

# Behavior Changes

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent     Non-Ambulatory     G-tube     Non-Verbal     Assistive Device  
Last BM \_\_\_\_\_

Describe the behavior: \_\_\_\_\_

When did it start? \_\_\_\_\_ Is this a new behavior? \_\_\_\_\_

If the behavior is not new, what has this behavior typically meant in the past? \_\_\_\_\_

Has the person had any change in routine or has anything abnormal happened? \_\_\_\_\_

Is the person communicating pain? \_\_\_\_\_

Are there any signs of infection? (redness, swelling, cough, fever, incontinence) \_\_\_\_\_

What makes the behavior worse/better? \_\_\_\_\_

Has any treatment been given? \_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

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Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

## Change in Condition

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent       Non-Ambulatory       G-tube       Non-Verbal       Assistive Device  
 Oxygen      Last BM \_\_\_\_\_

Description of condition (less responsive, lethargic, difficult to arouse, agitated, breathing difficulty): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does this person have:

Diabetes       Seizures       Change in Appetite/Weight/Fluid Intake       Other

Is there pain or discomfort? \_\_\_\_\_ Where? \_\_\_\_\_

What treatment has been done? \_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

## Change in Condition

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent       Non-Ambulatory       G-tube       Non-Verbal       Assistive Device  
 Oxygen      Last BM \_\_\_\_\_

Description of condition (less responsive, lethargic, difficult to arouse, agitated, breathing difficulty): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does this person have:

Diabetes       Seizures       Change in Appetite/Weight/Fluid Intake       Other

Is there pain or discomfort? \_\_\_\_\_ Where? \_\_\_\_\_

What treatment has been done? \_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

# Dental

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent     Non-Ambulatory     G-tube     Non-Verbal     Assistive Device

What is the person's temp? \_\_\_\_\_

Does the person have any of the following:  Bleeding gums     Facial swelling  
 Swollen gums     Odor from mouth     Chipped/Cracked teeth     Other

Did this person receive any injuries to the mouth? \_\_\_\_\_

Is the person in pain? \_\_\_\_\_ What has been done to relieve pain? \_\_\_\_\_

Are there behavioral changes? \_\_\_\_\_

Are there signs of infection or headache? \_\_\_\_\_

Is this person on seizure medications? \_\_\_\_\_ Name/Dose: \_\_\_\_\_

Is sedation required for dental procedures? \_\_\_\_\_ If yes, what type: \_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

# Dental

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent     Non-Ambulatory     G-tube     Non-Verbal     Assistive Device

What is the person's temp? \_\_\_\_\_

Does the person have any of the following:  Bleeding gums     Facial swelling  
 Swollen gums     Odor from mouth     Chipped/Cracked teeth     Other

Did this person receive any injuries to the mouth? \_\_\_\_\_

Is the person in pain? \_\_\_\_\_ What has been done to relieve pain? \_\_\_\_\_

Are there behavioral changes? \_\_\_\_\_

Are there signs of infection or headache? \_\_\_\_\_

Is this person on seizure medications? \_\_\_\_\_ Name/Dose: \_\_\_\_\_

Is sedation required for dental procedures? \_\_\_\_\_ If yes, what type: \_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

# Falls

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent     Non-Ambulatory     G-tube     Non-Verbal     Assistive Device  
Last BM \_\_\_\_\_

Date of fall: \_\_\_\_\_ Time of fall: \_\_\_\_\_ am or pm Staff \_\_\_\_\_

What was the person doing before the fall? \_\_\_\_\_

Where did the fall occur? \_\_\_\_\_

Was the person injured or lose consciousness? Describe: \_\_\_\_\_

\_\_\_\_\_

Recent history of falls?  Yes  No Describe: \_\_\_\_\_

History of:  Seizures     Diabetes     Psychiatric medication     Balance problems

List any known conditions that might increase the risk for falls: \_\_\_\_\_

Has pain med been given? \_\_\_\_\_ Name/Dose \_\_\_\_\_

\_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

\_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

# Falls

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent     Non-Ambulatory     G-tube     Non-Verbal     Assistive Device  
Last BM \_\_\_\_\_

