
ALLERGIES:

Drug	Classification	Dosage	Route	Frequency (time due)	Purpose	Nursing Considerations
Dextrose 5% water IV		250mls/hr	IV	once	Hydration	Remove IV BAG when Done
ASPIRIN	Blood thinner	81mg	PO	Daily	Blood thins	Monitor for hypotension
Lovenox	anticoagulant	30mg	SC	Daily 0600	Prevents clot	
Zetia	Ezetimibe	10 mg	PO	Daily	lowers cholesterol	Watch for dizziness
Humalog	Insulin	scale 3	SC	0745, 1145, 1645, 2100	Treats Diabetes	
Synthroid, Levothyroid	Levothyroxine	.075mg	PO	Daily	Treats hypothyroidism	
Protonix	Pantoprazole	40mg	PO	Daily 0630	Treats GERD	
Prednisone	Prednisone	30mg	PO	Daily	Decreases inflammation	
Rapamune	Sirolimus	1mg	PO	Daily	prevents organ rejection	
Vancomycin	Antibiotics	leach	IV		treats infections	

3. LABORATORY DATA

Test	Norms	On admission	Current value	Test	Norms	On admission	Current value
WBC	5.2-12.4		14.47	Sodium	132-146		147
Hemoglobin	12-18		12.4	Potassium	3.5-5.5		4.3
Hematocrit	37-47		41.3	Calcium	8.5-10		8.0
Platelets	130-400		277	BUN	9-23		30.4
PT	8.0-11.7		13.0	Creatinine	0.5-1.1		1.58
INR			1.12	Magnesium	1.5-2.5		86
aPTT	23.3-31.0		23	Blood Glucose			
HA1c				Urinalysis			

