

**CRITICAL CARE NURSING  
ASSESSMENT FORM**

ATTACH Patient I.D LABEL

**Safety Check:**  Resus.bag  Suction & correct setup  Alarms & limits  Bed rails  
 U.P.S (vent/crrt/monitor)  I.D band  Review manual handling form

Neurological

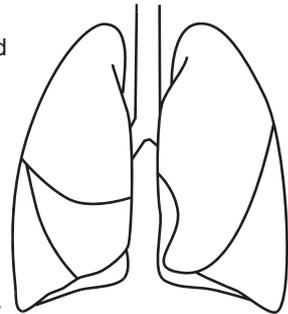
**See Critical Care Flow Chart for Neurological Assessment & Sedation/Analgesia Infusions**  
 Mental Status: \_\_\_\_\_  
 \_\_\_\_\_  
 GCS: Eye \_\_\_\_\_ Verbal \_\_\_\_\_ Motor \_\_\_\_\_ Pupils: L(mm) \_\_\_\_\_ R(mm) \_\_\_\_\_ Reaction L \_\_\_\_\_ R \_\_\_\_\_  
 Restraints:  Upper extremities  Lower extremities  
 Pain:  Denies  Present  Unable to assess due to \_\_\_\_\_  
 Gag reflex:  Present  Absent

Respiratory

**See Critical Care Flow Chart for Oxygen Therapy & Ventilator Settings**  
 Airway:  Maintains Own  BiPAP /CPAP  
 ETT: Size : \_\_\_\_\_ Length at teeth/gums \_\_\_\_\_ cm Cuff pressure: \_\_\_\_\_ cm/H20  
 Tracheostomy: size: \_\_\_\_\_  
 Oral Mucosa:  Intact  Other\*  
 Lip Condition:  Intact  Other\*  
 Tracheal stoma: Describe: \_\_\_\_\_  
 Cough:  Spontaneous  Stimulated by suctioning  
 Strong  Moderate  Weak  Absent  
 Respirations:  Ventilated  N.I.V  Non-ventilated  
 Easy/Regular  Deep  Shallow  
 Laboured  Intercostal use  Other \*  
 Chest Expansion:  Symmetrical  Asymmetrical  
 Paradoxical  Tracheal tug  
 Trachea:  Midline  Deviated left  Deviated right  
 \* Other (description) \_\_\_\_\_

Breath  
Sounds

- C Clear
- D Decreased
- W Wheezes
- FC Fine Crep's
- X Coarse Crep's
- A Absent
- B Bronchial
- I Inspiratory
- E Expiratory



<input type="checkbox"/> Chest tube #1 to: _____ <input type="checkbox"/> Suction _____ cm H2O <input type="checkbox"/> Underwater seal only Oscillation: <input type="checkbox"/> Present <input type="checkbox"/> Absent Air Leak: <input type="checkbox"/> Present <input type="checkbox"/> Absent Drainage: _____ S/C emphysema: <input type="checkbox"/> Present <input type="checkbox"/> Absent	<input type="checkbox"/> Chest tube #2 to: _____ <input type="checkbox"/> Suction _____ cm H2O <input type="checkbox"/> Underwater seal only Oscillation: <input type="checkbox"/> Present <input type="checkbox"/> Absent Air Leak: <input type="checkbox"/> Present <input type="checkbox"/> Absent Drainage: _____ S/C emphysema: <input type="checkbox"/> Present <input type="checkbox"/> Absent
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Cardiovascular

**See Critical Care Flow Chart for Vital Signs, Haemodynamics, and Neurovascular Assessment**  
 ECG: Lead: \_\_\_\_\_ Rate: \_\_\_\_\_ PR: \_\_\_\_\_ QRS: \_\_\_\_\_ QT: \_\_\_\_\_ ST Segment: \_\_\_\_\_ T wave \_\_\_\_\_  
 Interpretation: \_\_\_\_\_  
 Skin (peripheral):  Pink  Pale  Jaundiced  Flushed  Mottled  Cyanotic  Diaphoretic  
 Cold  Cool  Hot  Warm  Dry  Moist  
 Oedema:  Generalised  Localised to: \_\_\_\_\_ (sacral, ankle etc)

ECG Strips

**Rhythm Strip/ Haemodynamic Wave Forms**  
  
 PASTE STRIP HERE

**Gastrointestinal**

See **Critical Care Flow Chart for Rate/Type of Enteral Feeding and TPN**

**Abdomen:**  Soft  Firm  Flat  Rounded  
 Obese  Distended  Guarding  Rebound Tenderness

**Bowel Sounds:**  Absent  Present  
 Normal  Increased  Decreased

**Diet:**  NBM  CF  FF  Diet  Diabetic  Cardiac  Tube feeds  
 Special Consistency: \_\_\_\_\_  Other\*

**Feeding Tube:** Type: \_\_\_\_\_ Insitu to: \_\_\_\_\_ (L/R nare, mouth etc.)  
 Gastric  Duodenal  Jejunal

Insertion site:  Intact  Other\*  Placement verified by: \_\_\_\_\_  
 Administering Feeds  Clamped  Aspirated q4h  Straight drainage

