

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 Diabetes Mellitus
 Emphysema/COPD On Warfarin/Coumadin
 Other: _____

Medication Allergies

Additional information

Advanced Care Wishes: _____
 Recent events or changes in condition: _____

B2. Vital Signs

Blood Pressure ____/____ Pulse Oximeter _____ Temperature > 100.5° F or repeated Temp > 99° F O2 saturation < 90%
 Pulse Rate _____ Temperature _____ BP < 90 or > 200 systolic Finger stick glucose < 70 or > 300
 Respiratory Rate _____ Glucose Level _____ Apical heart rate > 100 or < 50 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: Agitation Decrease in eating or drinking Decline in function or gait Recent fall
 Confusion Pain Sleepiness or decreased alertness Shaking or chills in past 24 hours Recent weight gain
 Other: _____

A – ASSESSMENT



