

Patient's initials _____

Student's name _____

Patient's room _____

Date _____

Clinical Assessment Sheet

| | |
|-----------------------------|---------------------------------|
| VITAL SIGNS | T AP Resp B/P 02Sat |
| I & O | |
| BM | |
| CARES: | |
| Oral | |
| Hand/foot soak | |
| Nails | |
| Hair | |
| Skin / Backrub | |
| Meals | |
| Toileting | |
| Bed making, room clean/safe | |
| Treatments: | |
| Pt. teaching | |