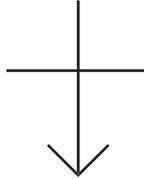
Description of aspirate: \_\_\_\_\_  
 \*Other (description) \_\_\_\_\_

**Stool:** Last BM: \_\_\_\_/\_\_\_\_/\_\_\_\_  Prior to admission  
 Stool colour: \_\_\_\_\_ Stool characteristic: \_\_\_\_\_

**Ostomy:**  Type: \_\_\_\_\_ Appearance of Stoma: \_\_\_\_\_

**Abdominal Drain:**  Type: \_\_\_\_\_ Location: \_\_\_\_\_  
 Drainage (describe): \_\_\_\_\_

+++ Incision  
 X Drain  
 /// Bruising  
 > Stab Site  
 O Ostomy



**Genitourinary**

See **Critical Care Flow Chart for Urine Output, Fluid Balance, & CRRT Monitoring**

**Catheter:**  Type: \_\_\_\_\_ Size: \_\_\_\_\_ Urine (description) \_\_\_\_\_

**Urethral/vaginal discharge:**  Describe: \_\_\_\_\_  Menstruating

**Vascular Access**

See **Critical Care Flow Chart for Drugs, Infusions, Concentrations, & Rates**

<p><input type="checkbox"/> <b>CVC:</b>          # Lumens _____ Location: _____</p> <p><b>Lumen's:</b> <input type="checkbox"/> Patent <input type="checkbox"/> Heparin lock <input type="checkbox"/> Other*</p> <p><b>Flush Bag:</b> <input type="checkbox"/> Normal saline  <input type="checkbox"/> Pressurised and adequate fluid  <input type="checkbox"/> Flushed and line transduced</p> <p><b>Site:</b> <input type="checkbox"/> No redness/swelling <input type="checkbox"/> Other*</p> <p><b>Dressing:</b> <input type="checkbox"/> D&amp;I *(describe) _____</p> <p><input type="checkbox"/> <b>PIV #1:</b>          Location: _____</p> <p><b>Site:</b> <input type="checkbox"/> No redness/swelling <input type="checkbox"/> Other*</p> <p><b>Dressing:</b> <input type="checkbox"/> D&amp;I *(describe) _____</p>	<p><input type="checkbox"/> <b>Arterial Line/ PICCO:</b>          Location: _____</p> <p><b>Flush Bag:</b> <input type="checkbox"/> Normal saline  <input type="checkbox"/> Pressurised and adequate fluid  <input type="checkbox"/> Flushed and line transduced</p> <p><b>Site:</b> <input type="checkbox"/> No redness/swelling <input type="checkbox"/> Other*</p> <p><b>Dressing:</b> <input type="checkbox"/> D&amp;I *(describe) _____</p> <p><input type="checkbox"/> <b>Other line</b>          Type: _____ Location: _____</p> <p><b>Site:</b> <input type="checkbox"/> No redness/swelling <input type="checkbox"/> Other*</p> <p><b>Dressing:</b> <input type="checkbox"/> D&amp;I *(describe) _____</p>
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**Integument & Musculoskeletal**

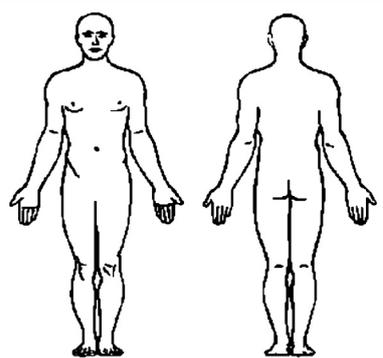
See **Critical Care Flow Chart for Position, Hygiene & activity**

Skin Condition (general) \_\_\_\_\_

<b>Sacrum</b> intact <input type="checkbox"/> marked <input type="checkbox"/> broken <input type="checkbox"/>	(L) (R) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>Heels</b> intact <input type="checkbox"/> marked <input type="checkbox"/> broken <input type="checkbox"/>	(L) (R) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>Elbows</b> intact <input type="checkbox"/> marked <input type="checkbox"/> broken <input type="checkbox"/>	(L) (R) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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Patient to be positioned 30 - 45 degrees head up unless contraindicated

Calf Compressor Device  TEDS



Dressing , Drain X, Splint ///

Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_\_ Name: \_\_\_\_\_ Signature: \_\_\_\_\_