Skills Check-off Scenarios

Scenario I

The following scenarios were designed for the beginning of the semester skills check-offs for the fourth semester students. The skills including vital signs, IV medications, abbreviated physical assessments and catheterizations.

Objectives:

1. Assessment and recognition of the signs and symptoms of congestive heart failure
    a. Assess for respiratory problems related to congestive heart failure
    b. Assess vital signs related to congestive heart failure
    c. Assess for dysrhythmias
    d. Assess Intake and Output for other signs of fluid retention.
2. Initiate interdisciplinary collaboration in a hospital setting.
    a. Report changes in the patient's condition to the physician
    b. Implement new orders received from the physician
    c. Chart findings on the appropriate charting sheets
3. Select appropriate interventions
    a. Check vital signs.
    b. Oxygen – Apply 2-4 L/nasal cannula as ordered
    c. Insert a Foley catheter
    d. Complete an assessment specific to evaluate congestive heart failure.
    e. Administer an IV medication
4. Monitor therapeutic response to interventions (Outcomes).
    a. Monitor that patient will not have difficulty breathing and will maintain oxygen saturations at $\geq$ 90%.
    b. Monitor urinary output

Case study: You are working the day shift at Butler Simulation Hospital. John Sims, a seventy-five year old male was admitted to your unit with hypertension, peripheral edema and shortness of breath. He has a past history of congestive heart failure. He was started on oxygen at 4 L via nasal canula and given 40 mg furosemide IV in the ER. His chest x-ray showed bilateral effusions in both lower lobes of his lungs. The ER doctor sent preliminary orders and said his primary care doctor would be in to write further medication orders. In report the ER nurse told you that John had taken his digoxin and aspirin this AM. It is now 1300. Begin initiating the orders from the order sheet.

Butler Clinical Learning Center Simulation Orders

ORDERED		Name: John A. Sims DOB 5/11/32
DATE	TIME	
	0730	ADMIT TO: ☒Telemetry Floor ☐Non-telemetry Floor
		DIAGNOSIS: ☐ Diabetes, ☐R/O Myocardial Infarction, ☒CHF, ☐S/P CABG, ☐Chest Pain, ☐Head Injury, ☐Stroke, ☐GI Bleed, ☐S/P Lung surgery______, ☐S/P abdominal surgery____, ☐S/P ortho surgery_______, ☐MVC________, ☐HTN, ☐Cancer____________☐Other_____________
		ALLERGIES: ☒No ☐Yes If yes, list:
		ACTIVITY: ☐ Bedrest ☒ BRP ☐ Activity as tolerated ☐ Other: ☐ I & O
		VITAL SIGNS: ☒ Every 4 hours ☐ Every shift Other: ☒O2 Sats. Q shift
		DIET: ☐NPO ☐ Clear liquid ☒2gm Low Na, low fat, ☐1800kcal ADA, ☐2000kcal ADA ☐ Other ________________________________
		☒ IV: Saline Lock ☐ D51/2NS with 20mEq KCL TRA _______ ☐ 0.9% Sodium Chloride IV TRA _____ ☐ Lactated Ringers TRA _______ ☐ Other: _______________________________
		O_2: ☐ None ☐ 2Liters/minute via Nasal Cannula ☐ Other: ___________ ☒ titrate to keep sats > 90%
		MEDICATIONS: ☒ Aspirin non enteric coated 325 mg po daily ☐ Acetaminophen 650mg po q 6 hours prn pain or temp > 101.5 F. ☒ laxative of choice ☐ Zolpidem 5 mgs prn HS ☒ NS flush IV BID and prn for IV flush Others__Nitroglycerin 0.4 mg SL prn chest pain q 5 minutes x 3 Digoxin 0.5 mg po q. AM Repeat furosemide 40 mg IV x1 after admission to floor ____
		(Treatments) ☒ Place Foley to DD ☐Dressing Changes ________________________________ ☐ Place NG Tube ☐ Other _________
		LAB TESTS: ☐ CBC ☐ Chem 7 ☐Routine UA ☐ Others_________________________________
		X-Rays: ☒ chest x-ray in AM ☐ Other ________________________________ ☐ ECG stat if chest pain occurs, notify MD
		☐ Additional orders

Date________ Time_1115____ Signature: *Dr. Chester Hart* *Patient ID*

Developed by dms Butler Community College

Butler Clinical Learning Center Medication Sheet

NURSING STATION WORKSHEET (MAR FORMAT)

ROOM-BED	PATIENT	DOB	WT	AGE/SEX	ADM DATE	ATTENDING PHYSICIAN
B5	**John A Sims**	5/11/32	81 kg	75/male	today	Dr. Hart

DRUG ALLERGIES: No known allergies

MEDICATION	ROUTE/SIG	ORDERING DOSE	0800-1559	1600-2359	0000-0759
Furosemide	IV on admission to floor	40 mg			
Digoxin	po	0.5 mg	0900		
Aspirin	po	325 mg	0900		
MOM	po prn	30 ml			
Nitroglycerin	SL prn chest pain q 5 min. x 3	0.4 mg			
Normal Saline Flush	IV bid and prn		0900	2100	

Signature/Initials

_________________________/______ _________________________/______
_________________________/______ _________________________/______
_________________________/______ _________________________/______
_________________________/______ _________________________/______
_________________________/______ _________________________/______

LABORATORY REPORT

Date	Time	Exam	Result
	0845	CBC	
		RBC	5.2 mc/L
		WBC	6400 mc/L
		Hct.	42%
		Hgb	13 gm/dL
		Platelet	160,000 ul
		MCV	84 f
		MCH	28 pg/cell
		MCHC	33 gm/dL
	0845	BMP	
		Sodium	135 mEq/L
		Potassium	2.9 mEq/L (L)
		Chloride	96 mEq/l
		Magnesium	2.1 mg/dL
	0845	ABGs	
		pH	7.35
		PaCO2	35 mm Hg
		PaO2	77 mm Hg (L)
		SO2	88 % (L)

REPORT OF MEDICAL HISTORY	Date of Exam

Note: This information is for official and medically-confidential

MEDICAL RECORD

l use only and will not be released to unauthorized persons.

