HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Pediatric Intensive Care Unit (PICU)		
Document:	Departmental Policy and Procedure		
Title:	Admission to Pediatric Intensive Care Unit		
Applies To:	All Pediatric Intensive Care Unit Staffs		
Preparation Date:	January 12, 2025	**Index No:**	PICU-DPP-003
Approval Date:	January 26, 2025	**Version :**	2
Effective Date:	February 26, 2025	**Replacement No.:**	PICU-DPP-003 (2)
Review Date:	February 26, 2028	**No. of Pages:**	13

1. PURPOSE:

1.1 To provide consistent process for admission to the pediatric intensive care unit.
1.2 To establish system and set responsibilities for pediatric intensive care unit.

2. DEFINITIONS:

2.1 **Admission** – is allowing a patient to stay in the hospital for investigations and treatment of disease. It delineates the steps taken for admitting patients to the pediatric intensive care unit.
- 2.1.1 **ER** – emergency room
- 2.1.2 **PMW** – pediatric medical ward
- 2.1.3 **PIMC** – pediatric intermediate care unit

3. POLICY:

3.1 The unit follows this policy in accordance with Maternity and Children Hospital, Hafer Al Batin policy for admission.
3.2 Admissions to pediatric intensive care unit are accepted from the emergency room, pedia medical ward, PIMC and referrals from other hospital.
3.3 The admissions are based on the admission criteria (see the policy of admission criteria to PICU).
3.4 The specialist on duty informs the on call consultant about all admissions as soon as possible.
3.5 Patient should be properly identified from the time of admission (application of patient's ID band with patient's 4 names for the Saudi/complete name for the Non – Saudi, medical record number, age and gender).

4. PROCEDURE:

4.1 The pediatric intensive care unit bed capacity is 5 beds and 1 bed for the isolation room.
4.2 Admission from ER:
- 4.2.1 The ER physician examines the patient and informs specialist on duty. They order and interpret result of required preliminary investigations that would help in making decision for admission.
- 4.2.2 The specialist on call will inform consultant and after consultation, they will arrange bed in PICU.
- 4.2.3 For critical patient e.g. requiring resuscitation, hemodynamically unstable etc., the ER team starts resuscitative management and immediately calls PICU consultant.
- 4.2.4 The team urgently stabilizes the patient and shifts him/her to PICU as quickly as possible.

4.3 Admission from PMW/PIMC:
- 4.3.1 If patient in PMW or PIMC has potential for significant deterioration or who require frequent monitoring of vital signs/mechanical ventilation will be transferred to PICU after being assessed by the physician.

4.4 Referred Patients:
- 4.4.1 Referred patients from other hospital are accepted by the consultant according to the admitting diagnosis of the patient.
- 4.4.2 If bed are not available, a fax reply is being sent stating the reason for non – acceptance.

4.5 The Pediatric physician will sign the admission request form, assess all new admission with specialist and approves the management plan.

4.6 Upon admission the assessment forms are duly filled by physicians and nurses.

4.7 The identification band is checked upon admission (4 names for the Saudi/ complete name for the Non – Saudi and Medical Record Number).

4.8 The admitting specialist or consultant discusses the status, immediate plans and interventions for the expected outcomes.

4.9 The physician obtains informed consent from parents (if needed).

4.10 Upon admission, the physician will write the order to be carried out including vital signs, blood work, radiological investigations, medications and etc.

4.11 The accepted age of the patient on admission is from 29 days to 14 years.

4.12 If the patient is suspected/confirmed of any infections, patient should be kept in the isolation room.

4.13 Nurses role in admission process:
- 4.13.1 Prepare the patient bed.
- 4.13.2 Obtain the medical equipment needed (preparing ventilator, cardiac monitors, suction machines etc.).
- 4.13.3 Do the initial nursing assessment.
- 4.13.4 Initiate nursing plan of care.
- 4.13.5 Carry out the Physician orders.
- 4.13.6 Document the changes in patients on the nurse's progress notes and inform the physician time to time.

