



DAILY PROGRESS NOTE CRITICAL CARE

Date: _____ Med/Surg Physician: _____ Unit Day: _____ Hospital Day: _____

INTERIM HISTORY:

PATIENT DATA:

Vitals: T: _____ T Max: _____ Pulse: _____ RR: _____
 BP: _____ MAP: _____ SVO2: _____ CVP: _____ SW: _____
 Base kg: _____ Today kg: _____ 24 Hr I: _____ 24 Hr O: _____
 Drips/Pressors: _____ 24 Hr Net Output: _____
 Chest Tube/Drains: _____

MEDICATIONS:

PHYSICAL EXAM:

Appearance: _____

HEENT: _____

Cardiovascular: _____

Pulmonary: _____

Gastrointestinal: _____

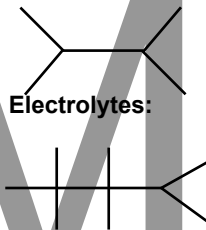
Genitourinary: _____

Extremities: _____

Neurological: _____

Skin/Decubid: _____

CBC:



Electrolytes:



N: _____ Ca: _____ Alb: _____ AST: _____ Trop: _____
 L: _____ Mg: _____ INR: _____ ALT: _____ CPK: _____
 B: _____ Ph: _____ Lac: _____ T.Bili: _____ D.Bili: _____

Cultures/Date	Results	Antibiotics	Start Date
Blood			
Resp			
Urine			
Catheter			
Spinal			
Wound			

VENTILATION: Vent Day #: _____
 Mode: _____ VT: _____ Rate: _____ FI02: _____
 Peep: _____ Peak/Plateau Pressure: _____ Autopeep: _____
 RSBI: _____ Suction Requirements: _____

ABG:

Lines:	Date Placed:
Foley:	
TLC: R / L IJ / FEM / SCL	
Art Line: R / L RAD / FEM	
PICC: R / L ARM	
Dialysis: R / L	
IJ / FEM / SCL TCC / Temp	

RESIDENT SIGNATURE: _____ DATE: _____ TIME: _____

ATTENDING SIGNATURE: _____ DATE: _____ TIME: _____



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RADIOLOGIC STUDIES:			<input type="checkbox"/> DVT PROPHYLAXIS
CXR:	2-D ECHO:	CT:	<input type="checkbox"/> GI PROPHYLAXIS
			<input type="checkbox"/> BOWEL MOVEMENT
			<input type="checkbox"/> PT/OT / SPEECH
			NUTRITION _____
			ROUTE _____

ASSESSMENT/PLAN:

SAMPLE

Name/Title	Signature	Date	Time
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INTENSIVIST ASSESSMENT / PLAN SUPPLEMENT: DISCHARGE PLANNING: REMAIN IN ICU STEPDOWN TELE GMF LTAC

COLLABORATIVE PLAN OF CARE: NURSING RESPIRATORY PHARMACY DIETARY WOUND CARE PT/OT SPEECH CASE MANAGEMENT

Name/Title	Signature	Date	Time
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