1. Name of Patient (First, Middle, Last)	2. Identification Number	3. Date of Birth
John A Sims	004303336	5/11/32

4a. Home street address			5. Examining Facility
511 Eleventh St.			Butler Community College Simulation Hospital
4b. City	State	Zip Code	
Yourcity	KS	67042	

6. Patient's occupation	7a. Height	b. Weight
Homemaker	5'10"	81 Kg

8. Current Used Medications at Home	9. Allergies (include medications, latex, bee stings and food)
Digoxin 0.125 mg daily Capoten 25 mg bid	Penicillin

10. Past/Current Medical History

Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Household Contact with anyone with tuberculosis		x		Shortness of Breath	x			Bone or join deformity		x	
Tuberculosis or positive TB test		x		Pain or Pressure in chest	x			Loss of finger or toe		x	
Blood in Sputum or when coughing		x		Chronic Cough	x			Painful shoulder or elbow		x	
Excessive bleeding after injury or dental work		x		Palpitation or pounding heart	x			Recurrent back pain or any back injury	x		
Suicide attempt or plans		x		Heart trouble	x			Knee injury		x	
Sleepwalking		x		High blood pressure	x			Foot trouble			
Wear corrective lenses	x			Low blood pressure		x		Nerve injury		x	
Eye surgery to correct vision		x		Cramps in your legs		x		Paralysis		x	
Complete vision loss in either eye		x		Frequent Indigestion		x		Epilepsy or seizure		x	
Wears a hearing aid		x		Stomach, liver, or intestinal trouble		x		Car, train, or sea sickness		x	
Stutters or Stammers		x		Gall bladder trouble		x		Frequent trouble sleeping	x		
Wears a brace or back support		x		Jaundice or Hepatitis		x		Depression or excessive worry		x	
Scarlet fever		x		Broken bones		x		Loss of memory		x	
Rheumatic fever		x		Skin diseases		x		Nervous trouble of any sort		x	
Swollen or painful joints		x		Tumor, growth, cyst, or Cancer		x		Periods of unconsciousness		x	
Frequent or severe headache		x		Hernia		x		Parent/sibling with diabetes, cancer, stroke or heart disease.		x	
Dizziness or fainting spells	x			Hemorrhoids or rectal Disease		x					
Eye Trouble		x		Frequent or painful urination		x		X-Ray or other radiation therapy		x	
Hearing Loss		x		Bed wetting since age 12		x		Chemotherapy		x	
Recurrent ear infections		x		Kidney stones or blood in urine		x		Asbestos or toxic chemical exposure		x	
Chronic or frequent colds	x			Sugar or Protein in urine		x		Plate or pin in any bone		x	
Severe tooth or gum trouble		x		Sexually transmitted disease(s)		x		Been told to cut down or criticized for alcohol use		x	
Sinusitis		x		Recent gain or loss of weight	x						
Hay Fever or allergic rhinitis		x		Eating Disorder		x		Easily fatigued	x		
Head injury		x		Arthritis, Rheumatism, or Bursitis		x		Used illegal substances		x	
Asthma		x		Thyroid trouble		x		Used tobacco		x	

11. Females only answer section 11

Check each item	Yes	No	Don't Know	Date of last menstrual period	Date of last pap smear	Date of last mammogram
Treated for a female disorder						
Change in menstrual pattern						

Check each item. If "yes," explain in blank space to right. List explanation by item number.

ITEM	Yes	No	
12. Have you been refused employment or been unable to hold a job or stay in school because of:			
a. Sensitivity to chemicals?		x	
b. Inability to perform certain motions?		x	
c. Inability to assume certain positions?		x	
d. Other medical reasons? (If yes, give reasons.)		x	
13. Have you ever been treated for a mental condition? (If yes, describe and give age at which occurred.)		x	Heart problems 2004
14. Have you had, or have you been advised to have, any operation? (If yes, describe and give age at which occurred.)		x	
15. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	x		
16. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)		x	
17. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, specify.)		x	
18. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and reason.)		x	
19. Have you ever been diagnosed with a learning disability? (If yes, give type and what is needed to help overcome.)		x	

20. List all immunizations received

Polio, Tetanus, Pneumonia

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics and their staff that are directly providing management of my care to review and input data into the Medical Record in accordance with local, state, and federal laws.

24a. Typed or Printed Name	24b. Signature	24c. Date
John Sims	John Sims	

NOTE: THIS DOCUMENT WILL BE PLACED IN THE MEDICAL RECORD

25. Physician's summary and elaboration of all pertinent data.

Chronic Heart Failure
Pleural effusion

26a. Typed or Printed Name of Physician or Examiner	26b. Signature	26c. Date	Patient Label Here
Dr. Simulation Getwell	Dr. Simulation Getwell		

Designed by mt revised by dms Butler Community College

Skills Check-off Scenarios
Scenario II

The following scenarios were designed for the beginning of the semester skills check-offs for the fourth semester students. The skills including vital signs, IV medications, abbreviated physical assessments and catheterizations.

Objectives:

1. Assessment and recognition of the signs and symptoms of pulmonary edema related to renal failure
   - c. Assess for respiratory problems related to pulmonary edema
   - d. Assess vital signs related to renal failure/pulmonary edema
   - e. Assess for respiratory distress
   - f. Assess Intake and Output for other signs of fluid retention.
2. Initiate interdisciplinary collaboration in a hospital setting.
   - g. Report changes in the patient's condition to the physician
   - h. Implement new orders received from the physician
   - i. Chart findings on the appropriate charting sheets
3. Select appropriate interventions
   - j. Check vital signs.
   - k. Oxygen – Apply 2-4 L/nasal cannula as ordered
   - l. Insert a Foley catheter
   - m. Complete an assessment specific to evaluate pulmonary edema.
   - n. Administer an IV medication
4. Monitor therapeutic response to interventions (Outcomes).
   - o. Monitor that patient will not have difficulty breathing and will maintain oxygen saturations at $\geq$ 90%.
   - p. Monitor urinary output

Case study: It is shift change and you were assigned Joel A Sims who was admitted to your unit yesterday with a new diagnosis of renal disease. The night nurse reports that about one hour ago Joel had difficulty breathing and crackles in both lungs. His blood pressure is steadily rising. At 0630 it was 172/114. She notified the physician. He ordered stat Bumetanide and Hydralazine along with some other new orders. She gave the Bumetanide and was waiting for the Hydralazine to arrive from the pharmacy. X-ray was just completing the portable chest x-ray. The unit secretary calls that the hydralazine has just arrived from pharmacy. Using the order sheet begin the care on your patient.

Butler Clinical Learning Center Simulation Orders

ORDERED		Name: Joel A. Sims DOB 12/23/32
DATE	TIME	
	1500	ADMIT TO: ☒Telemetry Floor ☐Non-telemetry Floor
		DIAGNOSIS: ☐ Diabetes, ☐R/O Myocardial Infarction, ☐ CHF, ☐S/P CABG, ☐Chest Pain, ☐Head Injury, ☐Stroke, ☐GI Bleed, ☐S/P Lung surgery______, ☐S/P abdominal surgery____, ☐S/P ortho surgery_______, ☐MVC________, ☐HTN, ☐Cancer____________☐Other: renal disease
		ALLERGIES: ☒No ☐Yes If yes, list:
		ACTIVITY: ☐ Bedrest ☒ BRP ☐ Activity as tolerated ☐ Other: ☐ I & O
		VITAL SIGNS: ☒ Every 4 hours ☐ Every shift Other: ☒O2 Sats. Q shift
		DIET: ☐NPO ☐ Clear liquid ☐2gm Low Na, low fat, ☐1800kcal ADA, ☐2000kcal ADA ☐ Other ___renal diet__800 ml per day fluid restriction
		☒ IV: Saline Lock ☐ D51/2NS with 20mEq KCL TRA _______ ☐ 0.9% Sodium Chloride IV TRA _____ ☐ Lactated Ringers TRA _______ ☐ Other: _________________________________
		O_2: ☐ None ☐ 2Liters/minute via Nasal Cannula ☐ Other: ___________ ☒ titrate to keep sats > 90%
		MEDICATIONS: ☐ Aspirin non enteric coated 325 mg po daily ☒ Acetaminophen 650mg po q 6 hours prn pain or temp > 101.5 F. ☒ laxative of choice ☐ Zolpidem 5 mgs prn HS ☒ NS flush IV BID and prn for IV flush Others_______________________________ Bumetanide 1 mg IV now and repeat in four hours hydralazine 40 mg IV now ____
		(Treatments) ☒ Place Foley to DD now ☐Dressing Changes ________________________________ ☐ Place NG Tube ☐ Other _________
		LAB TESTS: ☐ CBC ☒ Chem 7 ☐Routine UA ☒ Others:_renal profile, serum creatine
		X-Rays: ☒ chest x-ray in AM ☐ Other _________________________________ ☐ ECG stat if chest pain occurs, notify MD
		☐ Additional orders

