KAISER PERMANENTE®

NORMAL NEWBORN CLINICAL PATHWAY AND RECORD ADDENDUM

LOS > 36 hrs.

Document achievement of expected outcome on initial
Normal Newborn Clinical Pathway and Record

IMPRINT AREA

HEAD
N = WNL per admission assessment

LUNGS
Cl = Clear
M = Moist
W = Wheezes
E = Equal

HEART SOUNDS
RR = Regular rate
I = Irregular rhythm
M = Murmur
G = Gallop

COLOR
P = Pink
Pl = Plethoric
Ac = Acrocyanotic
D = Dusky
M = Mottled
W = Pale
J = Jaundiced
C = Cyanotic

EYES
Cl = Clear
D = Drainage

SKIN
Cl = Clear
D = Dry
R = Rash
P = Peeling
B = Bruising
Pe = Petechiae

CORD
C = Clamp Removed
D = Dry
M = Moist
U = Umbilical Tape

ABDOMEN
S = Soft
D = Distended

BOWEL SOUNDS
+ = Present
0 = Absent

ACTIVITY
A = Active
J = Jittery
S = Sleepy
I = Irritable
H = Hypotonic

CIRCUMCISION
Cl = Clean & Dry
B = Scant bleeding
* = Other, requires Focus Note

MED SITE
RAT = Right Anterior Thigh
LAT = Left Anterior Thigh

* = Other, requires Focus Note

*** LATCH Scoring Table** O = Observed R = Reported

	0	1	2
L = Latch	Too sleepy or reluctant No sustained latch or suck achieved	Repeated attempts for sustained latch & suck	Grasps breast/lips flanged Tongue down Rhythmic sucking
A = Audible Swallowing	None	A few with stimulation	Spontaneous and intermittent < 24° Spontaneous and frequent > 24°
A = Type Of Nipple	Inverted	Flat	Everted (after stimulation)
A = Comfort, Breast/Nipple	Cracked/bleeding, large blister or bruises Engorged/severe discomfort	Filling/mild/moderate discomfort Reddened/small blister or bruises	Non-tender Soft
A = Hold (Positioning)	Full assist/staff holds infant at breast	Minimal assist (elevate HOB, place pillow for support) Teach one side, mom does other Staff holds and then mom takes over	No assist from staff Mother able to position/hold infant

