

Room# Name: Age/Sex: Allergies:	Isolation: <input type="radio"/>	Admit Date & C/C: PMHX:	ATTENDING: TEAM:
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NEUROLOGICAL: Fever: <input type="radio"/> Orientation: Ambulation:	CARDIAC: Paced: <input type="radio"/> Rate: LVAD: <input type="radio"/> Rhythm: Pulses: Pressures:	SKIN:	TUBES/LINES/DRAINS:
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RESPIRATORY: O2: Sounds:	GI/GU: ACHS: <input type="radio"/> Diet: Last BM: Foley/Void:	MEDS/ORDERS:
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