CHANGE IN CONDITION

Resident Name ____ Room/Bed ________________ Date _____ /_____ /_____ Time____________

S - SITUATION

The change in condition (including symptoms or signs) I am calling about is ____

____. Since this started on ____ / ____ / ______ , it has gotten ☐ Worse ☐ Better ☐ Stayed the same.

The condition gets worse when ____

The condition gets better when ____

This change in condition has occurred before. ☐ No ☐ Yes: ____

The resident had a recent change in medications. ☐ No ☐ Yes: ____

Treatment for last episode (if applicable): ____

B - BACKGROUND (check all that apply)

B1. General information

Medical History

☐ Indwelling Catheter
☐ Emphysema/COPD
☐ Other:
☐ Diabetes Mellitus
☐ On Warfarin/Coumadin

Medication Allergies

____
____
____

Additional information

Advanced Care Wishes: ___________________________

Recent events or changes in condition:

B2. Vital Signs

Blood Pressure ___/___
Pulse Rate _______
Respiratory Rate _______
Pulse Oximeter ______
Temperature ______
Glucose Level ______

☐ Temperature > 100.5° F or repeated Temp > 99° F
☐ BP < 90 or > 200 systolic
☐ Apical heart rate > 100 or < 50
☐ O2 saturation < 90%
☐ Finger stick glucose < 70 or > 300
☐ Respiratory rate > 28 or < 10/min

B3. Localizing Signs or Symptoms

Urinary Tract

☐ Obvious blood in urine
☐ Painful or difficult urination

New or increased:

☐ Urgency or Frequency of urination
☐ Suprapubic Tenderness per Pt or nurse exam
☐ CVA Tenderness
☐ Urinary Incontinence
☐ Other:

Respiratory

☐ New or increasing cough
☐ Pleuritic chest pain
☐ Shortness of breath
☐ Blood in purulent sputum
☐ Runny, stuffy nose and/or sneezing
☐ Sore throat/headache
☐ Other infections in the community

Skin or Soft Tissue

Location: ________________________

☐ New or increasing pus draining from wound
☐ New or expanding redness around wound
☐ Pain/Tenderness
☐ New or increased swelling at the site
☐ Increased odor

Gastrointestinal

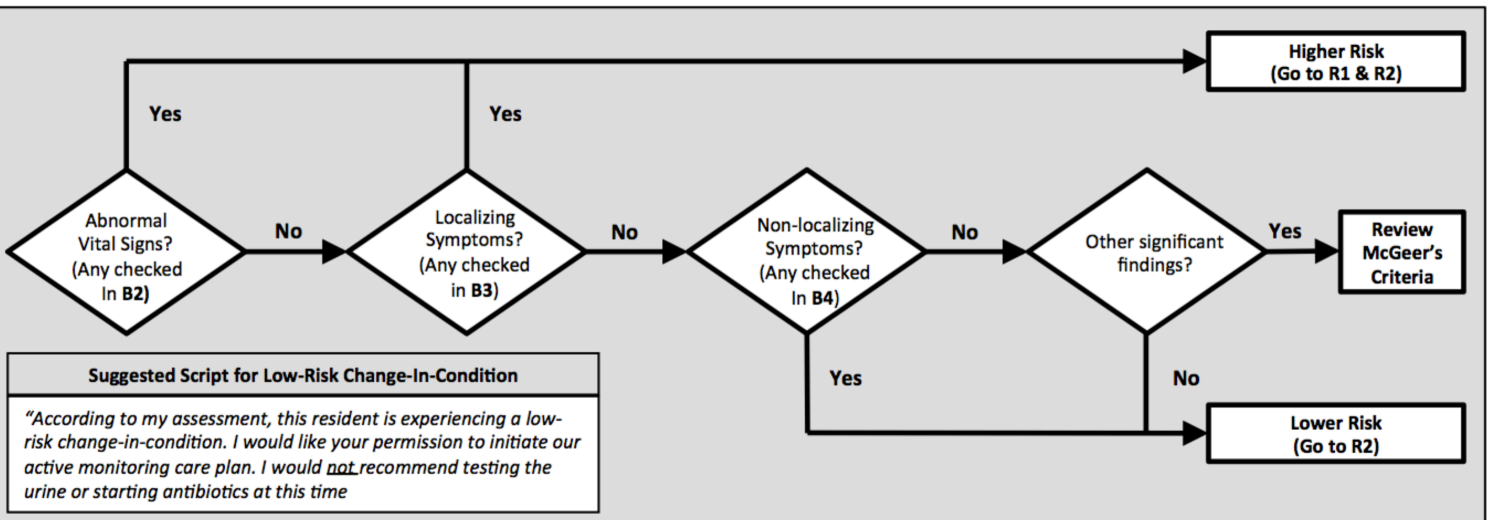
☐ Vomiting: ____ times in past 24 hours
☐ Diarrhea: ____ times in past 24 hours
☐ Other vomiting or diarrhea in community

B4. Non-Localizing Signs or Symptoms

New or worsening:

☐ Confusion
☐ Other:
☐ Agitation
☐ Pain
☐ Decrease in eating or drinking
☐ Sleepiness or decreased alertness
☐ Decline in function or gait
☐ Shaking or chills in past 24 hours
☐ Recent fall
☐ Recent weight gain

A – ASSESSMENT



R - RECOMENDATIONS

If higher risk: R1 and R2

If lower risk: R2

R1. Diagnostic and Therapeutic Orders

☐ Urinalysis ☐ Oxygen supplementation
☐ Urine Culture ☐ Nebulizer treatment
☐ CBC w/Diff ☐ Cough suppressants
☐ Chest X-Ray ☐ Other: ______________________
☐ Start Antibiotic(s) for this indication: __________________________
Antibiotic: ____________ Dose: _______ Frequency: _________ Days: ____
Antibiotic: ____________ Dose: _______ Frequency: _________ Days: ____
☐ Start these other medications: ___________________________________
☐ Other orders: ____
____

R2. Monitoring and Supportive Care Orders

☐ Monitor vital signs every _____ hours
☐ Oral fluids for hydration: _____ cc ______hr.
☐ IV fluids for hydration _____ cc ______hr.
☐ Monitor fluid intake/urine output every ____ hours
☐ Notify provider if symptoms worsen or if unresolved in ______ hours / days
☐ Other orders: ____
____
____
____

COMMUNICATION

Name of Family or Health Care Agent Notified: Date / / Time ☐ AM ☐ PM

Name of Primary Care Clinician Notified (specify MD/NP/PA): Date / / Time ☐ AM ☐ PM

Pending Notification Tasks:

Staff Name (RN/LPN) and Signature:

NURSING NOTES

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 Questions or comments about this form? Email Therese Van Male at vanmale@wisc.edu