T.C. YEDİTEPE UNIVERSITY FACULTY OF HEALTH SCIENCES
NURSING DEPARTMENT
PATIENT EVALUATION FORM

Student Name and Surname : **Date : ...../...../.....**

Introductory Information

Patient name/surname:	Gender :
Age :	Information source:
Education level :	Job Status :
Marital status:	Number of children:
Phone Number. :	Social security: ( ) Yes ( ) No
City / District where the patient lives:	
Physician:	Nurse :

Communication

Used Language: ..... Translator Need: ( ) No ( ) Yes

Communication Status: ( ) Verbal ( ) Written ( )Other .....

Communicate to : ( )Refuse ( ) automatically initiates ( ) only answers questions asked

Name-Surname and Degree of Relationship of the Relative to be Contacted when Required:.....

Phone Number :

Perception of Health Status

Hospitalization Date and Time:	Protocol No:
Clinic :	Medical Diagnosis:
How to Arrive at the Hospital: ( ) Stretcher ( ) Wheelchair ( ) By walking ( ) Other	
Type of Hospital Admission: ( ) Emergency ( ) Elective	Planned Initiative / Operation:
State of Consciousness: ( ) Conscious ( ) Unconscious ( ) Oriented ( ) Confused	
Prostheses Used: ( ) No ( ) Dental ( ) Lens ( ) Glasses ( ) Hearing aid ( ) Hip ( ) Pacemaker ( ) Other :	

Food Allergy: ( ) No ( ) Yes	Drug Allergy: ( ) No ( ) Yes.....	Food Allergy: ( ) No ( ) Yes .....
Patient ID bracelet: ( ) Yes ( )No	Allergy bracelet ( ) Yes ( ) No	
Blood group:	Had a blood transfusion before? ( ) No ( ) Yes	

If there is a reaction during the transfusion, please specify:

Cigarette: ( ) Not used ( ) Uses ..... pack / day | Quit date:

Alcohol : ( )Not used ( ) Uses ..... quantity / day / week | Quit date:

Substance / Drug Abuse: ( ) No ( ) Yes ..... Quit Date :

Is Isolation Needed? ( ) No ( ) Yes If the answer is yes; **Infection Factor:** .....


( ) Contact


( ) Tight Contact


( ) Droplet


( ) Respiratory

Past Diseases:	**Chronic Diseases:** ( ) No		
( ) Measles ( ) Rubella	( ) Diabetes Mellitus	( ) Cancer	( ) Tendency to Bleeding
( ) Mumps ( ) Chickenpox	( ) Heart disease	( ) Kidney Problems	( ) Seizure Problems
( ) Asthma ( ) Tuberculosis	( ) Thyroid Problems	( ) Arthritis	( ) Stroke (Cerebro Vascular Attack)
( ) Pneumonia ( ) Rheumatic Fever	( ) Hypertension	( ) Ulcer	( ) Anemia
Other :	( ) Migraine / Headache ( ) Other :		

Previous Hospitalization Status: ( ) No ( ) Yes, explain : .....

Reason for hospitalization	**Date**	**Duration of stay**	**Result**

Family Health History and Relationships

Family Health History and Relationships

( ) No Feature

( ) DM : ……

( ) Hypertension : ……

( ) Cancer : ……

( ) Heart diseases: ……

( ) Asthma / Allergy: ……

( ) TBC : ……

( ) Others : ……

Regularly Used Medications

Name Of Drug	Administration Route	Dose	Frequency	Usage time	Last Usage Time
1.					
2.					
3.					
4.					
5.					

Is there a possibility for the patient to harm herself/himself and her/his environment? ( ) No ( ) Yes

The Need for Restrictions ( )No ( ) Yes

The Need for Restrictions ( )No ( ) Yes

Nutrition -Metabolic Pattern

Height: …… ( ) Weight: …… BMI : …… kg/m2

Weight changes in the last six months: ( ) No ( ) Yes : ……

( ) Can be fed alone ( ) Needs help

Oral (Diet): …… ( ) NG : …… Parenteral : ……

( ) Increased appetite ( ) Decreased appetite ( ) Distension ( ) Oral Mucosa Deterioration ( ) Change in Perception of Taste and Smell