5. MATERIAL AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

6.1 Physicians

6.2 Nurse

7. APPENDICES:

7.1 Admission Request Form

7.2 Physician's Order Form

7.3 Transfer in Form (SBAR Process)

7.4 Infant /Pediatric Nursing Initial/Admission Assessment Form

7.5 Nurse's Progress Notes

8. REFERENCES:

8.1 American Academy of Pediatrics, Committee on Hospital Care and Pediatric Section of the Society of Critical Care Medicine, 2014.

8.2 Guidelines and Levels of Care for Pediatric Intensive Care Units. Pediatrics, 2014.

8.3 Joint Commission of International Accreditation Standards for hospital. Access to Case and Continuity of care, 6th edition, 2017.

9. APPROVALS:

	Name	Title	Signature	Date
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Reviewed by:	Mr. Sabah Turayhib Al Harbi	Director of Nursing		January 13, 2025
Reviewed by:	Dr. Ali Alfayez	PICU Head of the Department		January 14 2025
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KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ____/____/14____ H ____/____/20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

ADMISSION REQUEST FORM

Mobile Number:

ADMITTING CONSULTANT _____

SOURCE OF REFERRAL: ☐ Emergency Department ☐ Outpatient Clinics ☐ Day Care

☐ Others, please specify; _____

Category of Admission : ☐ Emergency ☐ Urgent ☐ Elective within _____ weeks (choose from 1 to 52)

Current Medical Problem? ☐ None ☐ Yes,: _____

_____

Current Medication? ☐ None ☐ Yes,: _____

_____

ADMISSION DIAGNOSIS: _____

_____

PLANNED SURGICAL PROCEDURE: ☐ None _____

_____

ESTIMATED BLOOD NEED: ☐ None ☐ Yes, _____ **Number of Units** _____ **Unit (s)**

Date of Admission (if Available): _____ **Estimated Length of Stay: (L.O.S)** _____ **days**

Date of Procedure (if Available): _____ **Expected Duration of procedure:** _____ **mins**

Admitting Officer: _____ **Signature:** _____ **Date:** ___/___/___

Admitting Consultant: _____ **Signature:** _____ **Date:** ___/___/___

ANESTHESIA CLINIC

PRE-OPERATIVE ASSESSMENT:

☐ Medically Fit and Ready for Surgery ☐ Needs further investigations ☐ Needs Referral

Plan: _____

_____

Anesthesiologist: _____ Signature: _____ Date: ___/___/___

Paid Treatment: Name: _____ Signature: _____
(Admitting Officer Team)

BED MANAGEMENT

Date of admission: ___/___/___ Time: _____ Department: _____

Ward/ Bed Number: _____ Name of Bed Manage. Officer: _____ Sign.: _____

OR COOR/ ADMISSION OFFICER

DONATION: ☐ Yes, Date___/___/___ ☐ No, (why) _____

Name of OR Coordinator / Admission Officer: _____ Signature: _____

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Region: ____________ المنطقة/المحافظة:

Dept./Unit: ____________ القسم/الوحدة:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: ____________ الاسم:

Nationality: ____________ الجنسية:

Age: ____________ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ___/___/14___ H ___/___/20___ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

PHYSICIAN ORDER FORM

ALLERGIC TO:

DATE	TIME	PHYSICIAN ORDERS	PHYSICIAN STAMP / SIGNATURE	RN INITIAL / JOB NUMBER

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Dept./Unit: _____ القسم/الوحدة:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ____/____/14____ H ____/____/20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

TRANSFER IN FORM (SBAR PROCESS)

DATE: TIME:

Situation

Transfer from / Transfer /Report To: _____ ☐ ID Band

Reason/Procedure: _____

Background:

Diagnosis: _____

Code Status: ☐ Full Code ☐ No Code/DNR ☐ DNI

Glasgow coma scale: ☐ Oriented/Follows Instructions ☐ Confused/Unable to Follow Instructions

Diet: _____

Fall Risk: ☐ Yes ☐ No Restraints: ☐ Yes ☐ No

Transfer Status: ☐ Walking ☐ Bed ☐ On chair ☐ Others _____

Ability to Stand: ☐ Independently ☐ With Assistance ☐ Unable to Stand ☐ On bed rest

Protective Isolation: ☐ None ☐ Contact ☐ Airborne ☐ Droplet ☐ Reverse ☐ Standard.