Date________ Time_1115____ Signature: *Dr. Chester Hart* *Patient ID*

Developed by dms Butler Community College

Butler Clinical Learning Center Medication Sheet

NURSING STATION WORKSHEET (MAR FORMAT)

ROOM-BED	PATIENT	DOB	WT	AGE/SEX	ADM DATE	ATTENDING PHYSICIAN
B6	**Joel A Sims**	12/23/32	81 kg	75/male	today	Dr. Hart

DRUG ALLERGIES: No known allergies

MEDICATION	ROUTE/SIG	ORDERING DOSE	0800-1559	1600-2359	0000-0759
Hydralazine	IV now	40 mg			
Normal Saline Flush	IV bid and prn		0900	2100	
Acetaminophen	Po prn pain or temp > 101.5	650 mg			
MOM	po prn	30 ml			
Bumetanide	IV now and repeat in 4 hours	1 mg	1100		

Signature/Initials

____________________________/______ ____________________________/______
____________________________/______ ____________________________/______
____________________________/______ ____________________________/______
____________________________/______ ____________________________/______
____________________________/______ ____________________________/______

LABORATORY REPORT

Date	Time	Exam	Result
	0845	CBC RBC WBC Hct. Hgb Platelet MCV MCH MCHC	 5.2 mc/L 6400 mc/L 42% 13 gm/dL 160,000 ul 84 f 28 pg/cell 33 gm/dL
	0845	BMP Sodium Potassium Chloride CO2 Magnesium	 135 mEq/L 2.9 mEq/L (L) 96 mEq/l 20 mEq/L (L) 1.9 mg/dL
	0845	BUN Creatinine Calcium Phosphorus	22 mg/dL (H) 1.7 mg/dL (H) 7.8 mg/dL (L) 4.9 mEq/dL (H)

MEDICAL RECORD	REPORT OF MEDICAL HISTORY	Date of Exam

Note: This information is for official and medically-confidential use only and will not be released to unauthorized persons.

1. Name of Patient (First, Middle, Last)	2. Identification Number	3. Date of Birth
Joel A Sims	0023033375	12/23/32

4a. Home street address			5. Examining Facility
1932 North First			Butler Community College Simulation Hospital
4b. City	State	Zip Code	
Yourtown	KS	67042	

6. Patient's occupation	7a. Height	b. Weight
Retired electrical engineer	5' 11"	81 Kg

8. Current Used Medications at Home	9. Allergies (include medications, latex, bee stings and food)
Crestor 10 mg once daily ASA 81 mg once daily	NKA

10. Past/Current Medical History

Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Household Contact with anyone with tuberculosis		x		Shortness of Breath	x			Bone or join deformity		x	
Tuberculosis or positive TB test		x		Pain or Pressure in chest		x		Loss of finger or toe		x	
Blood in Sputum or when coughing		x		Chronic Cough		x		Painful shoulder or elbow		x	
Excessive bleeding after injury or dental work		x		Palpitation or pounding heart	x			Recurrent back pain or any back injury		x	
Suicide attempt or plans		x		Heart trouble		x		Knee injury		x	
Sleepwalking		x		High blood pressure	x			Foot trouble		x	
Wear corrective lenses	x			Low blood pressure		x		Nerve injury		x	
Eye surgery to correct vision		x		Cramps in your legs	x			Paralysis		x	
Complete vision loss in either eye		x		Frequent Indigestion	x			Epilepsy or seizure		x	
Wears a hearing aid		x		Stomach, liver, or intestinal trouble		x		Car, train, or sea sickness		x	
Stutters or Stammers		x		Gall bladder trouble		x		Frequent trouble sleeping	x		
Wears a brace or back support		x		Jaundice or Hepatitis		x		Depression or excessive worry	x		
Scarlet fever		x		Broken bones		x		Loss of memory		x	
Rheumatic fever		x		Skin diseases		x		Nervous trouble of any sort		x	
Swollen or painful joints		x		Tumor, growth, cyst, or Cancer		x		Periods of unconsciousness		x	
Frequent or severe headache		x		Hernia		x		Parent/sibling with diabetes, cancer, stroke or heart disease.	x		
Dizziness or fainting spells		x		Hemorrhoids or rectal Disease		x					
Eye Trouble		x		Frequent or painful urination		x		X-Ray or other radiation therapy		x	
Hearing Loss	x			Bed wetting since age 12		x		Chemotherapy		x	
Recurrent ear infections		x		Kidney stones or blood in urine	x			Asbestos or toxic chemical exposure		x	
Chronic or frequent colds		x		Sugar or Protein in urine	x			Plate or pin in any bone		x	
Severe tooth or gum trouble		x		Sexually transmitted disease(s)		x		Been told to cut down or criticized for alcohol use		x	
Sinusitis		x		Recent gain or loss of weight	x						
Hay Fever or allergic rhinitis		x		Eating Disorder		x		Easily fatigued	x		
Head injury		x		Arthritis, Rheumatism, or Bursitis		x		Used illegal substances		x	
Asthma		x		Thyroid trouble		x		Used tobacco		x	

11. Females only answer section 11

Check each item	Yes	No	Don't Know	Date of last menstrual period	Date of last pap smear	Date of last mammogram
Treated for a female disorder						
Change in menstrual pattern						

Check each item. If "yes," explain in blank space to right. List explanation by item number.

ITEM	Yes	No	
12. Have you been refused employment or been unable to hold a job or stay in school because of:			
a. Sensitivity to chemicals?		x	
b. Inability to perform certain motions?		x	
c. Inability to assume certain positions?		x	
d. Other medical reasons? (If yes, give reasons.)		x	1933 repair of an inguinal hernia
13. Have you ever been treated for a mental condition? (If yes, describe and give age at which occurred.)		x	
14. Have you had, or have you been advised to have, any operation? (If yes, describe and give age at which occurred.)		x	
15. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	x		
16. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)		x	
17. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, specify.)		x	
18. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and reason.)		x	
19. Have you ever been diagnosed with a learning disability? (If yes, give type and what is needed to help overcome.)		x	

20. List all immunizations received

Polio, Tetanus, Pneumonia

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics and their staff that are directly providing management of my care to review and input data into the Medical Record in accordance with local, state, and federal laws.