( ) Nausea or Vomiting ( ) Problems in Teeth ( ) Dietary Restrictions ( ) Food Allergies

( ) Others, explain : ……

Number of Meals per Day: Main Meal: …… ( ) Snacks: …… Daily Fluid Intake: ……

Non-Preferred Foods: ……

Elimination

Bowel Habits: ( ) Normal ( ) Stoma ( ) Diaper

Frequency : ……/day Last defecation date: …… Quality: …… ( ) Use of laxatives: ……

( ) Incontinence (fecal) ( ) Constipation ( ) Melena ( ) Hematocesia ( ) Diarrhea

Bladder Habits: ( ) Normal ( ) Urostomy ( ) Catheterization:…… ( ) Dialysis: ……( ) Use of Diuretics: ……

Frequency : ……/day ( ) Incontinence (urinary) ( ) Anuria ( ) Polyuria ( ) Nocturia ( ) Oliguria ( ) Hematuria ( ) Dysuria ( ) Pollakiuria

Activity Exercise

Oxygen Use: ( ) No ( ) Yes, explain : ……lt/min (Mask / Nasal cannula etc)

( ) Tracheostomy ( ) Intubation ( ) Non-invasive Respiratory Support ( ) Duration……

Does patient exercise ( ) No ( ) Yes : Frequency: …… Duration : ……

Problems Experienced During Exercise: ( ) Chest Pain ( ) Throb ( ) Leg Pain ( ) Muscle Pain ( ) Dyspnoea ( ) Tiredness

( ) Other : ……

Performing Activities of Daily Living (According to Katz's Daily Living Activities Index)

Basic activity of Daily	Can do (3 points)	Help needed (2 points)	Cannot do (1 point)	Basic activity of Daily	Can do (3 points)	Help needed (2 points)	Cannot do (1 point)
-Bathing				-Transferring			
-Dressing				-Eating			
-Using the toilet				-Excretion			
Total	( ) 0-6 points : Dependent		( ) 7-12 points: Moderately Dependent		( ) 13-18 points : Independent		

Supporting Tools: ( ) No Requirement ( ) Crutches ( ) Grab Armbands ( ) Walking stick ( ) Wheelchair

( ) Others : ……

ITAKI FALLING RISK SCALE (FOR PATIENTS 17 YEARS AND OVER)

Evaluation Justification and Number:

1. Initial evaluation 2. Post-operative Period 3. Falling Patient 4. Change of clinical field (transferring) 5. Change of status

Fall Assessment		Risk factors	Justification for evaluation ( ) ……/……/……	Justification for evaluation ( ) ……/……/……
	Minor Risk Factors	65 years and older	1	1
		Unconscious	1	1
		Presence of history of falling within the last 1 month	1	1
		* Has a history of chronic illness	1	1
		Needs physical support (walker, crutches, personal support, etc.) while standing /walking.	1	1
		Urinary / fecal incontinence disorder	1	1
		Eyesight is poor	1	1
		More than 4 drugs used	1	1
		** Less than 3 care equipment attached to the patient	1	1
		Bed railings are missing / not working	1	1
		Physical obstacle (s) in walking areas	1	1
	Major Risk Factors	Conscious, not cooperative	5	5
		Balance problem when standing / walking	5	5
		Has dizziness	5	5
		Has orthostatic hypotension	5	5
		Has vision impairment	5	5
		Has a physical disability	5	5
		3 and more care equipment attached to the patient	5	5
		*** Risky drug use in the last week	5	5
	TOTAL SCORE			
	Intern Student Making the Assessment			

RISK LEVEL DETERMINATION TABLE

LOW RISK	A total score below 5
HIGH RISK	A total score of 5 and above (use the falling figure)

INFORMATION TABLE OF ITAKI FALLING RISK SCALE

*** Chronic Diseases**		*** Chronic Diseases**	*** Chronic Diseases**	
□ Hypertension	□ Hypertension	□ Hypertension	□ Hypertension	□ Hypertension
□ Digestive System	□ Digestive System	□ Digestive System	□ Digestive System	□ Digestive System
□ Respiratory System	□ Respiratory System	□ Respiratory System	□ Respiratory System	□ Respiratory System
□ Circulatory System Diseases	□ Circulatory System Diseases	□ Circulatory System Diseases	□ Circulatory System Diseases	□ Circulatory System Diseases
□ Neurological Diseases	□ Neurological Diseases	□ Neurological Diseases	□ Neurological Diseases	□ Neurological Diseases