Date of fall: \_\_\_\_\_ Time of fall: \_\_\_\_\_ am or pm Staff \_\_\_\_\_

What was the person doing before the fall? \_\_\_\_\_

Where did the fall occur? \_\_\_\_\_

Was the person injured or lose consciousness? Describe: \_\_\_\_\_

\_\_\_\_\_

Recent history of falls?  Yes  No Describe: \_\_\_\_\_

History of:  Seizures     Diabetes     Psychiatric medication     Balance problems

List any known conditions that might increase the risk for falls: \_\_\_\_\_

Has pain med been given? \_\_\_\_\_ Name/Dose \_\_\_\_\_

\_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

\_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

# Fever

Name\_\_\_\_\_ Age\_\_\_\_\_ BP\_\_\_\_\_ Temp\_\_\_\_\_ Pulse\_\_\_\_\_ Resp\_\_\_\_\_

Incontinent  Non-Ambulatory  G-tube  Non-Verbal  Assistive Device  
Last BM\_\_\_\_\_

When did fever start?\_\_\_\_\_ How high?\_\_\_\_\_  
Have there been any confusion or hallucinations?\_\_\_\_\_

Are there any signs of infection? (runny nose, cough, painful or frequent urination, nausea, vomiting, behavioral changes)\_\_\_\_\_

New Issue  Result of a fall or injury  At risk for skin breakdown

Has acetaminophen or ibuprofen been given?  Yes  No Did it lower the fever?  Yes  No  
Has there been a change in food and/or fluid intake?  Yes  No Describe:\_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

Physician Called\_\_\_\_\_ Date\_\_\_\_\_ Time\_\_\_\_\_

Completed by:\_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

# Fever

Name\_\_\_\_\_ Age\_\_\_\_\_ BP\_\_\_\_\_ Temp\_\_\_\_\_ Pulse\_\_\_\_\_ Resp\_\_\_\_\_

Incontinent  Non-Ambulatory  G-tube  Non-Verbal  Assistive Device  
Last BM\_\_\_\_\_

When did fever start?\_\_\_\_\_ How high?\_\_\_\_\_  
Have there been any confusion or hallucinations?\_\_\_\_\_

Are there any signs of infection? (runny nose, cough, painful or frequent urination, nausea, vomiting, behavioral changes)\_\_\_\_\_

New Issue  Result of a fall or injury  At risk for skin breakdown

Has acetaminophen or ibuprofen been given?  Yes  No Did it lower the fever?  Yes  No  
Has there been a change in food and/or fluid intake?  Yes  No Describe:\_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

Physician Called\_\_\_\_\_ Date\_\_\_\_\_ Time\_\_\_\_\_

Completed by:\_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

# Medication

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent     Non-Ambulatory     G-tube     Non-Verbal     Assistive Device  
Last BM \_\_\_\_\_

Omission     Wrong time     Wrong dose     Wrong person     Wrong medication     Other

Adverse drug reaction Signs/Symptoms of Adverse Reaction: \_\_\_\_\_

Medication involved: \_\_\_\_\_

If routine meds were not given—what medications were scheduled to be given at that time? \_\_\_\_\_

If wrong person's medications were given, what routine medications were given? \_\_\_\_\_

Is this medication for seizures or psychiatric diagnosis? \_\_\_\_\_

Has a recent level been drawn on this medication? \_\_\_\_\_ Results: \_\_\_\_\_

Has any treatment been given? \_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

# Medication

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent     Non-Ambulatory     G-tube     Non-Verbal     Assistive Device  
Last BM \_\_\_\_\_

Omission     Wrong time     Wrong dose     Wrong person     Wrong medication     Other

Adverse drug reaction Signs/Symptoms of Adverse Reaction: \_\_\_\_\_

Medication involved: \_\_\_\_\_

If routine meds were not given—what medications were scheduled to be given at that time? \_\_\_\_\_

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Is this medication for seizures or psychiatric diagnosis? \_\_\_\_\_

Has a recent level been drawn on this medication? \_\_\_\_\_ Results: \_\_\_\_\_

Has any treatment been given? \_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

# Nausea, Vomiting, Constipation or Diarrhea

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent     Non-Ambulatory     G-tube     Non-Verbal     Assistive Device  
Last BM \_\_\_\_\_