24a. Typed or Printed Name	24b. Signature	24c. Date
Joel Sims	Joel Sims	

NOTE: THIS DOCUMENT WILL BE PLACED IN THE MEDICAL RECORD

25. Physician's summary and elaboration of all pertinent data.

History or hyperlipidemia

Recent symptoms of dull pain in right flank, 16 Kg weight gain, shortness of breath, blood in urine and hypertension.

Diagnosis renal failure—unknown cause.

26a. Typed or Printed Name of Physician or Examiner	26b. Signature	26c. Date	Patient Label Here
Dr. Chester Hart	Dr. Chester Hart		

Designed by mt revised by dms Butler Community College

Skills Check-off Scenarios

Scenario III

The following scenarios were designed for the beginning of the semester skills check-offs for the fourth semester students. The skills including vital signs, IV medications, abbreviated physical assessments and catheterizations.

Objectives:

5. Assessment and recognition of the signs and symptoms of congestive heart failure
    a. Assess for respiratory problems related to congestive heart failure
    b. Assess vital signs related to congestive heart failure
    c. Assess for dysrhythmias
    d. Assess Intake and Output for other signs of fluid retention.
6. Initiate interdisciplinary collaboration in a hospital setting.
    a. Report changes in the patient's condition to the physician
    b. Implement new orders received from the physician
    c. Chart findings on the appropriate charting sheets
7. Select appropriate interventions
    a. Check vital signs.
    b. Oxygen – Apply 2-4 L/nasal cannula as ordered
    c. Insert a Foley catheter
    d. Complete an assessment specific to evaluate congestive heart failure.
    e. Administer an IV medication
8. Monitor therapeutic response to interventions (Outcomes).
    a. Monitor that patient will not have difficulty breathing and will maintain oxygen saturations at $\geq$ 90%.
    b. Monitor urinary output

Case study: You are working the day shift at Butler Simulation Hospital. Sally Sims, a seventy-two year old female was admitted to your unit with hypertension, peripheral edema and shortness of breath. She has a past history of congestive heart failure. She was started on oxygen at 4 L via nasal canula and given 40 mg furosemide IV in the ER. Her chest x-ray showed bilateral effusions in both lower lobes of his lungs. The ER doctor sent preliminary orders and said his primary care doctor would be in to write further medication orders. In report the ER nurse told you that Sally had taken her digoxin and aspirin this AM. It is now 1300. Begin initiating the orders from the order sheet.

Butler Clinical Learning Center Simulation Orders

ORDERED		Name: Sally A. Sims DOB 4/30/36
DATE	TIME	
	0730	ADMIT TO: ☒Telemetry Floor ☐Non-telemetry Floor
		DIAGNOSIS: ☐ Diabetes, ☐R/O Myocardial Infarction, ☒CHF, ☐S/P CABG, ☐Chest Pain, ☐Head Injury, ☐Stroke, ☐GI Bleed, ☐S/P Lung surgery______, ☐S/P abdominal surgery____, ☐S/P ortho surgery_______, ☐MVC________, ☐HTN, ☐Cancer____________☐Other_____________
		ALLERGIES: ☒No ☐Yes If yes, list:
		ACTIVITY: ☐ Bedrest ☒ BRP ☐ Activity as tolerated ☐ Other: ☐ I & O
		VITAL SIGNS: ☒ Every 4 hours ☐ Every shift Other: ☒O2 Sats. Q shift
		DIET: ☐NPO ☐ Clear liquid ☒2gm Low Na, low fat, ☐1800kcal ADA, ☐2000kcal ADA ☐ Other ________________________________
		☒ IV: Saline Lock ☐ D51/2NS with 20mEq KCL TRA _______ ☐ 0.9% Sodium Chloride IV TRA _____ ☐ Lactated Ringers TRA _______ ☐ Other: _______________________________
		O_2: ☐ None ☐ 2Liters/minute via Nasal Cannula ☐ Other: ___________ ☒ titrate to keep sats > 90%
		MEDICATIONS: ☒ Aspirin non enteric coated 325 mg po daily ☐ Acetaminophen 650mg po q 6 hours prn pain or temp > 101.5 F. ☒ laxative of choice ☐ Zolpidem 5 mgs prn HS ☒ NS flush IV BID and prn for IV flush Others__Nitroglycerin 0.4 mg SL prn chest pain q 5 minutes x 3 Digoxin 0.5 mg po q. AM Repeat furosemide 40 mg IV x1 after admission to floor ____
		(Treatments) ☒ Place Foley to DD ☐Dressing Changes ______________________________ ☐ Place NG Tube ☐ Other _________
		LAB TESTS: ☐ CBC ☐ Chem 7 ☐Routine UA ☐ Others________________________________
		X-Rays: ☒ chest x-ray in AM ☐ Other ________________________________ ☐ ECG stat if chest pain occurs, notify MD
		☐ Additional orders

Date________ Time_1115____ Signature: *Dr. Chester Hart* *Patient ID*

Developed by dms Butler Community College

Butler Clinical Learning Center Medication Sheet

NURSING STATION WORKSHEET (MAR FORMAT)

ROOM-BED	PATIENT	DOB	WT	AGE/SEX	ADM DATE	ATTENDING PHYSICIAN
B4	**Sally A Sims**	4/30/36	81 kg	72/female	today	Dr. Hart

DRUG ALLERGIES: No known allergies

MEDICATION	ROUTE/SIG	ORDERING DOSE	0800-1559	1600-2359	0000-0759
Furosemide	IV on admission to floor	40 mg			
Digoxin	po	0.5 mg	0900		
Aspirin	po	325 mg	0900		
MOM	po prn	30 ml			
Nitroglycerin	SL prn chest pain q 5 min. x 3	0.4 mg			
Normal Saline Flush	IV bid and prn		0900	2100	

Signature/Initials

________________________________/______ ____________________________/________
________________________________/______ ____________________________/________
________________________________/______ ____________________________/________
________________________________/______ ____________________________/________
________________________________/______ ____________________________/________

LABORATORY REPORT

Date	Time	Exam	Result
	0845	CBC RBC WBC Hct. Hgb Platelet MCV MCH MCHC	 5.2 mc/L 6400 mc/L 42% 13 gm/dL 160,000 ul 84 f 28 pg/cell 33 gm/dL
	0845	BMP Sodium Potassium Chloride Magnesium	 135 mEq/L 2.9 mEq/L (L) 96 mEq/l 2.1 mg/dL
	0845	ABGs pH PaCO2 PaO2 SO2	 7.35 35 mm Hg 77 mm Hg (L) 88 % (L)

Developed by dms Butler cc

REPORT OF MEDICAL HISTORY

Date of Exam

Note: This information is for official and medically-confidential

MEDICAL RECORD

l use only and will not be released to unauthorized persons.