Any culture (s) sent before transferring the patient to be followed by the receiving area.

☐ No ☐Yes (please specify date and site) _____

Communication: ☐ Language: _____ ☐ Hard of Hearing ☐ Visual Impairment

Other: _____

Assessment

Oxygen: Type of O2: _____ L/min.

Cardiac Rhythm: ☐ Sinus Rhythm ☐ Controlled Atrial fibrillation ☐ Bradycardia ☐ tachycardia

HR: ☐ BP: ☐ Temp: ☐ RR: ☐ Pain Score: ☐

IV/Tubes/Drains: ☐ IV ☐ Foley ☐ NG ☐ Other: _____

Allergies: _____

LABS: _____

Recent Medications/Narcotics: _____

Other: _____

Recommendation

Post Procedure Comments: _____

For Questions, Call: _____

Name: الاسم:	MRN: رقم الملف الطبي:

Current Medication List

1		15	
2		16	
3		17	
4		18	
5		19	
6		20	
7		21	
8		22	
9		23	
10		24	
11		25	
12		26	
13		27	
14		28	

Physician Name:_____ Stamp&Signature:_____

Sending Unit:_____ Nurse Name:_____ Signature:_____ Job number_____

Receiving Unit:_____ Nurse Name:_____ Signature:_____ Job number_____

GDOH-INP-TIF-159 ISSUED DATE:09/02/2013 2 OF 2 0 000000 001595 SN

Maternity and Children Hospital Hafar Al Batin, KSA

Infant/Pediatric Nursing Initial/Admission Assessment Form

NAME: _____

MRN : _____

ROOM NO: _____ BED NO: _____ AGE: _____

DATE & TIME OF ADMISSION: _____

DATE OF BIRTH: _____

GENDER: ☐ MALE ☐ FEMALE

DIAGNOSIS: _____

I. ADMISSION SOURCE: ☐ ER ☐ One Day Care ☐ OPD/ Clinic ☐ Other: _____

MODE OF ARRIVALS: ☐ Walking ☐ Stretcher/ Bed ☐ Wheelchair ☐ Other _____

INFORMATION SOURCE: ☐ Patient ☐ Family ☐ Old Records ☐ Not Available

II. ALLERGIES: ☐ Yes ☐ No If yes, include medication, food and food products _____

III. VITAL SIGNS:

Temperature:	Respiratory Rate:	Weight:	Pain Score:
Pulse:	Blood Pressure:	Height:	

IV. LEVEL OF CONSCIOUSNESS: ☐ Alert ☐ Lethargic ☐ Stuporous ☐ Coma

V. POSITION: ☐ Prone ☐ Supine ☐ Fowler's ☐ Semi-Fowler's ☐ Others _____

VII. RESPIRATORY STATUS: (AIRWAYS)

- Maintains own

☐ Mechanical Ventilator ☐ Spontaneous
☐ SIMV
☐ CMV
FIO_2 _____ O_2 _____ Resp. R. _____
PEEP _____ TV _____

ETT Size TT Size
☐ Oral airways size
☐ Nasal airway size
☐ Oxygen at _____ LPM
☐ Mask ☐ Nasal Cannula

VIII. BREATHING

A. Rhythm	B. Depth	C. Quality	D. Cough	E. Bronchial/ Lung Sound
☐ Regular ☐ Irregular ☐ Paradoxical	☐ Normal ☐ Shallow ☐ Deep	☐ Normal ☐ Labored ☐ Stridor	☐ None ☐ Productive ☐ Non-Productive	☐ Normal ☐ Rhonchi ☐ Wheeze ☐ Crackles

IX. CIRCULATION

A. Pulse		B. Skin			C. Infusion
☐ Regular ☐ Irregular	☐ Normal ☐ Weak ☐ Bounding	☐ Normal ☐ Warm ☐ Mottled ☐ Diaphoretic	☐ Pale ☐ Cyanotic ☐ Cool ☐ Edema	☐ Flushed ☐ Jaundice ☐ Dry	1. IV Fluids _____ at _____ ml level _____ drop per minute 2. IV Fluids _____ at _____ ml level _____ drop per minute