Reference: Tanı V. ve ark. Düşme Riskinin Değerlendirilmesi Sağlık Akademisyenleri Dergisi 2014; 1(1):21-26

HARIZMI FALLING RISK SCALE (0 - 16 YEARS)

Evaluation Justification and Number:

1. Initial evaluation 2. Post-operative Period 3. Falling Patient 4. Change of clinical field (transferring) 5. Change of status

Fall Assessment	Risk factors	Justification for evaluation ( ) ……/……/……	Justification for evaluation ( ) ……/……/……
	1) Has a neurological disease / symptom	5	5
	2) A change in oxygenation	5	5
	3) Has specific disease / symptom in terms of falling risk	15	15
	4) Is not put in a suitable bed	5	5
	5) Has vision impairment	5	5
	6) 3 or more care equipment attached to the patient	5	5
	7) Needs physical support (walker, crutches, personal support, etc.) while standing /walking.	5	5
	8) The patient is in the first 48 hours post-op.	5	5
	9) There is a risky drug use	5	5
	10) 0-3 age	15	15
	TOTAL SCORE		
	Intern Student Making the Assessment		

RISK LEVEL DETERMINATION TABLE

LOW RISK	**LOW RISK**
HIGH RISK	**HIGH RISK**

INFORMATION TABLE OF HARISM FALLING RISK SCALE

Neurological Diseases / Symptoms		**Neurological Diseases / Symptoms**		**Neurological Diseases / Symptoms**	
□Epilepsy	□Balance disorder	□ Thrombocytopenia	□ Idiopathic Thrombocytopenic Purpura	□ Hypnotics	□ Narcotics
□Mental Retardation	□Cooperation disorder etc	□ Hemophilia	□ Glass Bone Disease	□ Barbiturates	□ Chemotherapeutics
□Convulsion				□ Neuroleptics	□ Sedatives
Oxygenation Changes		**Patient Care Equipment**		□Antidepressants	□ Laxatives / Diuretics
□ Acidosis □ Edema	□ Dehydration	□ IV Infusion	□ Respirator	□ Acidosis	□ Antihypertensives
□ Anemia □ Anorexia	□ Syncope □ Dizziness	□ Permanent Catheter	□ Anemia		
□ Respiratory Diseases	□ Hypotension etc.	□ Perfuser Infusion pump	□Pacemaker etc.		