1. Name of Patient (First, Middle, Last)	2. Identification Number	3. Date of Birth
Sally A Sims	004303336	4/30/36

4a. Home street address			5. Examining Facility
430 Corona St.			Butler Community College Simulation Hospital
4b. City	State	Zip Code	
Yourcity	KS	67042	

6. Patient's occupation	7a. Height	b. Weight
Homemaker	5'5"	81 Kg

8. Current Used Medications at Home	9. Allergies (include medications, latex, bee stings and food)
Digoxin 0.125 mg daily Capoten 25 mg bid Calcium 500 mg bid	NKA

10. Past/Current Medical History

Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Household Contact with anyone with tuberculosis		x		Shortness of Breath	x			Bone or join deformity		x	
Tuberculosis or positive TB test		x		Pain or Pressure in chest	x			Loss of finger or toe		x	
Blood in Sputum or when coughing		x		Chronic Cough	x			Painful shoulder or elbow		x	
Excessive bleeding after injury or dental work		x		Palpitation or pounding heart	x			Recurrent back pain or any back injury	x		
Suicide attempt or plans		x		Heart trouble	x			Knee injury		x	
Sleepwalking		x		High blood pressure	x			Foot trouble			
Wear corrective lenses	x			Low blood pressure		x		Nerve injury		x	
Eye surgery to correct vision		x		Cramps in your legs		x		Paralysis		x	
Complete vision loss in either eye		x		Frequent Indigestion		x		Epilepsy or seizure		x	
Wears a hearing aid		x		Stomach, liver, or intestinal trouble		x		Car, train, or sea sickness		x	
Stutters or Stammers		x		Gall bladder trouble		x		Frequent trouble sleeping	x		
Wears a brace or back support		x		Jaundice or Hepatitis		x		Depression or excessive worry		x	
Scarlet fever		x		Broken bones		x		Loss of memory		x	
Rheumatic fever		x		Skin diseases		x		Nervous trouble of any sort		x	
Swollen or painful joints		x		Tumor, growth, cyst, or Cancer		x		Periods of unconsciousness		x	
Frequent or severe headache		x		Hernia		x		Parent/sibling with diabetes, cancer, stroke or heart disease.		x	
Dizziness or fainting spells	x			Hemorrhoids or rectal Disease		x					
Eye Trouble		x		Frequent or painful urination		x		X-Ray or other radiation therapy		x	
Hearing Loss		x		Bed wetting since age 12		x		Chemotherapy		x	
Recurrent ear infections		x		Kidney stones or blood in urine		x		Asbestos or toxic chemical exposure		x	
Chronic or frequent colds	x			Sugar or Protein in urine		x		Plate or pin in any bone		x	
Severe tooth or gum trouble		x		Sexually transmitted disease(s)		x		Been told to cut down or criticized for alcohol use		x	
Sinusitis		x		Recent gain or loss of weight	x						
Hay Fever or allergic rhinitis		x		Eating Disorder		x		Easily fatigued	x		
Head injury		x		Arthritis, Rheumatism, or Bursitis		x		Used illegal substances		x	
Asthma		x		Thyroid trouble		x		Used tobacco		x	

11. Females only answer section 11

Check each item	Yes	No	Don't Know	Date of last menstrual period	Date of last pap smear	Date of last mammogram
Treated for a female disorder	x			1988	2/07	2/07
Change in menstrual pattern			x			

Check each item. If "yes," explain in blank space to right. List explanation by item number.

ITEM	Yes	No	
12. Have you been refused employment or been unable to hold a job or stay in school because of:			
a. Sensitivity to chemicals?		x	
b. Inability to perform certain motions?		x	
c. Inability to assume certain positions?		x	
d. Other medical reasons? (If yes, give reasons.)		x	Hysterectomy 1998 at Butler Simulation Hospital
13. Have you ever been treated for a mental condition? (If yes, describe and give age at which occurred.)		x	Heart problems 2004
14. Have you had, or have you been advised to have, any operation? (If yes, describe and give age at which occurred.)		x	
15. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	x		
16. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)		x	
17. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, specify.)		x	
18. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and reason.)		x	
19. Have you ever been diagnosed with a learning disability? (If yes, give type and what is needed to help overcome.)		x	

20. List all immunizations received

Polio, Tetanus, Pneumonia

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics and their staff that are directly providing management of my care to review and input data into the Medical Record in accordance with local, state, and federal laws.

24a. Typed or Printed Name	24b. Signature	24c. Date
Sally Sims	Sally Sims	

NOTE: THIS DOCUMENT WILL BE PLACED IN THE MEDICAL RECORD

25. Physician's summary and elaboration of all pertinent data.

Chronic Heart Failure
Pleural effusion
Osteophorosis

26a. Typed or Printed Name of Physician or Examiner	26b. Signature	26c. Date	Patient Label Here
Dr. Simulation Getwell	Dr. Simulation Getwell		

Designed by mt revised by dms Butler Community College

Skills Check-off Scenarios
Scenario IV

The following scenarios were designed for the beginning of the semester skills check-offs for the fourth semester students. The skills including vital signs, IV medications, abbreviated physical assessments and catheterizations.

Objectives:

1. Assessment and recognition of the signs and symptoms of pulmonary edema related to renal failure
   c. Assess for respiratory problems related to pulmonary edema
   d. Assess vital signs related to renal failure/pulmonary edema
   e. Assess for respiratory distress
   f. Assess Intake and Output for other signs of fluid retention.
2. Initiate interdisciplinary collaboration in a hospital setting.
   g. Report changes in the patient's condition to the physician
   h. Implement new orders received from the physician
   i. Chart findings on the appropriate charting sheets
3. Select appropriate interventions
   j. Check vital signs.
   k. Oxygen – Apply 2-4 L/nasal cannula as ordered
   l. Insert a Foley catheter
   m. Complete an assessment specific to evaluate pulmonary edema.
   n. Administer an IV medication
4. Monitor therapeutic response to interventions (Outcomes).
   o. Monitor that patient will not have difficulty breathing and will maintain oxygen saturations at $\geq$ 90%.
   p. Monitor urinary output

Case study: It is shift change and you were assigned Sarah A Sims, a 78 year old female, who was admitted to your unit yesterday with a new diagnosis of renal disease. The night nurse reports that about one hour ago Sarah had difficulty breathing and crackles in both lungs. Her blood pressure is steadily rising. At 0630 it was 172/114. The nurse notified the physician. He ordered stat Bumetanide and Hydralazine along with some other new orders. She gave the Bumetanide and was waiting for the Hydralazine to arrive from the pharmacy. X-ray was just completing the portable chest x-ray. The unit secretary calls that the hydralazine has just arrived from pharmacy. Using the order sheet begin the care on your patient.

