

Patient's initials _____

Student's name _____

Patient's room _____

Date _____

NURSING PROCESS – Collecting data for the Assessment

NEUROLOGICAL ASSESSMENT:

LOC i.e., A&O, lethargic (GCS)	
Awakens to: verbal, painful, tactile stimuli	
Orientation to person, place & time	
Speech i.e., clear/appropriate/garbled/slurred	
Pupils	
Motor (grips, moves extremities)	
Sensory—pain scale	
Musculoskeletal – ROM	

CARDIOVASCULAR ASSESSMENT:

Heart Rhythm – regular/irregular	
Heart sounds: clear/distant, S1, S2, murmurs, best areas to listen	
Skin assessment :color, warmth, integrity, i.e., decub, turgor, capillary refill (fingers & toes)	
Edema – 1-4+, pitting vs. non-pitting	
Pulse-absent (unable to palpitate), weak & thready, normal, full, bounding	
NVD (neck vein distention)	
5 “P” of circulatory checks - pain, pallor, paralysis, pulse, paresthesia (tingling)	