* Sacred Heart Medical Center, Eugene Oregon

	DATE/SHIFT:	DATE/SHIFT:	DATE/SHIFT:	DATE/SHIFT:	DATE/SHIFT:
Vital Signs and Assessment	Care Plan reviewed by RN ☐ • Assessment q shift • **Weight**: ___ lbs. ___ gms. • **Vital signs** q ___ hr Time T P R Head Lungs Heart Sounds Color Eyes Skin Cord Abdomen Activity Circumcision Initial	Care Plan reviewed by RN ☐ • Assessment q shift • **Weight**: ___ lbs. ___ gms. • **Vital signs** q ___ hr Time T P R Head Lungs Heart Sounds Color Eyes Skin Cord Abdomen Activity Circumcision Initial	Care Plan reviewed by RN ☐ • Assessment q shift • **Weight**: ___ lbs. ___ gms. • **Vital signs** q ___ hr Time T P R Head Lungs Heart Sounds Color Eyes Skin Cord Abdomen Activity Circumcision Initial	Care Plan reviewed by RN ☐ • Assessment q shift • **Weight**: ___ lbs. ___ gms. • **Vital signs** q ___ hr Time T P R Head Lungs Heart Sounds Color Eyes Skin Cord Abdomen Activity Circumcision Initial	Care Plan reviewed by RN ☐ • Assessment q shift • **Weight**: ___ lbs. ___ gms. • **Vital signs** q ___ hr Time T P R Head Lungs Heart Sounds Color Eyes Skin Cord Abdomen Activity Circumcision Initial
Feedings	Breast/Bottle Feed • Assess mother's skill in feeding infant and assist her as needed • Monitor intake by wet diaper count and stool count				
	Time O/R L A T C H Total Initial Formula Amount				
	Void ☐ ☐ ☐ ☐ ☐ Stool ☐ ☐ ☐ ☐ ☐	Void ☐ ☐ ☐ ☐ ☐ Stool ☐ ☐ ☐ ☐ ☐	Void ☐ ☐ ☐ ☐ ☐ Stool ☐ ☐ ☐ ☐ ☐	Void ☐ ☐ ☐ ☐ ☐ Stool ☐ ☐ ☐ ☐ ☐	Void ☐ ☐ ☐ ☐ ☐ Stool ☐ ☐ ☐ ☐ ☐
Tests	Bilimeter • Bilirubin: Date ___ Time ___ Result ___ • Other	Bilimeter • Bilirubin: Date ___ Time ___ Result ___ • Other	Bilimeter • Bilirubin: Date ___ Time ___ Result ___ • Other	Bilimeter • Bilirubin: Date ___ Time ___ Result ___ • Other	Bilimeter • Bilirubin: Date ___ Time ___ Result ___ • Other
Treatments and Safety	• Bulb syringe in crib • Cord care ☐ ID bands on and checked ☐ Phototherapy ☐ Eyes covered Radiometer ___	• Bulb syringe in crib • Cord care ☐ ID bands on and checked ☐ Phototherapy ☐ Eyes covered Radiometer ___	• Bulb syringe in crib • Cord care ☐ ID bands on and checked ☐ Phototherapy ☐ Eyes covered Radiometer ___	• Bulb syringe in crib • Cord care ☐ ID bands on and checked ☐ Phototherapy ☐ Eyes covered Radiometer ___	• Bulb syringe in crib • Cord care ☐ ID bands on and checked ☐ Phototherapy ☐ Eyes covered Radiometer ___
Medications		**Document on MAR** →			
Teaching	• Teaching record continued →				
Psychosocial	• Assess parental attachment behavior • Involve significant others in care	• Encourage mother-infant coupling To mom's room at ___ ___ To NSY at ___ ___	• Encourage mother-infant coupling To mom's room at ___ ___ To NSY at ___ ___	• Encourage mother-infant coupling To mom's room at ___ ___ To NSY at ___ ___	• Encourage mother-infant coupling To mom's room at ___ ___ To NSY at ___ ___
	Signature / Init. Print Name Signature / Init. Print Name Signature / Init. Print Name	Signature / Init. Print Name Signature / Init. Print Name Signature / Init. Print Name	Signature / Init. Print Name Signature / Init. Print Name Signature / Init. Print Name	Signature / Init. Print Name Signature / Init. Print Name Signature / Init. Print Name	Signature / Init. Print Name Signature / Init. Print Name Signature / Init. Print Name

POSTPARTUM CLINICAL PATHWAY AND RECORD - (Beyond 36 hrs.)

DATE AND TIME OF DELIVERY	TYPE OF DELIVERY

Standards Of Care

- ☐ Postpartum BUCS
- ☐ PIH
- ☐ Perinatal Infections
- ☐ Other ______
- ☐ Perinatal Surgery
- ☐ Communicable Diseases
- ☐ Perinatal Loss
- ☐ Perinatal Substance Abuse
- ☐ Diabetes
- ☐ Adolescent

Level of Consciousness
A = Alert
D = Drowsy

Breasts
S = Soft
F = Filling
E = Engorged

Nipples
I = Intact
T = Tender
R = Reddened
C = Cracked

Fundus
F = Firm
B = Boggy
#↑ = Fingers umb.
#↓ = Fingers umb.
D = Filling
A = At umbilicus

Lochia
S = Scant
M = Moderate
H = Heavy

Bladder
O = Has not voided
QS = Quantity sufficient without difficulty Distended
F = Foley

Perineum
I = Intact
S = Swollen
B = Bruising

Hemorrhoids
O = None
E = Edematous

Edema
0 = None
1+ = Whitens, no indentation
2+ = Indents and returns
3+ = Indents and slow to return
4+ = Generalizes and does not come readily back

Homans
- = Negative
+ = Positive
(Indicate R or L)

Activity
A = Ad lib
B = Bedrest
C = Chair
N = Needs assist

Maternal/Infant Bonding
+ = Attachment behaviors demonstrated
/ = Attachment behaviors demonstrated
N/O = Not observed

Pain
0-10 (10 = severe)

Family Involvement
O = Observed
N/A = Not applicable
N/O = Not observed

* = See Focus Note

IMPRINT AREA

Care Plan discussed with patient/family. ______ (Initials)

