

Assessment Flow Sheet Date:	Norms for Age	Day 1	Day 2	Prioritized Nursing Diagnoses 2 Medical, 1 Psychsoc, 1 Teaching																										
COGNITIVE-PERCEPTUAL LOC (PERLA, reflexes) Sensory (Pain, hearing, vision, sensation) NUTRITIONAL-METABOLIC Integumentary Diet, weight, hydration, incision, IV's - fluid, rate, site				1. 2. 3. 4.																										
ACTIVITY - EXERCISE Motor (grips, gait, movement, limitations)				<p style="text-align: center;">NOTES:</p> Braden Skin Risk Assessment Scale _____ <p style="text-align: center;">High Fall Risk</p> Score of ≥ 5 is Criteria for High Risk <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Safety Risk Factor</th> <th style="text-align: right;">Score</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Medication Effect</td><td style="text-align: right;">1</td></tr> <tr><td><input type="checkbox"/> History/Potential for Falls</td><td style="text-align: right;">5</td></tr> <tr><td><input type="checkbox"/> Impaired Mobility</td><td style="text-align: right;">3</td></tr> <tr><td><input type="checkbox"/> High Risk Diagnosis</td><td style="text-align: right;">3</td></tr> <tr><td><input type="checkbox"/> Elimination Problems</td><td style="text-align: right;">1</td></tr> <tr><td><input type="checkbox"/> Altered Mental Status</td><td style="text-align: right;">1</td></tr> <tr><td><input type="checkbox"/> Sensory Deficit</td><td style="text-align: right;">2</td></tr> <tr><td><input type="checkbox"/> Language Barrier</td><td style="text-align: right;">2</td></tr> <tr><td><input type="checkbox"/> >65, <6</td><td style="text-align: right;">1</td></tr> <tr><td><input type="checkbox"/> Dizzy, Lightheaded</td><td style="text-align: right;">3</td></tr> <tr><td><input type="checkbox"/> Other _____</td><td style="text-align: right;">__</td></tr> <tr><td style="text-align: right;">TOTAL</td><td style="text-align: right;">___</td></tr> </tbody> </table> Erikson's Level of Development Maslow's needs:	Safety Risk Factor	Score	<input type="checkbox"/> Medication Effect	1	<input type="checkbox"/> History/Potential for Falls	5	<input type="checkbox"/> Impaired Mobility	3	<input type="checkbox"/> High Risk Diagnosis	3	<input type="checkbox"/> Elimination Problems	1	<input type="checkbox"/> Altered Mental Status	1	<input type="checkbox"/> Sensory Deficit	2	<input type="checkbox"/> Language Barrier	2	<input type="checkbox"/> >65, <6	1	<input type="checkbox"/> Dizzy, Lightheaded	3	<input type="checkbox"/> Other _____	__	TOTAL	___
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Respiratory (rhythm, rate effort, lung sounds, O ₂) Cardiovascular (rhythm, rate, apical & peripheral pulses, capillary refill)																														
ELIMINATION - G.I. (bowel sounds, distention, flatus BM, describe abdomen) Renal (I&O), Foley, etc. Drains, tubes, etc.																														
HEALTH PERCEPTION - MGMT Learning Needs																														
SLEEP - REST Usual pattern of sleep																														
SELF-PERCEPTION - SELF-CONCEPT																														
ROLE RELATIONSHIP																														
COPING - STRESS TOLERANCE																														
VALUES - BELIEF/CULTURAL																														
DEVELOPMENTAL ABILITIES																														