Sleep-Rest	**General Habits of Sleeping:** Normal Sleep Time: …… Sleeping Time: …… Time to fall asleep : …… Feeling rested after sleep: …… Daytime sleep: …… Waking up often: …….. Waking up early : …… Change in sleep time: …… **Using Methods That Make It Easier To Sleep:** ( ) Using drug (type, dose of drugs, frequency) : …… ( ) Take a bath ( ) Reading a book ( ) Listening to music ( ) Listening to relaxation tapes ( ) Other : …… **The Consequences and Causes of Change in Sleep Process**: …… …… **The Effect of Health / Cultural Beliefs on Sleeping Habits (religious, ethnic, cultural, etc.)**: ……
Sexuality-Breeding	**Compliance of General Appearance with identity**: ( ) No ( ) Yes Expressing a sexual problem: ( ) No ( ) Yes : …… **Does She / he receive help / medication / treatment for sexual problems?** : ( ) No ( ) Yes : …… **The need for knowledge about sexually transmitted diseases**: ( ) No ( ) Yes : …… **Receiving Infertility Treatment**: ( ) No ( ) Yes Number of pregnancies (Gravida): …… Number of births (Parity): …… Living child: …… Abortion-Abortus: …….. Age of menarche: …… Menstruation time: ……day Cycle of Menstruation: ……day **Menstrual disorder:** ( ) No ( ) Yes: …… Menopause: ( ) No ( ) Yes: …… **Education Requirements on Methods of Family Planning**: ( ) No ( ) Yes: …… **Gynecological Problems (disease, surgery):** …… Latest Pap-Smear Date and Result: Does She/he make self-examination breast / testicular examination regularly: ( ) No ( ) Yes: …….. Last examination date:……
Role-Relationship	**Situation of living with together**: ( ) Alone ( ) Family ( ) Couple/Partner ( ) Friends ( ) Other: …… **Individuals obligated to look after:** ( ) No ( ) Yes: …… **Disease-related work situation affected**: ( ) No ( ) Yes: …… Income status: ( ) Enough ( ) Partially enough ( ) Insufficient **Support Systems** (Family, Friend, Economic, Cultural, Social): ( ) No ( ) Yes:…… **The person was responsible for the care of the patient at home**: …… **The impact of the disease on family roles**: …… **Exploitation:** ( ) No ( ) Yes: …….. **Neglect:** ( ) No ( ) Yes: ……..
Self Perception Grip	**Perception of health status** (Evaluation with a score between 0 - 10) : …… **Emotional response regarding health status**: ( ) Denial ( ) Anger ( ) Chaffer ( ) Depression ( ) Acceptance ( ) Other:…… **Health checkups**: ( ) Regular ( ) Partially regular ( ) Irregular ( ) Not done **Perception of body image**: ( ) Satisfied ( ) Partially Satisfied ( ) Not satisfied **Self-definition of the patient** (Change in self-perception after illness or self-perception is questioned): ……
Coping styles	**Stress:** ( ) No ( ) Yes (Evaluation with a score between 0 - 10) : …… Perceived real and potential stressors:…… **Methods Used to Cope with Problems:** ( ) Problem Solving, Crying ( ) Praying ( ) Sharing Your Feelings ( ) Obtaining information ( ) Diverting attention to other areas ( ) Eating something ( ) Walking and exercise ( ) Exercise of Breathing ( ) Take a bath ( ) Reading a Problem-Oriented Book / Magazine ( ) Asking Problem-Related Questions and Obtaining Information ( ) Drinking alcohol or smoking ( ) Using drugs Experiencing loss / change in recent time: ( ) No ( ) Yes: ……
Values and Beliefs	**Preference of special dressing**: ( ) No ( ) Yes …… The **habit of special veiling**: ( ) No ( ) Yes…… Situations that will affect care and treatment in line with spiritual needs (blood transfusion, post-death care, eating habits, etc.)…… Practices specific to the belief that he / she wants to do while in the hospital ( ) No ( ) Yes Explain:……

FORM OF PHYSICAL EVALUATION

Vital Signs	Blood pressure: ……/……. …..mmHg	Breathing : ……/dk	Body Temperature: ……^{0}C	Pulse : ……../dk	SpO_2 : %.....

Pain

Does the patient have pain now?: ( ) No ( ) Yes

Where is the pain: ……

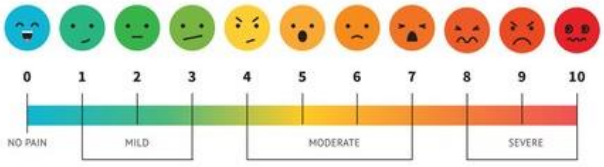
When did it start?: ……

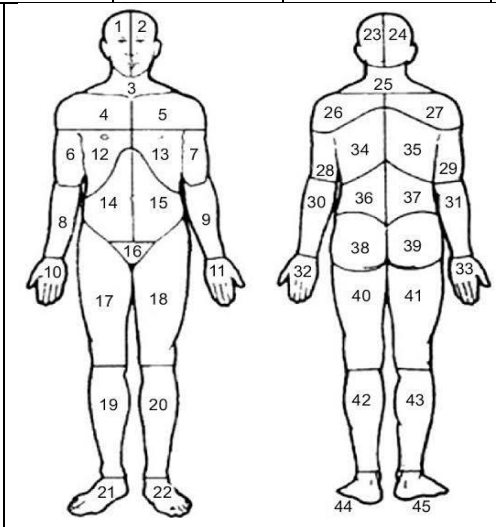
What is its quality?: ……

Factors that increase pain: ……

Factors that decrease pain: ……

Plot the current pain intensity on the scale.