	DATE/SHIFT	DATE/SHIFT	DATE/SHIFT	DATE/SHIFT	DATE/SHIFT
Assessment	Care Plan review by ______, R.N. TIME LOC Breasts Nipples Fundus Bladder Lochia Perineum Hemorrhoids Edema Homans Sign Activity Maternal/ Infant Bond Family Involvement Initial	Care Plan review by ______, R.N. TIME LOC Breasts Nipples Fundus Bladder Lochia Perineum Hemorrhoids Edema Homans Sign Activity Maternal/ Infant Bond Family Involvement Initial	Care Plan review by ______, R.N. TIME LOC Breasts Nipples Fundus Bladder Lochia Perineum Hemorrhoids Edema Homans Sign Activity Maternal/ Infant Bond Family Involvement Initial	Care Plan review by ______, R.N. TIME LOC Breasts Nipples Fundus Bladder Lochia Perineum Hemorrhoids Edema Homans Sign Activity Maternal/ Infant Bond Family Involvement Initial	Care Plan review by ______, R.N. TIME LOC Breasts Nipples Fundus Bladder Lochia Perineum Hemorrhoids Edema Homans Sign Activity Maternal/ Infant Bond Family Involvement Initial
Tests	As Ordered	As Ordered	As Ordered	As Ordered	As Ordered
Treatment/Activity	Pericare Sitz Bath Other	Pericare Sitz Bath Other	Pericare Sitz Bath Other	Pericare Sitz Bath Other	Pericare Sitz Bath Other
Pain Management/ Pt's. Comfort Level	Analgesia (document time & rating): Location of Pain Pain Rating Intervention Desired: Yes or No Pain Rating After Intervention Initial	Analgesia (document time & rating): Location of Pain Pain Rating Intervention Desired: Yes or No Pain Rating After Intervention Initial	Analgesia (document time & rating): Location of Pain Pain Rating Intervention Desired: Yes or No Pain Rating After Intervention Initial	Analgesia (document time & rating): Location of Pain Pain Rating Intervention Desired: Yes or No Pain Rating After Intervention Initial	Analgesia (document time & rating): Location of Pain Pain Rating Intervention Desired: Yes or No Pain Rating After Intervention Initial
Psychosocial Discharge Planning	**Refer To Initial Postpartum Clinical Pathway**				
Teaching	Continue Patient Education Record ☐ Patient Learning Checklist in use	Continue Patient Education Record ☐ Patient Learning Checklist in use	Continue Patient Education Record ☐ Patient Learning Checklist in use	Continue Patient Education Record ☐ Patient Learning Checklist in use	Continue Patient Education Record ☐ Patient Learning Checklist in use
Feeding (Breast and/or Bottle)	Breastfeed q 2-3° Bottle-feeding: formula 20 cal q 3-4° Instruction and support given prn. ☐ Breast pump	Breastfeed q 2-3° Bottle-feeding: formula 20 cal q 3-4° Instruction and support given prn. ☐ Breast pump	Breastfeed q 2-3° Bottle-feeding: formula 20 cal q 3-4° Instruction and support given prn. ☐ Breast pump	Breastfeed q 2-3° Bottle-feeding: formula 20 cal q 3-4° Instruction and support given prn. ☐ Breast pump	Breastfeed q 2-3° Bottle-feeding: formula 20 cal q 3-4° Instruction and support given prn. ☐ Breast pump