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BNP				Cultures blood/sputum						
DIAGNOSTIC TESTS										
Chest X-ray: 8/26/18 aorta calcified Diffuse Bilateral interstitial infiltrate.				Abnormal studies: HEADCT: Marked atrophy 8/26/18						
Abnormal studies:		Abnormal studies:		Abnormal studies: Extensive white matter,						
4. PHYSIOLOGICAL DATA-VITAL SIGNS										
Vital Signs: Temp 102.2 (F) °C ☐ Axillary ☐ Tympanic ☒ Oral ☐ Core ☐ Rectal				Admission weight: 105 lb						
Pulse 76 ☐ Apical ☐ Radial				Yesterday's weight						
Respiratory Rate ☐ Even/regular ☐ Labored/SOB ☐ Dyspnea				Today's weight 105 lb						
on Exertion BP 137 / 92 ☒ Supine ☐ Sitting ☐ Standing				Height						
5. NEUROLOGICAL/SENSORY										
Orientation: ☐ Time ☐ Place ☐ Person ☐ Purpose				Sensation: ☒ Normal ☐ Impaired ☐ Absent						
Pain: Grade 0 /10 Scale used: ☐ 0-10 Numeric ☐ FLACC ☐ Wong-Baker				What makes the pain worse:						
FACES										
Pain Location: NA				What makes the pain better:						
Character: ☐ Sharp ☐ Dull ☐ Ache ☐ Heavy ☐ Pinprick ☐ Cramp ☐ Other										
Level of Consciousness: ☒ Alert ☐ Lethargic ☐ Obtunded ☐ Stuporous ☐ Semicomatose ☐ Coma										
Coordination: ☒ Symmetrical ☐ Asymmetrical ☐ Unsteady				PERRLA: # 7 mm ☐ Brisk ☐ Sluggish ☐ Fixed ☐ Nystagmus  1 2 3 4 5 6 7 8mm						
Strength: 4 Right arm 4 Left arm 4 Right leg 4 Left leg 0=No movement 1=Trace movement 2=Moving, not against gravity 3=Moving against gravity, not against resistance 4=Moving against gravity, some resistance 5=Full power				Glascow Coma Scale: Total of all 3 columns <table border="1"> <tr> <td> Eyes 4=Open spontaneously 3=To speech 2=To pain 1=None Total 4 </td> <td> Motor 6=Obeys command 5=Localizes pain 4=Withdraws 3=Flexion 2=Extension 1=None Total 6 </td> <td> Verbal 5=Oriented 4=Confused 3=Inappropriate words 2=Incomprehensible words 1=None Total 5 </td> </tr> </table>				Eyes 4=Open spontaneously 3=To speech 2=To pain 1=None Total 4	Motor 6=Obeys command 5=Localizes pain 4=Withdraws 3=Flexion 2=Extension 1=None Total 6	Verbal 5=Oriented 4=Confused 3=Inappropriate words 2=Incomprehensible words 1=None Total 5
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Touch: ☒ Normal ☐ Decreased	Smell: ☒ Normal ☐ Decreased	Hearing: ☒ Normal ☐ Tinnitus ☐ HOH ☐ Hearing Aid ☐ Deaf
Vision: ☒ Normal ☐ Glasses ☐ Contacts ☐ Cataracts ☐ Glaucoma ☐ Blurred vision ☐ Diplopia		
Neurosensory comments:		
Nursing Diagnosis:		
6. CIRCULATORY/CARDIOVASCULAR		
Color: ☐ Pink ☒ Pale ☐ Jaundice ☐ Flushed ☐ Cyanotic ☐ Mottled ☐ Dusky	Capillary refill: ☒ <3 seconds ☐ >3 seconds	
Skin: ☒ Dry ☐ Moist ☐ Clammy ☐ Warm ☐ Cold ☐ Hot	Tele monitored rhythm:	
Peripheral Edema: ☒ None ☐ +1 ☐ +2 ☐ +3 ☐ +4 ☐ Pitting ☐ Non-pitting	Heart Sounds: ☒ S1 ☒ S2 Rhythm: ☒ Regular ☐ Irregular	
Location:	Implanted Pacemaker: ☐ Yes ☐ No	
Peripheral pulses:		
Right radial ☒ Present ☐ Absent	Left radial ☒ Present ☐ Absent	Right pedal ☒ Present ☐ Absent Left Pedal ☒ Present ☐ Absent
Circulatory Comments:		
Nursing Diagnosis:		
7. RESPIRATORY/PULMONARY		
Breath Sounds: ☒ Clear ☐ Diminished ☐ Absent ☐ Crackles ☐ Wheezes	Pattern: ☒ Regular ☐ Irregular	
Location: ☐ Throughout ☒ RUL ☒ RML ☒ RLL ☒ LUL ☒ LLL	Character: ☐ Full ☐ Shallow ☐ Deep ☐ Labored ☐ SOB	
Sputum: ☒ White/Clear ☐ Tan ☐ Yellow ☐ Green ☐ Rusty ☐ Pink ☐ Red	Amount: ☐ Small ☐ Moderate ☐ Large	
Cough: ☐ None ☐ Nonproductive ☒ Productive ☐ Suctioning required	Pulse Oximeter: 97 %	
Secretions: ☐ Yes ☒ No Consistency: ☐ Frothy ☐ Thick ☐ Thin	Oxygen: ☐ Room air O ₂ 4 L/min. or O ₂ %	
Suctioning Method: ☐ Oral ☐ Nasotracheal ☐ ETT ☐ Trach ☐ Bulb	Mode: ☒ N/C ☐ Mask ☐ Trach	
Respiratory Comments: Lungs sounded clear during auscultation	ABGs: pH pO ₂ pCO ₂ HCO ₃	
Nursing Diagnosis:		
8. NUTRITION/HYDRATION		
Diet: ☐ NPO ☒ Regular ☐ Cl. Liquid ☐ Full liquid ☐ Soft ☐ Pureed ☐ Other	Aspiration Risk: ☒ Yes ☐ No	
Feeding Method: ☒ Self ☐ Assisted ☐ NG ☐ G-Tube ☐ J-Tube	Nausea: ☐ Yes ☒ No	
Parenteral Nutrition: ☐ TPN ☐ PPN	Vomiting: ☐ Yes ☒ No	
Tube Feeding Formula: Rate:	Flatus: ☐ Yes ☒ No	