Butler Clinical Learning Center Simulation Orders

ORDERED		Name: Sarah A. Sims DOB 9/1732
DATE	TIME	
	1500	ADMIT TO: ☒Telemetry Floor ☐Non-telemetry Floor
		DIAGNOSIS: ☐ Diabetes, ☐R/O Myocardial Infarction, ☐ CHF, ☐S/P CABG, ☐Chest Pain, ☐Head Injury, ☐Stroke, ☐GI Bleed, ☐S/P Lung surgery______, ☐S/P abdominal surgery____, ☐S/P ortho surgery_______, ☐MVC________, ☐HTN, ☐Cancer____________☐Other: renal disease
		ALLERGIES: ☒No ☐Yes If yes, list:
		ACTIVITY: ☐ Bedrest ☒ BRP ☐ Activity as tolerated ☐ Other: ☐ I & O
		VITAL SIGNS: ☒ Every 4 hours ☐ Every shift Other: ☒O2 Sats. Q shift
		DIET: ☐NPO ☐ Clear liquid ☐2gm Low Na, low fat, ☐1800kcal ADA, ☐2000kcal ADA ☐ Other ___renal diet__800 ml per day fluid restriction
		☒ IV: Saline Lock ☐ D51/2NS with 20mEq KCL TRA _______ ☐ 0.9% Sodium Chloride IV TRA _____ ☐ Lactated Ringers TRA _______ ☐ Other: _________________________________
		O_2: ☐ None ☐ 2Liters/minute via Nasal Cannula ☐ Other: ___________ ☒ titrate to keep sats > 90%
		MEDICATIONS: ☐ Aspirin non enteric coated 325 mg po daily ☒ Acetaminophen 650mg po q 6 hours prn pain or temp > 101.5 F. ☒ laxative of choice ☐ Zolpidem 5 mgs prn HS ☒ NS flush IV BID and prn for IV flush Others________________________________ Bumetanide 1 mg IV now and repeat in four hours hydralazine 40 mg IV now
		(Treatments) ☒ Place Foley to DD now ☐Dressing Changes ________________________________ ☐ Place NG Tube ☐ Other _________
		LAB TESTS: ☐ CBC ☒ Chem 7 ☐Routine UA ☒ Others:_renal profile, serum creatine
		X-Rays: ☒ chest x-ray in AM ☐ Other _________________________________ ☐ ECG stat if chest pain occurs, notify MD
		☐ Additional orders

Date________ Time_1115____ Signature: *Dr. Chester Hart* *Patient ID*

Butler Clinical Learning Center Medication Sheet

NURSING STATION WORKSHEET (MAR FORMAT)

ROOM-BED	PATIENT	DOB	WT	AGE/SEX	ADM DATE	ATTENDING PHYSICIAN
B2	Sarah A Sims	9/17/32	69 kg	78/female	today	Dr. Hart

DRUG ALLERGIES: No known allergies

MEDICATION	ROUTE/SIG	ORDERING DOSE	0800-1559	1600-2359	0000-0759
Hydralazine	IV now	40 mg			
Normal Saline Flush	IV bid and prn		0900	2100	
Acetaminophen	Po prn pain or temp > 101.5	650 mg			
MOM	po prn	30 ml			
Bumetanide	IV now and repeat in 4 hours	1 mg	1100		

Signature/Initials

______________________________/_____ ______________________________/_____
______________________________/_____ ______________________________/_____
______________________________/_____ ______________________________/_____
______________________________/_____ ______________________________/_____
______________________________/_____ ______________________________/_____

LABORATORY REPORT

<table>
<tr><td>Date</td><td>Time</td><td>Exam</td><td>Result</td></tr>
<tr><td></td><td>0845</td><td>
CBC
RBC
WBC
Hct.
Hgb
MCV
MCH
MCHC</td><td>

5.2 mc/L
6400 mc/L
42%
13 gm/dL
84 f
28 pg/cell
33 gm/dL</td></tr>
<tr><td></td><td>0845</td><td>BMP
Sodium
Potassium
Chloride
CO2
Magnesium</td><td>135 mEq/L
2.9 mEq/L (L)
96 mEq/l
20 mEq/L (L)
1.9 mg/dL</td></tr>
<tr><td></td><td>0845</td><td>BUN
Creatinine
Calcium
Phosphorus</td><td>22 mg/dL (H)
1.7 mg/dL (H)
7.8 mg/dL (L)
4.9 mEq/dL (H)</td></tr>
</table>

MEDICAL RECORD	REPORT OF MEDICAL HISTORY	Date of Exam

Note: This information is for official and medically-confidential use only and will not be released to unauthorized persons.

1. Name of Patient (First, Middle, Last)	2. Identification Number	3. Date of Birth
Sarah A Sims	0023033378	9/17/32

4a. Home street address			5. Examining Facility
1932 North First			Butler Community College Simulation Hospital
4b. City	State	Zip Code	
Yourtown	KS	67042	

6. Patient's occupation	7a. Height	b. Weight
Retired school teacher	5' 4"	69 Kg

8. Current Used Medications at Home	9. Allergies (include medications, latex, bee stings and food)
Crestor 10 mg once daily ASA 81 mg once daily	NKA

10. Past/Current Medical History

Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Household Contact with anyone with tuberculosis		x		Shortness of Breath	x			Bone or join deformity		x	
Tuberculosis or positive TB test		x		Pain or Pressure in chest		x		Loss of finger or toe		x	
Blood in Sputum or when coughing		x		Chronic Cough		x		Painful shoulder or elbow		x	
Excessive bleeding after injury or dental work		x		Palpitation or pounding heart	x			Recurrent back pain or any back injury		x	
Suicide attempt or plans		x		Heart trouble		x		Knee injury		x	
Sleepwalking		x		High blood pressure	x			Foot trouble		x	
Wear corrective lenses	x			Low blood pressure		x		Nerve injury		x	
Eye surgery to correct vision		x		Cramps in your legs	x			Paralysis		x	
Complete vision loss in either eye		x		Frequent Indigestion	x			Epilepsy or seizure		x	
Wears a hearing aid		x		Stomach, liver, or intestinal trouble		x		Car, train, or sea sickness		x	
Stutters or Stammers		x		Gall bladder trouble		x		Frequent trouble sleeping	x		
Wears a brace or back support		x		Jaundice or Hepatitis		x		Depression or excessive worry	x		
Scarlet fever		x		Broken bones		x		Loss of memory		x	
Rheumatic fever		x		Skin diseases		x		Nervous trouble of any sort		x	
Swollen or painful joints		x		Tumor, growth, cyst, or Cancer		x		Periods of unconsciousness		x	
Frequent or severe headache		x		Hernia		x		Parent/sibling with diabetes, cancer, stroke or heart disease.	x		
Dizziness or fainting spells		x		Hemorrhoids or rectal Disease		x					
Eye Trouble		x		Frequent or painful urination		x		X-Ray or other radiation therapy		x	
Hearing Loss	x			Bed wetting since age 12		x		Chemotherapy		x	
Recurrent ear infections		x		Kidney stones or blood in urine	x			Asbestos or toxic chemical exposure		x	
Chronic or frequent colds		x		Sugar or Protein in urine	x			Plate or pin in any bone		x	
Severe tooth or gum trouble		x		Sexually transmitted disease(s)		x		Been told to cut down or criticized for alcohol use		x	
Sinusitis		x		Recent gain or loss of weight	x						
Hay Fever or allergic rhinitis		x		Eating Disorder		x		Easily fatigued	x		
Head injury		x		Arthritis, Rheumatism, or Bursitis		x		Used illegal substances		x	
Asthma		x		Thyroid trouble		x		Used tobacco		x	

11. Females only answer section 11

Check each item	Yes	No	Don't Know	Date of last menstrual period	Date of last pap smear	Date of last mammogram
Treated for a female disorder	x			1979		2007
Change in menstrual pattern						

Check each item. If "yes," explain in blank space to right. List explanation by item number.