Print Name	Initials	Signature	Title	Print Name	Initials	Signature	Title

Progress Codes: 1 = Problem ongoing 2 = Outcome met

WHL (within normal limits) CODES	ASSESSMENT	NOC'S	DAY'S	EVE'S	PATIENT PROBLEMS	EXPECTED OUTCOMES	PROGRESS	PLANNED INTERVENTIONS	CARE DELIVERED NOC'S	CARE DELIVERED DAY'S	CARE DELIVERED EVE'S
+ present – absent ↓ decrease ↑ increase		*	*	*							
NEURO WHL = Alert, oriented x 3	WNL				☐ Headache	☐ 1 No headache		☐ Analgesics per order			
no headache, no visual disturbance,	Headache				☐ Visual disturbance	☐ 2 No visual disturbance		☐ Neuro checks q ______			
no seizure, DTR – 1-2+, clonus – negative	Visual disturbance				☐ Potential for seizure	☐ 3 No seizures		☐ Seizure precautions			
	DTR/Clonus				☐ Weakness/Numbness	☐ 4 No weakness/numbness		☐ DTR's as ordered			
☐ **Refer to Special Observation Record**	Seizure				☐			☐ Evaluate weakness/numbness			
RESP WHL = Even, unlabored, lungs	WNL				☐ Altered ventilation	☐ 1 Lung sounds clear		☐ Lung sounds q ______			
clear, no abnormal breath sounds	Abnormal lung sounds	R L	R L	R L	☐ Excessive secretions	☐ 2 Respiration even/unlabored		☐ Respirations q ______			
CODES: CR = crackles (rales),	O_2 sat (%)/O_2 liters (L)				☐ Cough	☐ 3 Respiratory rate WNL		☐ Cough and deep breath q ______			
RH = rhonchi, WH = wheezes,	Cough/Describe				☐	☐ 4 Cough under control		☐ Inspirometer q ______			
Insp = inspiratory, Exp = expiratory	Secretions/Describe					☐ 5 Absence of cyanosis		☐ O_2 ______ O_2 sat q ______			
	Resp. labored/SOB					☐ 6 O_2 SAT > 95%		☐ Suction PRN			
						☐ 7 Decreased secretions		☐ RT referral			
HEART/PULSE WHL – Heart rhythm regular.	WNL				☐ Edema	☐ 1 ≤ edema		☐ TEDs as ordered			
BP 140/90 or less. No edema, negative	Edema Site/Degree				☐ Hypertension	☐ 2 BP within parameter		☐ Elevate extremities			
Homans sign	Homan's sign	R L	R L	R L	☐ Deep vein thrombosis	☐ 3 No evidence of DVT		☐ BP and heart rate q ______			
☐ **Refer to Special Observation Record**	Irregular rhythm				☐			☐ Assess pulse q ______			
Edema: 1+ = mild/ 2+ = mod; 3+ = severe	Abnormal BP										
GI WHL = Abdomen non tender, no nausea	WNL				☐ Nausea	☐ 1 Tolerates oral intake		☐ I&O			
no vomiting, no diarrhea, no constipation,	Feeds Self/Assist				☐ Vomiting	☐ 2 No nausea or vomiting		☐ Restrict fluids			
no epidemic pain.	Epigastric pain				☐ Epigastric pain	☐ 3 No epigastric pain		☐ NPO/Diet ______ % eaten		R L	D
Bowel sounds present	Nausea				☐ Altered elimination	☐ 4 Normal elimination		☐ Antiemetics as ordered			
	Emesis/Describe				☐ Abnormal blood sugar	☐ 5 Abdomen soft/non-tender		☐ IV therapy as ordered			
	Diarrhea/Constipation				☐	☐ 6 Blood sugar under control		☐ Stool softeners as ordered			
☐ **Refer to Diabetic Record**	BM							☐ Check blood glucose as ordered			
☐ **Refer to CPN/PPN Order Sheet**								☐ Refer to dietitian			
GU-GYN WHL = Urine clear, no difficulty	WNL				☐ Altered kidney function	☐ 1 Urine protein negative		☐ Urine protein q ______			
voiding, no dysuria, urine protein negative.	Urine abnormal color/clarity				☐ Urinary tract infection	☐ 2 No UTI or treatment initiated		☐ Push fluids			
No abnormal vaginal discharge.	Difficulty voiding/Dysuria				☐ Altered liver function	☐ 3 Normal kidney function		☐ PIH labs as ordered			
Uterine contractions within threshold.	Urine protein				☐ Potential for premature delivery	☐ 4 Normal liver function tests		☐ Monitor uterine contractions			
FHR/WHL = Rate 120 - 160	Vaginal bleeding/Discharge				☐ Potential for complications for fetus	☐ 5 No abnormal vaginal discharge		☐ Refer to Preterm Birth/HUM			
NST/WHL = Reactive	Amount/Color				☐ Potential for uterine infection	☐ 6 Uterine contractions within threshold		☐ Notify MD for contractions >			