X. NUTRITION

Diet:	Alternative Route:	Nutritional Screening:
☐ Regular ☐ Special ☐ Fluid Restriction Amount: _____	☐ Nasogastric Tube (Size) _____ ☐ Gastric Tube (Size) _____ ☐ Total Parenteral Nutrition _____	(Refer to Dietitian if any of the below apply) ☐ Malabsorption ☐ Renal Disease ☐ Liver Disease ☐ BMI less than 19 or Greater than 40 ☐ Unable to take oral feeding ☐ Others _____ Referred: Yes No
Appetite ☐ Good ☐ Fair ☐ Poor Comments: _____	**Difficulties:** ☐ Swallowing ☐ Nausea ☐ Vomiting ☐ Indigestion	

XI. ELIMINATION

Bowel Movement
☐ Normal ☐ Constipation
☐ Loose ☐ Colostomy

Urine
☐ Normal ☐ Amber ☐ Polyuria ☐ Cloudy ☐ Oliguria ☐ Hematuria
☐ Foley Catheter Fr. Size _____
☐ Condom Catheter Connected to Urine bag, amount _____

XII. OTHERS: (Gastric tubes, dressing, restraint (cuff), pressure sore) _____

XIII. MEDICATION BROUGHT FROM HOME: (Include Homeopathic Remedies) ☐ Yes ☐ No

Medication	Dose	Route	Frequency	Last Dose	If unable to take, why?

XIV. LOCATION OF MEDICATION:

☐ None ☐ Given to Pharmacy ☐ Given to Family ☐ Given to Patient Care Area

XV. FUNCTIONAL SCREENING:

If patient needs assistance with any of the following, refer to rehabilitation **Date:** _____

Physical Therapy	☐ Mobility in Bed	☐ Transfer	☐ Walking	☐ N/A
Occupational Therapy	☐ Eating ☐ Washing	☐ Toileting ☐ Yes ☐ No ☐ Dressing ☐ Transfer		☐ N/A ☐ N/A
Speech Therapy	☐ Swallowing			☐ N/A

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RN Initial/ Date/ Time:

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Infant/Pediatric Nursing Initial/Admission Assessment Form

NAME: _____

MRN : _____

ROOM NO: _____ BED NO: _____ AGE: _____

DATE & TIME OF ADMISSION: _____

DATE OF BIRTH: _____

GENDER: ☐ MALE ☐ FEMALE

XVI: PAIN ASSESSMENT SCALE:

A. Numerical Rating Scale : Pain Score 0-10 (0-No Pain), (5-Moderate Pain), (10-Worst Possible Pain)
Pain Score: _____

B. Wong Baker Pain Scale: (Tick the appropriate)

Intensity: ☐ No Pain ☐ 1-2 Mild Pain, Annoying ☐ 3-4 Nagging Pain, Uncomfortable ☐ 5-6 Miserable ☐ 7-8 Intense, Dreadful, Horrible ☐ 9-10 Worst Pain, Possible

C. Behavioral Pain Scale (To assess pain in ventilated, unconsious and/or sedated patients, please write appropriate answer and sum up)

CATEGORY DESCRIPTION

CATEGORY	DESCRIPTION	SCORE	PATIENT'S SCORE
Facial Expression	Relaxed	1	
	Partially Tightened (e.g. brow lowering)	2	
	Fully Tightened (e.g. Eyelid Closing)	3	
	Grimacing	4	
Upper Limb	No Movement	1	
	Partially Bent	2	
	Fully Bent, with finger flexion	3	
	Permanently Retracted	4	
Compliance with Ventilation	Tolerating Movement	1	
	Coughing with Movement	2	
	Fighting with ventilator	3	
	Unable to control ventilation	4	
	PATIENT'S TOTAL PAIN SCORE		

SCORING 0-3 No Pain 4-6 Mild Pain 7-9 Moderate Pain 10-12 Severe Pain

a. **Location:** Where does it hurt? _____ b. **Onset:** When did the pain start? _____

c. **Duration:** How long have you had this pain? _____

d. **Quality:** ☐ Constant, on and off ☐ Radiating ☐ Dull or Sharp ☐ Burning on pressure