ITEM	Yes	No	
12. Have you been refused employment or been unable to hold a job or stay in school because of:			
a. Sensitivity to chemicals?		x	
b. Inability to perform certain motions?		x	1984 Hysterectomy, cystocele repair
c. Inability to assume certain positions?		x	
d. Other medical reasons? (If yes, give reasons.)		x	
13. Have you ever been treated for a mental condition? (If yes, describe and give age at which occurred.)		x	
14. Have you had, or have you been advised to have, any operation? (If yes, describe and give age at which occurred.)		x	
15. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	x		
16. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)		x	
17. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, specify.)		x	
18. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and reason.)		x	
19. Have you ever been diagnosed with a learning disability? (If yes, give type and what is needed to help overcome.)		x	

20. List all immunizations received

Polio, Tetanus, Pneumonia

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics and their staff that are directly providing management of my care to review and input data into the Medical Record in accordance with local, state, and federal laws.

24a. Typed or Printed Name	24b. Signature	24c. Date
Sarah Sims	Sarah Sims	

NOTE: THIS DOCUMENT WILL BE PLACED IN THE MEDICAL RECORD

25. Physician's summary and elaboration of all pertinent data.

History or hyperlipidemia

Recent symptoms of dull pain in right flank, 16 Kg weight gain, shortness of breath, blood in urine and hypertension.

Diagnosis renal failure—unknown cause.

26a. Typed or Printed Name of Physician or Examiner	26b. Signature	26c. Date	Patient Label Here
Dr. Chester Hart	Dr. Chester Hart		

Skills Check-off Scenarios

ScenarioV

The following scenarios were designed for the beginning of the semester skills check-offs for the fourth semester students. The skills including vital signs, IV medications, abbreviated physical assessments and catheterizations.

Objectives:

9. Assessment and recognition of the signs and symptoms of congestive heart failure
   a. Assess for respiratory problems related to congestive heart failure
   b. Assess vital signs related to congestive heart failure
   c. Assess for dysrhythmias
   d. Assess Intake and Output for other signs of fluid retention.
10. Initiate interdisciplinary collaboration in a hospital setting.
    a. Report changes in the patient's condition to the physician
    b. Implement new orders received from the physician
    c. Chart findings on the appropriate charting sheets
11. Select appropriate interventions
    a. Check vital signs.
    b. Oxygen – Apply 2-4 L/nasal cannula as ordered
    c. Insert a Foley catheter
    d. Complete an assessment specific to evaluate congestive heart failure.
    e. Administer an IV medication
12. Monitor therapeutic response to interventions (Outcomes).
    a. Monitor that patient will not have difficulty breathing and will maintain oxygen saturations at $\geq$ 90%.
    b. Monitor urinary output

Case study: You are working the day shift at Butler Simulation Hospital. Chad Sims, a seventy-seven year old male was admitted to your unit with hypertension, peripheral edema and shortness of breath. He has a past history of congestive heart failure. He was started on oxygen at 4 L via nasal canula and given 40 mg furosemide IV in the ER. His chest x-ray showed bilateral effusions in both lower lobes of his lungs. The ER doctor sent preliminary orders and said his primary care doctor would be in to write further medication orders. In report the ER nurse told you that Chad had taken his digoxin and aspirin this AM. It is now 1300. Begin initiating the orders from the order sheet.

Butler Clinical Learning Center Simulation Orders

ORDERED		Name: Chad A. Sims DOB 8/27/31
DATE	TIME	
	0730	ADMIT TO: ☒Telemetry Floor ☐Non-telemetry Floor
		DIAGNOSIS: ☐ Diabetes, ☐R/O Myocardial Infarction, ☒CHF, ☐S/P CABG, ☐Chest Pain, ☐Head Injury, ☐Stroke, ☐GI Bleed, ☐S/P Lung surgery______, ☐S/P abdominal surgery____, ☐S/P ortho surgery_______, ☐MVC________, ☐HTN, ☐Cancer____________☐Other_____________
		ALLERGIES: ☒No ☐Yes If yes, list:
		ACTIVITY: ☐ Bedrest ☒ BRP ☐ Activity as tolerated ☐ Other: ☐ I & O
		VITAL SIGNS: ☒ Every 4 hours ☐ Every shift Other: ☒O2 Sats. Q shift
		DIET: ☐NPO ☐ Clear liquid ☒2gm Low Na, low fat, ☐1800kcal ADA, ☐2000kcal ADA ☐ Other ________________________________
		☒ IV: Saline Lock ☐ D51/2NS with 20mEq KCL TRA _______ ☐ 0.9% Sodium Chloride IV TRA _____ ☐ Lactated Ringers TRA _______ ☐ Other: _______________________________
		O_2: ☐ None ☐ 2Liters/minute via Nasal Cannula ☐ Other: ___________ ☒ titrate to keep sats > 90%
		MEDICATIONS: ☒ Aspirin non enteric coated 325 mg po daily ☐ Acetaminophen 650mg po q 6 hours prn pain or temp > 101.5 F. ☒ laxative of choice ☐ Zolpidem 5 mgs prn HS ☒ NS flush IV BID and prn for IV flush Others__Nitroglycerin 0.4 mg SL prn chest pain q 5 minutes x 3 Digoxin 0.5 mg po q. AM Repeat furosemide 40 mg IV x1 after admission to floor ____
		(Treatments) ☒ Place Foley to DD ☐Dressing Changes ______________________________ ☐ Place NG Tube ☐ Other _________
		LAB TESTS: ☐ CBC ☐ Chem 7 ☐Routine UA ☐ Others_______________________________
		X-Rays: ☒ chest x-ray in AM ☐ Other ______________________________ ☐ ECG stat if chest pain occurs, notify MD
		☐ Additional orders

Date________ Time_1115____ Signature: *Dr. Chester Hart* *Patient ID*

Developed by dms Butler Community College

Butler Clinical Learning Center Medication Sheet

NURSING STATION WORKSHEET (MAR FORMAT)

ROOM-BED	PATIENT	DOB	WT	AGE/SEX	ADM DATE	ATTENDING PHYSICIAN
B3	**Chad A Sims**	8/27/31	81 kg	77/male	today	Dr. Hart