	Uterine contraction #/Hr.				☐	☐ 7 Fetal heart rate WNL		threshold/unusual vag. discharge			
	Frequency/Duration/Intensity					☐ 8 No uterine infection		☐ Tocolytics/Abx as ordered			
☐ **Refer to Special Observation Record**	Fetal Heart rate							☐ FHT q ______ NST q ______			
	NST WNL										
SKIN WHL = Warm, dry, intact, elastic turgor,	SKIN WNL				☐ Altered skin integrity	☐ 1 Skin intact		☐ Wound care as ordered			
no rash, no pressure ulcer, no breakdown.	Rash, breakdown				☐ Altered ability to perform self-care	☐ 2 Incision intact/no inflammation		☐ Antibiotics as ordered			
WOUND WHL = suture lines intact, healing at	Bath: self / assist / total				☐	☐ 3 Skin condition maintained/improved		☐ Bath/Oral care/Pericare			
expected rate, no inflammation, no drainage						☐ 4 Self care/with assist		☐ Assist with toileting PRN			
	Wound WNL							☐ Antipyretics PRN			
MOBILITY WHL = Ambulates safety, ad lib,	Mobility WNL				☐ Altered mobility/Activity	☐ 1 Performs ADL at level		☐ Assist with ADL PRN			
moves all extremities with full ROM	Complete bedrest/BRP				☐ Altered safety	prescribed by MD		☐ Encourage bedrest exercise			
or baseline.	Left side/Trendelenburg				☐ Potential for spread of infection	☐ 2 Stable with ambulation		☐ PT referral			
GENERAL SAFETY WHL = Rails up, call	General safety WNL				☐	☐ 3 Infection control protocol maintained		☐ Fall precautions			
light within reach, environment uncluttered.	IC precautions in place					☐ 4 Treatment in progress		☐ Infection control precautions			
If applicable, proper infection control other											
than univ. precautions in place.											
COMFORT WHL = Patient verbalizes pain	WNL (comfort zone____)				☐ Altered comfort	☐ 1 Pain within comfort zone		☐ Analgesic per order			
levels is within comfort zone. No pain	Pain site				☐			☐ Position for comfort			
related behavior.	Time/Pain level							☐			
	Intervention (refer to MAR)							☐			
CODE: Pain scale 0 -10 (10 most severe).	Evaluation time/Pain level							☐			
PSYCHOSOCIAL/EMOTIONAL WHL =	WNL				☐ Altered coping	☐ 1 Calm/Cooperative		☐ Listen to patient/family concerns			
Support system is available and sufficient	Altered emotional status				☐ Altered family process	☐ 2 Verbalizes feelings		☐ Address spiritual/cultural needs			
to meet patient's needs, patient calm, able	Special spiritual needs				☐ Spiritual/Cultural needs	☐ 3 Support system in place		☐ Address age specific needs			
to verbalize coping strategies. Spiritual,	Special cultural needs				☐ Age specific needs	☐ 4 Participates in care/plan		☐ Refer to Social Services			
cultural and age specific concerns met.	Age specific needs				☐ Substance abuse	☐ 5 Spiritual/Cultural concerns met		☐ Refer to ______________			
	Support system needs				☐ Domestic violence	☐ 6 Age specific needs met		☐ Provide interpreter			
	Requires Social Services				☐	☐ 7 Appropriate referrals done		☐			
	Requires interpreter										
EDUCATION WHL = Proficient at required	Education WNL				☐ Knowledge deficit	☐ 1 Verbalizes understanding of		☐ Teaching per learning checklist			
skills, verbalizes understanding of critical	Needs identified				☐ Self care deficit	teaching topics		☐ Informational materials provided			
items.					Re: ☐ Follow up care ☐ Diet	☐ 2 Proficient return demonstration		☐ Equipment/Supplies given			
☐ **Refer to Learning Checklist**	Discharge Plans WNL				☐ Community ☐ Meds	of skills per checklist		☐ Refer to Discharge Planner			
	Needs identified				☐ Equipment Use ☐ Activity	☐ 3 Equipment/Supplies ordered					
DISCHARGE PLANS WHL = Needs met					☐ Procedures						
		Time: Initial:	Time: Initial:	Time: Initial:							
	No change from last entry										