Quality	**Pharmacological treatment**	**Non-pharmacological treatment**	**Responses against pain**
1.Charley horse 2.Flammable 3.Stinging 4.Spasm 5.Throbbing 6.Pressure 7. Crushers/ squeezers	1. Nonsteroidal anti-inflammatories 2. Narcotic analgesics 3. Adjuvant therapy 4.Other ……	1.Massage 2. Distraction 3.Music 4. Change of position 5. Hot / cold application 6.Other……	1.Anger/Crying 2.Decreased activity 3.Decreased appetite 4.Sleeping problems 5.Poor concentration 6.Asking for analgesia 7. Sweating / throb 8.Other ……

Follow-up of pain: If the patient has pain and an attempt is made (medication, cold application, etc.), write the course of the pain.

If medication has been prescribed for your patient's pain, note:

Date	**Hour**	**Name of drug**	**Dose**	**Via**

Skin System and Leather Attachments

Skin: ( ) Normal ( ) Dry ( ) Moist / sweaty ( ) Red ( ) Cyanotic ( ) Cold ( ) Warm ( ) Faint

( ) Jaundice ( ) Petechiae ( ) Purpura ( ) Ecchymosis ( ) Hematoma ( ) Itching ( ) Lesion ( ) Scar ( ) Other: ……

Leather turgor: ( ) Normal ( ) Diminished /Dehydrated Edema: ( ) No ( ) Yes , write the location:……

Gode : ( ) +1 [0-15 sec] ( ) +2 [15-30 sec] ( ) +3 [30-45 sec] ( ) +4 [45 sec and over] ( ) No gode

Nails: ( ) Normal ( ) Clubbing ( ) Cyanosis ( ) Other: ……

IV catheter: ( ) No ( ) Peripheral ( ) Central ( ) Time of insertion of IV catheter: …… ( ) Appearance : ……

BRADEN SCALE (A total score of less than 16 indicates the risk of pressure injury.)

Sense / Perception		**Moisture**		**Activity**		**Mobility**		**Nutrition**		**Friction & Shear**		**Total**
Completely limited	1	Constantly moist	1	Bedfast	1	Completely immobile	1	Very poor	1	Problem	1	
Very limited	2	Very moist	2	Chairfast	2	Very limited	2	Probably inadequate	2	Potential problem	2	
Slightly limited	3	Occasionally moist	3	Walks occasionally	3	Slightly limited	3	Adequate	3	No apparent problem	3	
No impairment	4	Rarely moist	4	Walks frequently	4	No limitation	4	Excellent	4			

Pressure Sore ( ) Where is its location: …… Phase: ( ) Phase I ( ) Phase II ( ) Phase III ( ) Phase IV

CLASSIFICATION OF PRESSURE SORE

PHASE I	The area is rash, the skin is intact, and it is reversible with protective measures.	**PHASE III**	A subcutaneous ulcer that does not spread to the muscle.
PHASE II	It is a superficial ulcer with impaired skin integrity and may have the appearance of erythema.	**PHASE IV**	It is an ulcer that also involves muscles or bones.

Head, Face and Neck System

Hair / Scalp: ( ) Clean ( ) Oily ( ) Dry ( ) Dandruff ( ) Shedding ( ) Mass ( ) Scar

Mouth-Throat: ( ) Throat ache ( ) Status of Lymph Nodes

Voice: ( ) Normal ( ) Raucous ( ) Has difficulty speaking

Swallow: ( ) Normal ( ) Dysphagia ( ) Odynophagia

Lips: ( ) Pink and colorful ( ) Dry and cracked ( ) Wound / bleeding ( ) Bruising

Tongue: ( ) Pink and colorful ( ) Red ( ) Chapped ( ) Wound / bleeding ( ) Other

Saliva: ( ) Normal ( ) Diminished ( ) Increased ( ) Dark or sticky

Oral mucosa : ( ) Pink and colorful ( ) Dry ( ) Mouth sore ( ) Bleeding ( ) Halitosis

Gums: ( ) Pink and colorful ( ) Edematous/Red ( ) Bleeding ( ) The number of decayed teeth: ……

Lymphadenopathy: ( ) No ( ) Yes (location) : …….. ( ) Preoricular ( ) Suboccipital ( ) Tonsils ( ) Posterior cervical ( ) Submandibular ( ) Subclavicular ( ) Axils ( ) Cervical ( ) Inguinal

Eyes: ( ) Red ( ) Combustion/Sting ( ) Itching ( ) Effluence ( ) Strabismus ( ) No problem

Color of Conjunctiva:……..

