

***Ventilator Assisted Children/Home Program
Respite Care Documentation***

Patient: _____ Date: _____

Start Time: _____ End Time: _____

Vital Signs					
Time	Pulse	Respiratory Rate	Temperature	B/P	Nurses Initials

Flow Sheet

Please document any problems or changes in the progress note section.

	Time and Description		Time and Description
Respiratory System Assessment		Ventilator Please note time	
Suctioning (amount, color, frequency, and consistency)		Settings (IMV, PEEP/EPAP, PIP/IPAP, Tidal Volume, O2, mist temp)	
treatments/results		POX	
emergency equipment		End Tidal CO2	
Elimination GI/GU		Nutrition	
GI Assessment		Diet Type	
G-Tube Assessment		Intake	
Urinary Assessment		Emesis * amount and description	
Skin/Wound/Stoma Care		Musculoskeletal	
Trach care		ROM/PROM	
GT/JT care		Splints/mafos/vest	

Care Provider's Signature: _____

Date: _____