KAISER PERMANENTE

24-HR PATIENT CARE RECORD - ANTEPARTUM

ROOM	DATE	IMPRINT AREA

DIAGNOSIS

EDC	GEST. AGE	G	P

CLINICAL CARE PATHS/STANDARDS/PROTOCOLS

- ☐ BUCS (L&D/APT)
- ☐ Hyperemesis
- ☐ Pregnancy Induced Hypertension
- ☐ Premature Rupture of Membrane
- ☐ Substance Abuse
- ☐ Perinatal Surgery
- ☐ Adolescent
- ☐ Preterm Labor
- ☐ Pain Management
- ☐ Diabetes
- ☐ Placenta Previa
- ☐ Communicable Diseases
- ☐ Perinatal Infections
- ☐ Other ________________

PROTOCOL

- ☐ Nifedipine
- ☐ Terbutaline
- ☐ Heparin Management
- ☐ PPN/CPN
- ☐ $MgSO_4$

		N	D	E
Care Plan discussed with patient/family	Care Plan reviewed by RN			

DIAGNOSTIC TEST/PROCEDURE

TIME OUT	TIME IN	PROCEDURE/TEST	INITIAL

PHYSICIAN NOTIFICATION

TIME	DOCTOR	REASON	RESPONSE	INITIAL

SHIFT	PRINT NAME	INITIAL	SIGNATURE	TITLE

KARDEX CHART

Internal HX	
G P SAB TAB LIVE	
PREVIOUS BIRTH	☐ YES ☐ NO
EDC	
COMMUNICATION:	
PRIM. LANG.	☐ INTERPRETER NEEDED
SUPPORT PERSON	PHONE
MOTHER BLOOD TYPE Rh:	
HBsAg Status	
Rubella Status	
VDRL OR RPR	
HERPES HX	☐ YES ☐ NO
DATE OF LAST CULTURE	

Call H.O. FOR: POST DEL		OTHER ORDER	☐ TOX CHARTING = ^	
TEMP. ↑ 100.6			VITAL SIGNS: FHT Q	PT. CARE:
PULSE ↑120 ↓60			^ TPR Q	^ PROT/S/A Q
BP SYST ↑150 ↓90 DIAST ↑90 ↓50			^ BT Q Pulse Oximetry Intermit. ☐	^ I&O Q
LOCHIA > 1 PAD / $\frac{1}{2}$ HOUR ↑PERINEUM DISCOMFORT NOT RELIEVED by Rx			^ NEURO CHECKS Q	☐ ONE TOUCH II
NO VOID Q 6°			^ WEIGHT Q	☐ DIABETIC Record
DIET:			PAD COUNT	LAST BM
FLUID RESTRICTIONS:				
ACTIVITY	☐ Highrick for Falls ☐ AMB ☐ Asst Min ☐ Mod ☐ Max ☐ BRP ☐ Min ☐ Mod		HYGIENE: SHOWER ☐ WALK ☐ SITC BATH ☐ Self ☐ ASST ☐ Via W/C	
	☐ BED REST ONLY ☐ DANGLE/CHAIR			
POST-OP CARE	T/C/DB Q ________ ☐ Foley DC@ ________ Date ________ ☐ Turn with other activity		INC SPIROMETER Q ________ VD by ________	

DATE	X - RAY/LABS
	RHOGAM Work up ☐ N/A ☐
Specimen Collection	> 6 DAY ☐
	< 6 DAY ☐
BLD Draw	> 6 DAY
	< 6 DAY ☐
	BLD Glucose ☐
Baby Labs:	

DELIVERY HX	
☐ AROM ☐ SROM	DATE/TIME
☐ INDUCTION ☐ AUGMENTATION	
MODE:	
DELIVERY	DATE: TIME:
☐ SVD ☐ FORCEPS ☐ VACUUM ☐ C BIRTH	
EPISIOTOMY	
LACERATIONS	
ANESTHESIA	
EBL	
TUBAL LIGATION	☐ N/A ☐ WITH C BIRTH
☐ PP - DATE/TIME	
☐ CONSENTS ON CHART	
DIAGNOSIS AND/OR COMPLICATIONS AND/OR SURGICAL INTERVENTIONS	
PRENATAL GESTATION BY WEEKS	
ROOM	NAME