DRUG ALLERGIES: No known allergies

MEDICATION	ROUTE/SIG	ORDERING DOSE	0800-1559	1600-2359	0000-0759
Furosemide	IV on admission to floor	40 mg			
Digoxin	po	0.5 mg	0900		
Aspirin	po	325 mg	0900		
MOM	po prn	30 ml			
Nitroglycerin	SL prn chestpain q 5 min. x 3	0.4 mg			
Normal Saline Flush	IV bid and prn		0900	2100	

Signature/Initials

________________________________/______ ____________________________/ _______
________________________________/______ ____________________________/ _______
________________________________/______ ____________________________/ _______
________________________________/______ ____________________________/ _______
________________________________/______ ____________________________/ _______

LABORATORY REPORT

Date	Time	Exam	Result
	0845	CBC	
		RBC	5.2 mc/L
		WBC	6400 mc/L
		Hct.	42%
		Hgb	13 gm/dL
		Platelet	160,000 ul
		MCV	84 f
		MCH	28 pg/cell
		MCHC	33 gm/dL
	0845	BMP	
		Sodium	135 mEq/L
		Potassium	2.9 mEq/L (L)
		Chloride	96 mEq/l
		Magnesium	2.1 mg/dL
	0845	ABGs	
		pH	7.35
		PaCO2	35 mm Hg
		PaO2	77 mm Hg (L)
		SO2	88 % (L)

REPORT OF MEDICAL HISTORY

Date of Exam

Note: This information is for official and medically-confidential

MEDICAL RECORD

l use only and will not be released to unauthorized persons.

1. Name of Patient (First, Middle, Last)	2. Identification Number	3. Date of Birth
Chad A Sims	004303336	8/27/31

4a. Home street address			5. Examining Facility
430 Corona St.			Butler Community College Simulation Hospital
4b. City	State	Zip Code	
Yourcity	KS	67042	

6. Patient's occupation	7a. Height	b. Weight
Retired Baker	5'10"	81 Kg

8. Current Used Medications at Home	9. Allergies (include medications, latex, bee stings and food)
Digoxin 0.125 mg daily Capoten 25 mg bid	NKA

10. Past/Current Medical History

Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Household Contact with anyone with tuberculosis		x		Shortness of Breath	x			Bone or join deformity		x	
Tuberculosis or positive TB test		x		Pain or Pressure in chest	x			Loss of finger or toe		x	
Blood in Sputum or when coughing		x		Chronic Cough	x			Painful shoulder or elbow		x	
Excessive bleeding after injury or dental work		x		Palpitation or pounding heart	x			Recurrent back pain or any back injury		x	
Suicide attempt or plans		x		Heart trouble	x			Knee injury		x	
Sleepwalking		x		High blood pressure	x			Foot trouble			
Wear corrective lenses	x			Low blood pressure		x		Nerve injury		x	
Eye surgery to correct vision		x		Cramps in your legs		x		Paralysis		x	
Complete vision loss in either eye		x		Frequent Indigestion		x		Epilepsy or seizure		x	
Wears a hearing aid		x		Stomach, liver, or intestinal trouble		x		Car, train, or sea sickness		x	
Stutters or Stammers		x		Gall bladder trouble		x		Frequent trouble sleeping	x		
Wears a brace or back support		x		Jaundice or Hepatitis		x		Depression or excessive worry		x	
Scarlet fever		x		Broken bones		x		Loss of memory		x	
Rheumatic fever		x		Skin diseases		x		Nervous trouble of any sort		x	
Swollen or painful joints		x		Tumor, growth, cyst, or Cancer		x		Periods of unconsciousness		x	
Frequent or severe headache		x		Hernia		x		Parent/sibling with diabetes, cancer, stroke or heart disease.		x	
Dizziness or fainting spells	x			Hemorrhoids or rectal Disease		x					
Eye Trouble		x		Frequent or painful urination		x		X-Ray or other radiation therapy		x	
Hearing Loss		x		Bed wetting since age 12		x		Chemotherapy		x	
Recurrent ear infections		x		Kidney stones or blood in urine		x		Asbestos or toxic chemical exposure		x	
Chronic or frequent colds	x			Sugar or Protein in urine		x		Plate or pin in any bone		x	
Severe tooth or gum trouble		x		Sexually transmitted disease(s)		x		Been told to cut down or criticized for alcohol use		x	
Sinusitis		x		Recent gain or loss of weight	x						
Hay Fever or allergic rhinitis		x		Eating Disorder		x		Easily fatigued	x		
Head injury		x		Arthritis, Rheumatism, or Bursitis		x		Used illegal substances		x	
Asthma		x		Thyroid trouble		x		Used tobacco		x	

11. Females only answer section 11

Check each item	Yes	No	Don't Know	Date of last menstrual period	Date of last pap smear	Date of last mammogram
Treated for a female disorder						
Change in menstrual pattern						

Check each item. If "yes," explain in blank space to right. List explanation by item number.

ITEM	Yes	No	
12. Have you been refused employment or been unable to hold a job or stay in school because of:			
a. Sensitivity to chemicals?		x	
b. Inability to perform certain motions?		x	
c. Inability to assume certain positions?		x	Repair of inguinal hernia 1987
d. Other medical reasons? (If yes, give reasons.)		x	
13. Have you ever been treated for a mental condition? (If yes, describe and give age at which occurred.)		x	Heart problems 2004
14. Have you had, or have you been advised to have, any operation? (If yes, describe and give age at which occurred.)		x	
15. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	x		
16. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)		x	
17. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, specify.)		x	
18. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and reason.)		x	
19. Have you ever been diagnosed with a learning disability? (If yes, give type and what is needed to help overcome.)		x	

20. List all immunizations received

Polio, Tetanus, Pneumonia

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics and their staff that are directly providing management of my care to review and input data into the Medical Record in accordance with local, state, and federal laws.

24a. Typed or Printed Name	24b. Signature	24c. Date
Chad Sims	Chad Sims	

NOTE: THIS DOCUMENT WILL BE PLACED IN THE MEDICAL RECORD

25. Physician's summary and elaboration of all pertinent data.

Chronic Heart Failure
Pleural effusion

26a. Typed or Printed Name of Physician or Examiner	26b. Signature	26c. Date	Patient Label Here
Dr. Simulation Getwell	Dr. Simulation Getwell		

Scenario References

Black, J. & Hawks, J (2005) Medical Surgical Nursing Clinical Management for Positive *Outcomes* 7th ed. Elsevier Saunders, St Louis

Hopper, J. & Vallerand, A (2005) Davis's Drug Guide for Nurses 10th ed. F.A. Davis, Philadelphia

Palm Skyscape (2006) Drug Guide Skyscape, Inc.

Potter, P. & Perry, A. (2007) Basic Nursing Essential for Practice 6th ed. Mosby Elsevier, St. Louis

Reviewed and edited by Faculty at Butler community College