

Assessment Checklist

Items	Status
Name: <u>Abdullah Eid ALAIWoot</u>	
Consent for services signed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NO
Date of visit <u>23/9/24</u>	Time of visit <u>11:30</u> Location <u>PT home</u> File number <u>400</u>
Patient Demographic	Gender <u>M</u> Age <u>73</u> Weight <u></u> ID <u></u>
Companion Data	Name <u></u> Relation: <u></u> ID <u></u>
Surgery	Knee replacement
Protocol	<input checked="" type="checkbox"/> Oral <input type="checkbox"/> Hybrid <input type="checkbox"/> IV
Number of visits	1/day for 5days <input type="checkbox"/> 2/day for days <input type="checkbox"/> As per Physician <input checked="" type="checkbox"/>
Medication on going.	Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Patient Vial count	Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Blood pressure <u>132/63</u>	Pulse Value Pre: <u>51</u> Post: <u></u> Respiratory rate: <u>16</u> Temperature <u>36.6°C</u> Blood Glucose /DL <u>141 mg/dL</u>
Oxygen saturation (SPO2) <u>97</u>	Pre: <u></u> Post: <u></u>
Allergy: <u>No:</u>	Urine (Normal) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Bowel Mvt (Normal) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Pain score	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Other Note <u></u>
Drainage wound care (every other day)	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Other Note <u></u>
Compressive socks	Fit <input checked="" type="checkbox"/> Tight <input type="checkbox"/> Loose <input type="checkbox"/>
Ice machine applied every 2H	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Medication counts correct	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Posture position optimal	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Documentation complete	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
scopolamine patch behind their ear	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site Clinical examination	Normal <input checked="" type="checkbox"/> Swelling <input type="checkbox"/> Inflamed <input type="checkbox"/> Oedema <input type="checkbox"/>
Surgical site Skin color	Normal <input checked="" type="checkbox"/> Bluish <input type="checkbox"/> Inflamed <input type="checkbox"/> Pale <input type="checkbox"/>
Psychological behavioral	Calm <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Restless <input type="checkbox"/> Agitated <input type="checkbox"/>
Emotions	Normal <input checked="" type="checkbox"/> Anxious <input type="checkbox"/> Sad <input type="checkbox"/> Tearful <input type="checkbox"/> Angry <input type="checkbox"/> Fretful <input type="checkbox"/>
Regular Sleep Pattern	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Speech	Normal <input checked="" type="checkbox"/> Abnormal <input type="checkbox"/>
Oriented	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Consciousness	Alert <input checked="" type="checkbox"/> Confused <input type="checkbox"/> Agitated <input type="checkbox"/> Drowsy <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <input type="checkbox"/>
Bed fall Risk	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Functional risk assessment	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Notify physician <input type="checkbox"/>
Laboratory test needed	<input checked="" type="checkbox"/> Yes <u>on 25/9/24</u> <input type="checkbox"/> NO
Urgent notification	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Note : <u></u>

Additional Observation: REMOVED THE CANNULA

Assessment done by	<u>R.N. Khalid Abdallah</u>
Date <u>23/9/24</u>	Morning <input checked="" type="checkbox"/> Afternoon <input type="checkbox"/> Night <input type="checkbox"/>
Signature	<u></u>