BABY INFORMATION	
SEX ☐ MALE ☐ FEMALE	
WEIGHT: SGA ☐	LGA ☐
APGARS 1 5	10
ROOM IN ☐	ICN ☐
NUTRITION	
BREAST ☐	BOTTLE ☐
ROUTINE ☐	SELF SUFF ☐
WITH ASST ☐	Q 3-4° ☐
SUPPLEMENT ☐	D.Wt. ☐
BLOOD TYPE/COOMBS:	
DIAPER CHANGE ☐ VSQ4° ☐ VSQ8° ☐	
BLD GLUCOSE ☐ PROCEDURE ASST < 1HR ☐	
BLD DRAW < 6/DAY	
MEC: YES ☐ NONE BELOW ☐ NO ☐	
CIRC. YES ☐ DATE:	

IN-PT ANTENATAL PRENATAL DAY:
NSTQ
TOCO ONLY ☐ CONTINUOUS ☐
ONE TOUCH II
URINE DIPS Q
BMZ
24HR COLLECT START DATE & TIME:
DIABETIC RECORD ☐

MOTHER GRASP:	
RESP: O_2 CANULA ☐ O_2 MASK ☐	LACTATION CONSULT ☐
DRSG. CHANGE: SIMPLE ☐ MOD ☐	BREAST PUMP ☐
INC: DRAINS ☐	
PERINEUM HOT/COLD COMPRESSES ☐	
PREOPTEST PREP ☐	
PROCEDURE ASST < 1 HR ☐	

PN ☐ VAG ☐ C/S ☐	M.R.#	AGE:	ADMIT:	PROVIDER:

KARDEX CHART Part II

DATE	MEDICATIONS	D/C DATE/TIME	TIME OF ADMINISTRATION		
			NIGHTS	DAYS	EVENINGS
	IV Care: Epid. Drip Mgmt. ☐/IV Lock ☐/IV Lock 2nd IV ☐ PCA ☐	IV start date/time	Size:	IV Tubing ^	MEDS: 1-5 ☐ 6-10 ☐ 11-15 ☐ >15 ☐

DATE	PRN MEDICATIONS	D/C DATE/TIME	DATE	BOTTLE	PARENTERAL FLUIDS	D/C DATE/TIME
				IV Care: Epid. Drip Mgmt. ☐/IV Lock ☐/IV Lock - 2nd IV ☐		

ALLERGIES:____________________________ Soc. Ser. Referral ☐ Called: __________ Pt. seen date/time:

DATE	NURSE	NEEDS OR PROBLEMS	NURSE to NURSE ORDER	EXPECTED OUTCOMES	RESOLVED

PATIENT EXPIRATION INFORMATION/RELEASE

Name: ___	Autopsy Requested: Yes No	NOK/Executor:	Organ/Tissue Donation: Yes No	**Release of Body**	Mortuary ___	**Remarks:**
M R# ___	Autopsy Permit Signed: Yes No	Name: ___	Consents Signed: Yes No		Other ___	
Room # / Unit ___	Family/Designee Contacted:	Address: ___	Audit Complete: Yes No	**Valuables**	Date: ___	
Death Date: ___ Time: ___	Family/Designee Undecided:	___	*Public Administrator Case: Yes No	Safety Deposit Key # ___ NA	Time: ___	
Fatal Demise	MD for F/U:	Phone:	PA Notified: Date: Time:	Release to Family Mortuary	By: ___	
Mother's Name: ___	Pathology Notified-Date/Time:	Death Cert W/S Comp: Yes No		**Belongings**		
M R# ___	Autopsy Complete-Date/Time:	Staff M.D.	Curator: Yes No Consent Signed: Yes No	Family Mortuary Dec Aff HousekKpg		
Retain/Dispose: Yes No Consent: Yes No		Coroner's Case: Yes No NC#	Arrangements Made by Family: Yes No	Release Signed: Yes No		

