

**University Medical Center  
Critical Care / Stepdown Patient Kardex**

Primary MD \_\_\_\_\_

Age: \_\_\_\_\_ Admit Date: \_\_\_\_\_

Allergies: \_\_\_\_\_

Advance Directive: \_\_\_\_\_ Code Status: \_\_\_\_\_

Addressograph \_\_\_\_\_

Chief complaint on admission / Admitting Diagnosis: \_\_\_\_\_

ICU Diagnosis / Surgery & Date of Surgery: \_\_\_\_\_

Past Medical / Surgical Hx.: \_\_\_\_\_

Consults: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

<u>Daily Plan</u>	<u>Date:</u> _____	LOS: _____ Current Problems:    Resolution:
-------------------	--------------------	--

**Flu Vaccine**  
Was it given  Yes  No If no, why:  Refused  Not Indicated  MD Order Needed

**Pneumonia Vaccine**  
Was it given  Yes  No If no, why:  Refused  Not Indicated  MD Order Needed

<u>Discharge Plan:</u>	Home / Alone / With Spouse / with Family / Other _____ Facility: _____ Needs: Rehab Y / N Subacute Y / N Long term placement: Y / N Referrals: Social Services Y / N Discharge Planning Y / N Other discipline: _____
------------------------	---

<u>Safety/Activity</u>	Falls Protocol Level: _____ Gait steady Y / N Cane / Walker Activity: <input type="checkbox"/> Bedrest <input type="checkbox"/> Dangle <input type="checkbox"/> OOB to Chair <input type="checkbox"/> Ad Lib <input type="checkbox"/> OOB with Assist <input type="checkbox"/> Sitter <input type="checkbox"/> Physical Restraints - Type: _____ Speech consult date _____ Results _____ Swallow eval. Date _____ Results _____ PT consult date _____ Frequency _____ Treatments _____
------------------------	---

<u>Teaching / Psychosocial</u>	Teaching needs _____ _____ Family issues _____ Psych consult: Y / N Date: _____ Psych nurse: Y / N Date: _____
--------------------------------	---