XVII. "BRADEN SCALE" SKIN RISK ASSESSMENT (Write the appropriate answer and sum up from "a" to "f" to get the total score)

CATEGORY	PARAMETERS	SCORE	PATIENT'S SCORE
A. SENSORY PERCEPTION	No Impairment	4	
	Lighty Limited	3	
	Very Limited	2	
	Complete Limited	1	
B. MOISTURE	Rarely Moist	4	
	Occasionally Moist	3	
	Very Moist	2	
	Constantly Moist	1	
C. ACTIVITY	Walks Frequently	4	
	Walks Occasionally	3	
	Chair Bound	2	
	Bedfast	1	
D. MOBILITY	No Limitation	4	
	Slightly Limited	3	
	Very Limited	2	
	Completely Immobile	1	
E. NUTRITION	Excellent	4	
	Adequate	3	
	Probably Inadequate	2	
	Very Poor	1	
F. SHEAR & FRICTION	No Apparent Problem	4	
	Potential Problem	3	
	Problem	2	
	Significant Problem	1	
"BRADEN SCALE" TOTAL PATIENT'S SKIN RISK ASSESSMENT SCORE **Score of less than 16, patient is "at risk" for the development of pressure sores.**			

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RN Initial/ Date/ Time:

Maternity and Children Hospital Hafar Al Batin, KSA

Infant/Pediatric Nursing Initial/Admission Assessment Form

NAME: _____

MRN : _____

ROOM NO: _____ BED NO: _____ AGE: _____

DATE & TIME OF ADMISSION: _____

DATE OF BIRTH: _____

GENDER: ☐ MALE ☐ FEMALE

XVIII. "HUMPTY DUMPTY" FALL RISK ASSESSMENT (Write & sum up the appropriate answer from "a" to "g" to get the total score is 12 or above at risk for falls) Minimum Score is 7 Maximum score is 23

PARAMETER	CRITERIA	SCORE / TIME			
A. Age	Less than 3 years old	4			
	3 to less than 7 years old	3			
	7 to less than 13 years old	2			
	13 years old and above	1			
B. Gender	Male	2			
	Female	1			
C. Diagnosis	Neurological Diagnosis	4			
	Alteration in Oxygentaion (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/ Dizziness, etc.)	3			
	Psychological/ Behavioral Disorders	2			
	Other Diagnosis	1			
D. Cognitive Impairments	Not Aware of Limitation	3			
	Forgets Limitation	2			
	Oriented to own ability	1			
E. Environmental Facors	History of falls or Infants – Toddler placed in bed	4			
	Patient used assistive devices or Infant-Toddler in crib or furniture/ Lighting (Triple Room)	3			
	Patient Placed in bed	2			
	Outpatient area	1			
F. Response To Surgery/ Sedation/ Anesthesia	Within 24 hours	3			
	Within 48 hours	2			
	More than 48 hours/ None	1			
G. Medication Usage	Multiple usage of: Sedatives (excluding ICU patients sedated and paralyzed) Hypnotics, Barbiturates, Phenothiazines, Antidepressants, Laxatives/ Diuretics, Narcotics	3			
	One of the medications listed above	2			
	Other Medications/ None	1			
PATIENT' SCORE					
DATE					
INITIAL					
COMPUTER NO.					

Note: Perform "Humpty Dumpty" fall risks re-assessment every shift, ife there is a change of patient clinical status, post operative and other procedure, and after a fall. If the score is high risk educate and implement the intervention guide for fall risk prevention.

XIX. SOCIAL STATUS

☐ Single ☐ Married ☐ Lives Alone ☐ Lives with family ☐ Lives with Friends

XX. ORIENTATION TO UNIT/ ENVIRONMENT

☐ Toilets	☐ Phone	☐ ID Band	☐ Visitors Policy
☐ Patient Handbook	☐ Visiting Time	☐ Patient's right/ Responsibilities	☐ Smoking POlicy
☐ Bed Control/ Rails	☐ Call Bell	☐ Safety Measures	

XXI. EDUCATION/ GENERAL NEED

Repeated, unscheduled admissions	☐ Yes	☐ No
Newly diagnosed chronic/ terminal illness	☐ Yes	☐ No
Family education needed for in-home care	☐ Yes	☐ No

