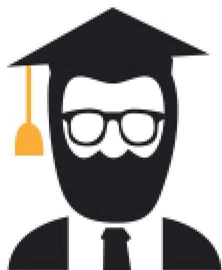

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I INTRODUCE YOURSELF	Your Name:	Your Title:	Reason for Being There:

S SITUATION

Patient:
Age:
Gender:
Height/Weight:
Allergies:
Code status:
Privacy Code:
Time:
Attending Physician:
Patient Chief Complaint:
Chief Informant: Family History:

History of Current Problem:

B BACKGROUND

Past Medical History:	**Current Medications:**	**Social History:**

A ASSESSMENT

VITAL SIGNS:

B/P	HR	RR	TEMP	SP02	PAIN

FALLS RISK Y_____ N_____	**IV Site:**	**Accu check:**	**IV Fluids:**

ISOLATION	Isolation Precautions: Y____ N_	Contact	Air	Droplet

HEENT	
RESPIRATORY	
CARDIOVASCULAR	
NEUROLOGICAL	
GI/GU I & O	
MUSCULOSKELETAL	
INTEGUMENTARY	
LYMPHATIC	
ENDOCRINE	
PSYCHOLOGICAL FAMILY - SUPPORT	
SAFETY	

LABS/TEST	**Abnormal:**	**Pending: Ordered**

R REQUEST/ RECOMMENDATION

Hand off report to: ____________________

From: ____________________

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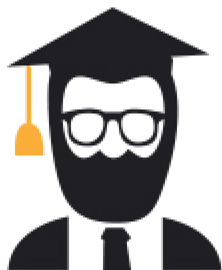

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