Ears: ( ) Effluence ( ) Ringing ( ) Malformation ( ) Itching ( ) No problem ( ) Hearing problem, write:……..

Nose: ( ) Effluence ( ) Epistaksis ( ) Reduced smelling ( ) Defect ( ) Blockage ( ) No problem

Impaired sense of taste: ( ) No ( ) Yes: ……

Cardiovascular System

Hit the apex (by hand) ( ) Felt ( ) Not felt

Explain if there is any pathological finding in heart sounds: ……..

Pulse : ( ) Normal ( ) Tachycardia ( ) Bradycardia ( ) Throb ( ) Filiform (fibrous)

Apical rhythm: ( ) Regular ( ) Irregular

Peripheral Pulses: 0 = No 1 = Weak 2 = Mid 3 = Strong

Pulses	Left	Right	Pulses	Left	Right
Brachial			Femoral		
Radial			Dorsalis Pedis		
Popliteal			Posterior Tibial		

Blood Pressure: ( ) Normal ( ) Hypertension ( ) Hypotension ( ) Orthostatic Hypotension

( ) Neck veins fullness ( ) Cyanosis ( ) Chest pain ( ) Syncope ( ) Varicose vein ( ) Pretibial edema ( ) No problem

Capillary Refill Time: ( ) < 3 sec. ( ) > 3 sec. Homans Sign : ( ) No ( ) Yes

Respiratory System

The shape of chest: ( ) Normal ( ) Abnormal : ……..

Chest: ( ) Equally-symmetrically participates in breathing ( ) Does not participate equally-symmetrically in breathing

Quality of breathing : ( ) Regular ( ) Irregular ( ) Dyspnoea ( ) Paroxysmal Nocturnal Dyspnea ( ) Orthopnea ( ) Cyanosis ( ) Apnea ( ) Bradypnoea ( ) Tachypnea ( ) Hyperventilation ( ) Hypoventilation ( ) Cheyne-Stokes Respiration ( ) Kussmaul Respiration ( ) Biot Respiration ( ) Hemoptysis

Respiratory Sounds : ( ) Normal ( ) Abnormal ---> ( ) Rales ( ) Rhonchus ( ) Wheezing ( ) Stridor

Pain with breathing: ( ) No ( ) Yes

Cough: ( ) No ( ) Yes, explain [dry cough, cough with phlegm etc.] : ……

Phlegm: ( ) No ( ) Yes, explain [color, consistency etc.] : ……

Gastrointestinal System

( ) Hematemesis ( ) Hemorrhoids ( ) Stomachache ( ) Epigastric burning

Abdomen : ( ) Tender ( ) Tense ( ) Rigid ( ) Distension ( ) Scar ( ) Mass ( ) Acid ( ) Debris ( ) Color change ( ) Hepatomegaly

Bowel sounds: ( ) Normoactive ( ) Hyperactive ( ) Hypoactive

Rebound sensitivity: ( ) No ( ) Yes ( ) No problem

Musculoskeletal System

( ) No problem

( ) Kyphosis ( ) Scoliosis ( ) Lordosis ( ) Spinal Deformity ( ) Tremor ( ) Amputation ( ) Walking disruption ( ) Posture deterioration

Joints: ( ) Normal ( ) Red ( ) Swelling ( ) Limitation of movement ( ) Contracture ( ) Deformity

Strength: Upper limb: ROM : ( ) Complete ( ) Limited / Lower limb : ROM : ( ) Complete ( ) Limited

Neurological System and Emotional Status

( ) Dizziness ( ) Headache ( ) Weakness ( ) Have an attack ( ) Sedated ( ) Peripheral neuropathy

