

**CONSULTATIONS REQUESTED:**  
 Anesthesia    Social Worker    CNS/Psych Liaison    Wound Care  
 Pastoral Care    IV Therapy    Dietitian    Enteral

In this section indicates an order is needed from M.D.  
 In this section indicates department notified

Swallowing Assess.    R.T.  
 PT    OT    Speech

**PATIENT PROBLEM STATEMENT**

|  |  |  |
|--|--|--|
| <p>1. Impaired Gas Exchange Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>        | <p>7. Altered Level of Consciousness Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p> | <p>13. Impaired Skin Integrity Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>     |
| <p>2. Alteration in Cardiac Output Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p> | <p>8. Alteration in Comfort Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>          | <p>14. Alteration in GI Function Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>   |
| <p>3. Impaired Tissue Perfusion Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>    | <p>9. Anxiety Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>                        | <p>15. Altered Urinary Elimination Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p> |
| <p>4. Altered Fluid Vol: Excess Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>    | <p>10. Grieving Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>                      | <p>16. Alteration in Nutrition<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>                 |
| <p>5. Altered Fluid Vol: Deficit Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>   | <p>11. Knowledge Deficit Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>             | <p>17. Other:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>                                  |
| <p>6. Alteration in Temperature Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>    | <p>12. Alteration in Mobility Related to:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>        | <p>18. Other:<br/><input type="checkbox"/> Active _____ <input type="checkbox"/> Resolved _____<br/><input type="checkbox"/> Acute _____ <input type="checkbox"/> Chronic _____</p>                                  |

| PROCEDURE | TIME | LAB DRAWN | TIME | SITE | NEW LINE (Type) | TIME | SITE | Dressing/Change IV | TIME | SITE |
|-----------|------|-----------|------|------|-----------------|------|------|--------------------|------|------|
|           |      |           |      |      |                 |      |      |                    |      |      |
|           |      |           |      |      |                 |      |      |                    |      |      |
|           |      |           |      |      |                 |      |      |                    |      |      |

| NEW IV INSERTIONS |        |      |       |        |          |       | I.V. SITE ASSESSMENT |      |      |       |       |      |      |       |        |      |      |       |  |  |  |  |  |  |  |  |
|-------------------|--------|------|-------|--------|----------|-------|----------------------|------|------|-------|-------|------|------|-------|--------|------|------|-------|--|--|--|--|--|--|--|--|
| DATE              | SITE # | TIME | GAUGE | LENGTH | LOCATION | INIT. | 11 - 7               |      |      |       | 7 - 3 |      |      |       | 3 - 11 |      |      |       |  |  |  |  |  |  |  |  |
|                   |        |      |       |        |          |       | DATE                 | TIME | CODE | INIT. | DATE  | TIME | CODE | INIT. | DATE   | TIME | CODE | INIT. |  |  |  |  |  |  |  |  |
|                   |        |      |       |        |          |       |                      |      |      |       |       |      |      |       |        |      |      |       |  |  |  |  |  |  |  |  |
|                   |        |      |       |        |          |       |                      |      |      |       |       |      |      |       |        |      |      |       |  |  |  |  |  |  |  |  |
|                   |        |      |       |        |          |       |                      |      |      |       |       |      |      |       |        |      |      |       |  |  |  |  |  |  |  |  |
|                   |        |      |       |        |          |       |                      |      |      |       |       |      |      |       |        |      |      |       |  |  |  |  |  |  |  |  |
|                   |        |      |       |        |          |       |                      |      |      |       |       |      |      |       |        |      |      |       |  |  |  |  |  |  |  |  |
|                   |        |      |       |        |          |       |                      |      |      |       |       |      |      |       |        |      |      |       |  |  |  |  |  |  |  |  |

**IV Therapy Assessment Code**  
0 - No Complications   3 - Pain w/ Erythema   6 - PURULENT DRAINAGE  
1 - Infiltration   4 - Pain Erythema & streaking   \* - See patient progress record for further details  
2 - Pain at the site   5 - Pain Erythema & cording

**IV Site Codes**  

|       |      |
|-------|------|
| Right | Left |
| RH    | LH   |
| RFA   | LFF  |
| RACF  | LACF |
| RuA   | LuA  |

|            |       |      |
|------------|-------|------|
| Jugular    | Right | Left |
| Subclavian | RJ    | LJ   |
| Radial     | RS    | LS   |
| Femoral    | RR    | LR   |
|            | RF    | LF   |

**HEALTHCARE**  
*Hospital*

**Nursing Flowsheet  
Critical Care**

Addressograph