PHYSICAL DEFICITS (Please write appropriate information in examples)

Cardiovascular: ☐ Yes ☐ No Examples _____

Respiratory: ☐ Yes ☐ No Examples _____

Neurological: ☐ Yes ☐ No Examples _____

Sensory/ Speech: ☐ Yes ☐ No Examples _____

Gastrointestinal/ Nutritional : ☐ Yes ☐ No Examples _____

Genitourinary : ☐ Yes ☐ No Examples _____

Musculoskeletal/ mobility: ☐ Yes No Examples _____

Skin/ Wound: ☐ Yes ☐ No Examples _____

Cognitive/ Mental : ☐ Yes ☐ No Examples _____

Endocrine: ☐ Yes ☐ No Examples _____

Language Barriers : ☐ Yes ☐ No Examples _____

Other Concern: _____

Please affix your initial, date and time at the bottom of each page.
RN Initial/ Date/ Time:

Maternity and Children Hospital Hafar Al Batin, KSA

Infant/Pediatric Nursing Initial/Admission Assessment Form

NAME: _____

MRN : _____

ROOM NO: _____ BED NO: _____ AGE: _____

DATE & TIME OF ADMISSION: _____

DATE OF BIRTH: _____

GENDER: ☐ MALE ☐ FEMALE

XXII. DISCHARGE PLANNING		
SOCIOECONOMIC NEEDS:		
Lack of needed caregiver, Family Support	☐ Yes	☐ No
At Risk of abuse or neglect	☐ Yes	☐ No
Inadequate resources, insurance, financial	☐ Yes	☐ No
Foster parent, Guardian etc.	☐ Yes	☐ No
Inadequate or In Appropriate post hospital plans	☐ Yes	☐ No
ENVIRONMENTAL NEEDS:		
Change in living arrangements	☐ Yes	☐ No
In-home care or equipment	☐ Yes	☐ No
Vocational and/or role loss	☐ Yes	☐ No
Inability to complete ADL	☐ Yes	☐ No
PSYCHOLOGICAL NEEDS:		
Potential of harm to self or others	☐ Yes	☐ No
Suspected drug or alcohol abuse	☐ Yes	☐ No
Inappropriate patient/ family behaviors	☐ Yes	☐ No
Difficult adjustment to diagnosis (acceptance or diagnosis)	☐ Yes	☐ No

REFERRAL INDICATED:

Referal sent to: ☐ Social Services ☐ Home Care ☐ Other _____

High Risk indicated but no referral sent, why? _____

XXIII. GROWTH AND DEVELOPMENT	
Height:	**Head Circumference:**
Weight:	**BMI:**

XXIV. PROBLEM SUMMARY LIST "ACTION : REFER TO MULTIDISCIPLINARY PLAN OF CARE FORM"

SERIAL NUMBER	ASSESSMENT/ PATIENT NEEDS FINDINGS

NURSE NAME _____ SIGNATURE _____ DESIGNATION _____

COMPUTER NO. _____ DATE (DD/MM/YY) _____ TIME _____

NOTE: Please fill-up the data required completely and legibly. Put Check (✓) if applicable . Use military time on your documentation. Affix your initial, date, and time at the bottom of each page. Draw a line across empty spaces.

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Region: _____ المنطقة/المحافظة:

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MRN: | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ سنة Years ☐ شهر Months ☐ يوم Days ☐ العمر:

Date of Birth: ____ / ____ / 14____ H ____ / ____ / 20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

NURSES PROGRESS NOTES FORM

DATE &TIME	NURSES NOTES (D-data A-action R-response)	REGISTERED NURSE INITIAL WITH ID NUMBER

Note: Write the time in each entry & affix your initial at the end of each paragraph. Document your complete Name, Initial, Job number, Date & Time at the closure of your documentation. Draw a line across empty spaces.

Name: الاسم:	MRN: رقم الملف الطبي:

NURSES PROGRESS NOTES FORM

DATE &TIME	NURSES NOTES (D-data A-action R-response)	REGISTERED NURSE INITIAL WITH ID NUMBER

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