

## **Nursing Admission Note**

## **Template**

Use this templated guide for writing effective nursing admission notes. Please keep in mind that charting by exception keeps your documentation concise and relevant to the needs of the patient.

Patient Name	DOB (mo/day/yr)	
Preferred Name (if applicable)	Admission Date/Time	
Sex (M/F)	Chief Complaint (or diagnosis)	
Known Allergies		
Relevant Medical History		
Risk Considerations  • Fall Risk  • Braden Score  • Suicide or Self-Harm Risk  • Infection Control Precautions		
<ul> <li>Psychosocial/Cultural Needs</li> <li>Mental Status</li> <li>Language/Interpreter Needs</li> <li>Mobility Status</li> <li>Living/Support Situation</li> <li>Cultural/Spiritual Consideration</li> </ul>	ons	

## **Initial Assessment Concerns**

<ul> <li>Last Set of Vital Signs</li> <li>BP</li> <li>HR</li> <li>Temp</li> <li>RR</li> <li>O2</li> </ul>			
Standard Exam Findings Outside of Standard Functional Limits  • Neurological  • Respiratory  • Cardiovascular  • Gastrointestinal  • Genitourinal  • Musculoskeletal  • Psychiatric			
nitial Impression and Care Goals			
Immediate Interventions Performed  Examples:  • Precautions  • Escalated Monitoring  • Completed Emergency or ASAP Orders			
Priority Care Objectives  Examples:  • Planned Next Steps of Care  • Recommendations			

Nurse's Signature/Credentials\_\_\_\_\_\_Date/Time\_\_\_\_\_