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mL/hr.			
Residual: ☐ No ☐ Yes Amt. _____ mL			
Weight: ☐ Gain _____ # lbs./kg ☐ Loss _____ # lbs./kg ☐ No change		Mucous Membranes: ☐ Dry ☐ Moist Skin Turgor: ☐ No problem ☐ Tenting ☐ Taut	
Intake: PO <u>600</u> IV <u>100 mL</u> NG _____ Blood _____ Other _____ 24 hour total _____	Output: Urine <u>voided 2 times</u> NG _____ Emesis _____ Stool <u>NO BM</u> Drains _____ Other _____ 24 hour total _____	24 hour net I/O: +/- _____	
Nutrition/Hydration comments:			
Nursing Diagnosis:			
9. GI/FECAL ELIMINATION			
Bowel Sounds: ☐ Absent ☐ Hypoactive ☒ Active ☐ Hyperactive		Location: ☐ RUQ ☐ RLQ ☐ LUQ ☐ LLQ ☐ Throughout	
Abdomen: ☒ Soft ☐ Flat ☐ Distended ☐ Round ☐ Firm ☐ Tender ☐ Flatus		Ostomy: ☒ No ☐ Yes Type: _____	Incontinence: ☐ Yes ☐ No
Last BM: _____ Stool: ☐ Formed ☒ Soft ☐ Hard ☐ Liquid # _____		Color: ☒ Brown ☐ Black/Tarry ☐ Clay/Gray ☐ Yellow ☐ Green	
Fecal Elimination Comments:			
Nursing Diagnosis:			
10. GU/URINARY ELIMINATION			
Urine: ☒ Clear ☐ Cloudy ☐ Sediment		Color: ☐ Straw ☒ Yellow ☐ Amber ☐ Pink ☐ Red	
Last void: time _____ amount <u>600</u> mL		Catheter: ☐ None ☐ In/Out ☐ Condom ☐ Foley ☐ Suprapubic Insertion date: _____	
Symptoms: Frequency: ☐ Urgency: ☐ Dysuria: ☐ Nocturia: ☐ Incontinence: ☐ Yes ☒ No			
Urinary Elimination Comments:			
Nursing Diagnosis:			
11. REST AND EXERCISE			
Activity: ☐ Bed rest ☐ BSC ☐ BRP ☐ Chair ☒ Ambulate		Mobility Aids: ☒ Cane ☐ W/C ☐ Crutches ☐ Walker	
Functional level: ☐ Independent ☒ Dependent ☐ Assistance		Gait: ☐ Steady ☒ Unsteady ☐ Unable to ambulate	

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ROM: ☐ Active ☐ Passive ☐ Assistive ☐ Limited ☐ Full		Sleep Patterns: ☒ Uninterrupted ☐ Interrupted ☐ Insomnia ☐ Day time sleepiness # hrs sleep/night _____		
Cast/Brace/Traction: Type _____ Location _____		Restraints: Type _____ Location _____		
Rest and Exercise Comments:				
Nursing Diagnosis:				
MORSE FALL SCALE/RISK SCREENING				
Variables		Score	To obtain the Morse Fall Score add the score from each category. Morse Fall Score ☐ High Risk 45 and higher ☐ Moderate Risk 25-44 ☐ Low Risk 0-24	
History of Falls within last 12 months	☐ No ☒ Yes	☐ 0 ☒ 25		
Secondary Diagnosis	☐ No ☒ Yes	☐ 0 ☒ 15		
Ambulatory Aids	☐ None/bedrest/nurse assist ☒ Crutches/cane/walker ✓ ☒ Furniture ✓	☐ 0 ☒ 15 ☒ 30		
IV or IV access	☐ No ☒ Yes	☐ 0 ☒ 20		
Gait	☐ Normal/bedrest/wheelchair ☒ Weak ✓ ☐ Impaired	☐ 0 ☒ 10 ☐ 20		
Mental Status	☐ Know own limits ☐ Overestimates or forgets limits	☐ 0 ☐ 15		
Total		115		
Rest and Exercise Comments: High Risk for fall. Patient's goal is to walk w/o assistance.				
Nursing Diagnosis:				
12. SKIN INTEGRITY/INTEGUMENTARY				

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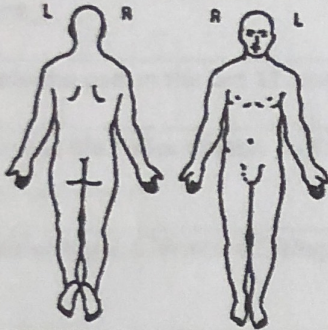
Skin Condition: ☒ Intact ☐ Skin tear ☐ Bruise ☐ Rash ☐ Burn ☐ Wound/Ulcer (complete documentation)
 Location _____ Stage _____