Light reflex : Right: + / - Left: + / - Pupil size: ( ) Isochoric ( ) Anisocoric

Control of swallowing: ( ) Normal ( ) Can't swallow

Control of sense: ( ) Normal ( ) Loss of feeling ( ) Numbness/Tingle ( ) Hot/Cold intolerance

Coordination of balance: ( ) No ( ) Yes Handgrip (Right/Left) : ( ) Equal ( ) Nor equal ( ) Strong ( ) Weak

Use of leg muscles (Right/Left) : ( ) Equal ( ) Not equal ( ) Strong ( ) Weak ( ) Paralysis ( ) Paranesthesia ( ) Hemiplegia ( ) Paraplegia ( ) Quadriplegia

Emotional Status: ( ) Calm ( ) Depressed ( ) Crying ( ) Excited ( ) Anxious ( ) Uneasy ( ) Angry ( ) No problem

GLASGOW COMA SCALE

Eye Opening Response		**Motor Response**		**Verbal Response**	
No response	1	No response	1	No response	1
To pain	2	Abnormal extension	2	Incomprehensible sounds	2
To speech	3	Abnormal flexion	3	Inappropriate words	3
Spontaneously	4	Flex to withdraw from pain	4	Confused	4
		Moves to localized pain	5	Oriented to time, person, and place	5
		Obeys command	6		

Total point: ( ) 3-8 point Coma ( ) 8-9 point Stupor ( )10-11 point Lethargy
( )12-13 point Confusion ( )13-14 point Delirium and Mild neurological damage ( )15 point Conscious

LABORATORY FINDINGS

Date	Name of Test	Normal Values	Patient's Values	Interpretation of the Findings

RADIOLOGICAL EXAMINATIONS

Date	Name of Test	Result

PHARMACEUTICAL APPLICATIONS TRACKING SCHEDULE

STARTING DATE	NO	NAME OF DRUG	DOSAGE	FREQUENCY	HOURS OF THE MEDICINE DELIVERED	CUT DATE
	1					
	2					
	3					
	4					
	5					
	6					
	7					
	8					
	9					
	10					
	11					
	12					
	13					
	14					
	15					
	16					
	17					
	18					
	19					
	20					
	21					

DATE	REGISTER OF THE DRUGS GIVEN (Write your medicines with the number)																								IMPLEMENTING NURSE
	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07	

ISSUES TO BE CONSIDERED IN THE DISCHARGE PLAN

Drug :

……

……

……

Diet :

……

……

Exercise :

……

……

Supporting self-care / special health needs:

……

……

Medical Examination:

……

……

Education for the complications of the disease:

……

……

……

……

NURSING DIAGNOSIS DETERMINED IN THE PATIENT (write in order of priority)	
Collaborative Diagnoses	**Nursing Diagnoses and Risks**
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**
5.	**5.**
6.	**6.**
7.	**7.**
8.	**8.**
9.	**9.**
10.	**10.**

EDUCATION PLAN

The subject of Education : ..... **Education Place, Time and Duration:**.....

Educational Objectives:

.....

Material to be used: .....

Content of the Education:

.....

Evaluation Questions of Education:

1) .....
2) .....

Evaluation of Education:.....

References:.....

MEDICAL DIAGNOSTIC INFORMATION FORM
Medical Diagnosis of the Patient:
Etiology:
Pathophysiology:
Diagnostic Methods:
Clinical Symptoms - Signs:
Medical Treatment and Nursing Management:
References: **1)** **2)** **3)** **4)** **5)**

FORM OF DRUG INFORMATION	
Drug & Dosage	
Route of Administration	
Mechanism of Action	
Why is the patient taking this drug?	
Side effects	
Drug & Dosage	
Route of Administration	
Mechanism of Action	
Why is the patient taking this drug?	
Side effects	
Drug & Dosage	
Route of Administration	
Mechanism of Action	
Why is the patient taking this drug?	
Side effects	
Drug & Dosage	
Route of Administration	
Mechanism of Action	
Why is the patient taking this drug?	
Side effects	
Drug & Dosage	
Route of Administration	
Mechanism of Action	
Why is the patient taking this drug?	
Side effects	
Drug & Dosage	
Route of Administration	
Mechanism of Action	
Why is the patient taking this drug?	
Side effects	