LEGEND: Areas enclosed in double lines and bolded are to be completed by PSW/RPN
All other areas to be completed by RPN or RN only

DATE: (D/M/Y)													
	Food taken	**B**	**L**	**D**	**B**	**L**	**D**	**B**	**L**	**D**	**B**	**L**	**D**
NUTRITION	Record breakfast, lunch and dinner as percentage												
	Swallowing problems(✓)												
	Supplements (✓)												
	Chewing problems (✓)												
	Tube feeding amt (mL)												
	Flushing amount (mL)												
	Total (mL)												
	24 hour total												
TIME OF DAY		**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**
VITAL SIGNS	Temperature												
	Pulse												
	Respiration												
	Blood pressure												
	Oxygen saturation												
	Weight												
PATIENT RATED PAIN INTENSITY	**10**	•	•	•	•	•	•	•	•	•	•	•	•
		•	•	•	•	•	•	•	•	•	•	•	•
		•	•	•	•	•	•	•	•	•	•	•	•
		•	•	•	•	•	•	•	•	•	•	•	•
	5	•	•	•	•	•	•	•	•	•	•	•	•
		•	•	•	•	•	•	•	•	•	•	•	•
		•	•	•	•	•	•	•	•	•	•	•	•
		•	•	•	•	•	•	•	•	•	•	•	•
	0	•	•	•	•	•	•	•	•	•	•	•	•
	Acceptable Y/N												
SPECIMENS	Type collected and time												
PROCEDURES/ TREATMENTS	Oxygen												
REST/UP	No. of hours up												
	No. of hours napping												
	No. of hours sleep												
LEVELS OF OBSERVATION	Routine checks(✓)												
	1:1 observation (✓)												
	Watchmate (✓)												
INITIALS	**PSW/ Care provider**												
	RPN/ RN												