☐ Incision ☐ Other _____

Location#1 _____ Type of condition _____ ☐ Drainage _____ ☐ Odor _____

Location#2 _____ Type of condition _____ ☐ Drainage _____ ☐ Odor _____

Location#3 _____ Type of condition _____ ☐ Drainage _____ ☐ Odor _____



Indicate location or Intact:

S Surgical site
 B Burn
 E Ecchymosis
 F Fracture/Cast
 Pe Petechiae
 P Pressure ulcer & stage _____
 O Other _____
 M Edema
 R Rash
 D Dressing
 N Inflammation
 G Gangrene/Necrosis
 I IV Site
 Patent
 Swollen
 Red
 Infiltrated
 A Drains
 None
 Penrose
 Hemovac
 JP

Braden Scale					Score
Sensory	1. Completely limited	2. Very limited	3. Slightly limited	4. No Impairment	3
Moisture	1. Constantly moist	2. Very moist	3. Occasionally moist	4. Rarely moist	4
Activity	1. Bedfast	2. Chairfast	3. Walks occasionally	4. Walks frequently	2
Mobility	1. Completely immobile	2. Very limited	3. Slightly limited	4. No limitations	3
Nutrition	1. Very poor	2. Probably inadequate	3. Adequate	4. Excellent	3
Friction and Shear	1. Problem	2. Potential problem	3. No apparent problem	Score of 18 or less = at risk	18

IV sites: ☒ Patent ☐ Swollen ☐ Red ☐ Infiltrated Location: _____ Gauge Needle: _____ Start date: _____

Skin Comments:

Nursing Diagnosis:

13. HORMONE REGULATION/REPRODUCTION/ENDOCRINE

Thyroid Disease: ☐ Yes ☒ No Estrogen Use: ☐ Yes ☒ No Testosterone use: ☐ Yes ☒ No Steroid use: ☒ Yes ☐ No

Diabetes: ☒ Yes ☐ No ☒ Type I ☐ Type II Number of year with diabetes: _____

14. PSYCHOSOCIAL VARIABLES

Mood/Affect: ☒ Cooperative ☒ Cheerful ☐ Angry ☐ Anxious ☐ Crying ☐ Withdrawn ☐ Flat Affect ☐ Depressed ☐ Fearful ☐ Combative

Level of education: ☐ None ☐ Elementary ☐ High School ☐ College ☐ Post Graduate

Understands directions: ☒ Yes ☐ No

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Decision-making: ☐ None ☐ Concrete ☒ Abstract ☐ Impaired		Judgment: ☒ Appropriate ☐ Inappropriate ☐ Dementia	
History/Evidence of: ☐ Physical Abuse ☐ Neglect ☐ Sexual Abuse ☐ Thoughts of suicide or self-harm ☐ Depression ☐ Psychiatric history			
Recreational drug use: ☐ Drug _____ How much _____ How long _____		Alcohol use: ☐ How often _____ How much _____	
Tobacco use: In the last 12 months ☐ Yes ☐ No How often _____ How much _____			
Recent life stress or loss: ☐ Yes ☐ No _____		Coping methods with current illness/hospitalization: ☐ Good ☐ Fair ☐ Poor	
Body Image: ☐ Positive ☐ Negative ☐ Changing		Sexuality: ☐ Heterosexual ☐ Bisexual ☐ Homosexual ☐ Transgender ☐ Transsexual	
Ability to write English: ☐ Yes ☐ No		Ability to read English: ☐ Yes ☐ No	
Language Barrier: ☐ None ☐ ESL ☐ Speech Impediment ☐ Intubated ☐ Trached		Support System: ☐ Yes ☐ No Living Situation: _____	
Psychosocial Comments:			
Nursing Diagnosis: Ineffective airway clearance related to pneumonia as evidence by O ₂ 80%.			
Narrative Charting: Ineffective air Patient was feeling tired the whole day. She looked very restless, although talking to her helped change her mood. When her daughter left home she went to sleep and continued sleeping. Overall,			

she was breathing normal on 4Liters. GI was normal, BM none today but voided twice. Auscultated her heart, listened to S1 and S2 and it sounded normal. Alert/Oriented x 2.