Name: ___	Autopsy Requested: Yes No	NOK/Executor:	Organ/Tissue Donation: Yes No	**Release of Body**	Mortuary ___	**Remarks:**
M R# ___	Autopsy Permit Signed: Yes No	Name: ___	Consents Signed: Yes No		Other ___	
Room # / Unit ___	Family/Designee Contacted:	Address: ___	Audit Complete: Yes No	**Valuables**	Date: ___	
Death Date: ___ Time: ___	Family/Designee Undecided:	___	*Public Administrator Case: Yes No	Safety Deposit Key # ___ NA	Time: ___	
Fatal Demise	MD for F/U:	Phone:	PA Notified: Date: Time:	Release to Family Mortuary	By: ___	
Mother's Name: ___	Pathology Notified-Date/Time:	Death Cert W/S Comp: Yes No		**Belongings**		
M R# ___	Autopsy Complete-Date/Time:	Staff M.D.	Curator: Yes No Consent Signed: Yes No	Family Mortuary Dec Aff HousekKpg		
Retain/Dispose: Yes No Consent: Yes No		Coroner's Case: Yes No NC#	Arrangements Made by Family: Yes No	Release Signed: Yes No		

Name: ___	Autopsy Requested: Yes No	NOK/Executor:	Organ/Tissue Donation: Yes No	**Release of Body**	Mortuary ___	**Remarks:**
M R# ___	Autopsy Permit Signed: Yes No	Name: ___	Consents Signed: Yes No		Other ___	
Room # / Unit ___	Family/Designee Contacted:	Address: ___	Audit Complete: Yes No	**Valuables**	Date: ___	
Death Date: ___ Time: ___	Family/Designee Undecided:	___	*Public Administrator Case: Yes No	Safety Deposit Key # ___ NA	Time: ___	
Fatal Demise	MD for F/U:	Phone:	PA Notified: Date: Time:	Release to Family Mortuary	By: ___	
Mother's Name: ___	Pathology Notified-Date/Time:	Death Cert W/S Comp: Yes No		**Belongings**		
M R# ___	Autopsy Complete-Date/Time:	Staff M.D.	Curator: Yes No Consent Signed: Yes No	Family Mortuary Dec Aff HousekKpg		
Retain/Dispose: Yes No Consent: Yes No		Coroner's Case: Yes No NC#	Arrangements Made by Family: Yes No	Release Signed: Yes No		

Name: ___	Autopsy Requested: Yes No	NOK/Executor:	Organ/Tissue Donation: Yes No	**Release of Body**	Mortuary ___	**Remarks:**
M R# ___	Autopsy Permit Signed: Yes No	Name: ___	Consents Signed: Yes No		Other ___	
Room # / Unit ___	Family/Designee Contacted:	Address: ___	Audit Complete: Yes No	**Valuables**	Date: ___	
Death Date: ___ Time: ___	Family/Designee Undecided:	___	*Public Administrator Case: Yes No	Safety Deposit Key # ___ NA	Time: ___	
Fatal Demise	MD for F/U:	Phone:	PA Notified: Date: Time:	Release to Family Mortuary	By: ___	
Mother's Name: ___	Pathology Notified-Date/Time:	Death Cert W/S Comp: Yes No		**Belongings**		
M R# ___	Autopsy Complete-Date/Time:	Staff M.D.	Curator: Yes No Consent Signed: Yes No	Family Mortuary Dec Aff HousekKpg		
Retain/Dispose: Yes No Consent: Yes No		Coroner's Case: Yes No NC#	Arrangements Made by Family: Yes No	Release Signed: Yes No		

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M R# ___	Autopsy Permit Signed: Yes No	Name: ___	Consents Signed: Yes No		Other ___	
Room # / Unit ___	Family/Designee Contacted:	Address: ___	Audit Complete: Yes No	**Valuables**	Date: ___	
Death Date: ___ Time: ___	Family/Designee Undecided:	___	*Public Administrator Case: Yes No	Safety Deposit Key # ___ NA	Time: ___	
Fatal Demise	MD for F/U:	Phone:	PA Notified: Date: Time:	Release to Family Mortuary	By: ___	
Mother's Name: ___	Pathology Notified-Date/Time:	Death Cert W/S Comp: Yes No		**Belongings**		
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Retain/Dispose: Yes No Consent: Yes No		Coroner's Case: Yes No NC#	Arrangements Made by Family: Yes No	Release Signed: Yes No		

*For P.A. case obtain the following information before sending chart to Medical Records:

1. Name/Address ___
2. Date of birth ___
3. Social Security Number ___
4. Religion ___
5. Marital Status ___
6. Name of any known relatives/friends ___
7. Employer ___
8. Insurance ___
9. Regular Physician ___
10. Cause of Death ___
11. Personal Effects (credit cards, cash, keys) ___

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