Description of concern (for example: chronic constipation, fecal impactions, c-diff, diarrhea, GERD): \_\_\_\_\_  
\_\_\_\_\_

When did the problem start? \_\_\_\_\_ How long has it been going on? \_\_\_\_\_

What treatment has been given? \_\_\_\_\_

Are there any complaints of stomach pain or tenderness? \_\_\_\_\_

Are there any changes in appetite/fluid intake? \_\_\_\_\_

Are there any unusual behavioral changes? \_\_\_\_\_

Is blood present in the stools or vomit (coffee ground emesis)? \_\_\_\_\_

Have the bowel movements over the past week been abnormal? \_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

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Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent     Non-Ambulatory     G-tube     Non-Verbal     Assistive Device  
Last BM \_\_\_\_\_

Description of concern (for example: chronic constipation, fecal impactions, c-diff, diarrhea, GERD): \_\_\_\_\_  
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List new medications: \_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

# Pain

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent     Non-Ambulatory     G-tube     Non-Verbal     Assistive Device  
Last BM \_\_\_\_\_

What did the person tell you about their pain? \_\_\_\_\_

What are the behavioral signs of the pain? \_\_\_\_\_

Where is the pain located? \_\_\_\_\_ When did it start? \_\_\_\_\_

What makes the pain better? \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

Has any treatment been given? \_\_\_\_\_

Was it effective? \_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

# Pain

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent     Non-Ambulatory     G-tube     Non-Verbal     Assistive Device  
Last BM \_\_\_\_\_

What did the person tell you about their pain? \_\_\_\_\_

What are the behavioral signs of the pain? \_\_\_\_\_

Where is the pain located? \_\_\_\_\_ When did it start? \_\_\_\_\_

What makes the pain better? \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

Has any treatment been given? \_\_\_\_\_

Was it effective? \_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

# Seizures

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent     Non-Ambulatory     G-tube     Non-Verbal     Assistive Device

What is the person's temp? \_\_\_\_\_ How long did the seizure last? \_\_\_\_\_

Description of the seizure: \_\_\_\_\_

Were there any injuries? \_\_\_\_\_

What was the behavior before the seizure? \_\_\_\_\_

After the seizure? \_\_\_\_\_

Is this person on seizure medications? \_\_\_\_\_ Name/Dose \_\_\_\_\_

Have any seizure medications been missed?  Yes  No

menses or PMS     flashing lights     illness (flu, etc)     exposed to hot weather

Has anything been done to help? \_\_\_\_\_

List medication allergies: \_\_\_\_\_

List new medications: \_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

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Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Incontinent     Non-Ambulatory     G-tube     Non-Verbal     Assistive Device

What is the person's temp? \_\_\_\_\_ How long did the seizure last? \_\_\_\_\_

Description of the seizure: \_\_\_\_\_

Were there any injuries? \_\_\_\_\_

What was the behavior before the seizure? \_\_\_\_\_

After the seizure? \_\_\_\_\_

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Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

# Skin

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

- Pressure Ulcer     Skin Tear     Other     Non-Ambulatory     Non-verbal  
 Wound     Rash     Incontinent     G-tube     Assistive Device

Description of condition: (location, size, bleeding, draining, swelling, odor, spreading) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there pain or discomfort? \_\_\_\_\_ Describe: \_\_\_\_\_  
 New Issue     Result of a fall or injury     At risk for skin breakdown  
(non-ambulatory)

What treatment has been done? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List medication allergies: \_\_\_\_\_  
List new medications: \_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_

# Skin

Name \_\_\_\_\_ Age \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

- Pressure Ulcer     Skin Tear     Other     Non-Ambulatory     Non-verbal  
 Wound     Rash     Incontinent     G-tube     Assistive Device

Description of condition: (location, size, bleeding, draining, swelling, odor, spreading) \_\_\_\_\_  
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Is there pain or discomfort? \_\_\_\_\_ Describe: \_\_\_\_\_  
 New Issue     Result of a fall or injury     At risk for skin breakdown  
(non-ambulatory)

What treatment has been done? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List medication allergies: \_\_\_\_\_  
List new medications: \_\_\_\_\_

Physician Called \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Completed by: \_\_\_\_\_ Name of supervisor notified: \_\_\_\_\_