Cardiovascular Assessment

Cardiovascular Assessment Parameters

WDS: Absence of peripheral edema, regular pulse 60-100 bpm with no irregularities, extremities warm and dry, no evidence of chest pain, discomfort, or heaviness, and no shortness of breath. No cyanosis, no subjective reports of cardiac related symptoms, or calf tenderness.

Integumentary Assessment

Integumentary Assessment Parameters

WDS: Skin dry and intact. No rashes, lumps, sores, lacerations, draining areas or bruises. No skin discoloration.
No subjective reports of integumentary related symptoms including itching.

Respiratory Assessment

Respiratory Assessment Parameters

WDS: Breathing on room air, respirations quiet, regular & non-laboured, no accessory muscle use. Lung sounds clear & audible (capable of being heard), no abnormal sounds on auscultation, sputum clear, white or absent.
O2 sats > 95 % on room air, no subjective reports or respiratory related issues. RR 10-20 respirations/min at rest.
No persistent or productive cough. Nail beds and mucous membranes pink. Capillary refill <2sec.

Neurological Assessment

Neurological Assessment Parameters

WDS: Alert and orientated to person,place and time and obeys simple commands. Able to verbalize- understandable and moderately paced, able to move purposefully, behavior appropriate for reason for admission. No subjective reports of neurological related symptoms including impaired sensation, swallowing difficulty, dizziness, headache, memory loss or neurological pain. Pupils equal, round, reactive to light and accommodate.

EENT Assessment

EENT Assessment Parameters

WDS: No discharge, obstruction or swelling of eyes, ears, nose, or mouth. No subjective reports of EENT related symptoms

GI Gastrointestinal Assessment

GI Assessment Parameters

WDS: Abdomen soft and symmetrical, not distended and pain free. Bowel sounds present on auscultation in any quadrant. Non-tender on palpation. No nausea or vomiting, no constipation or diarrhea, no incontinence of stool and normal bowel patterns. No swallowing difficulties and tolerating prescribed diet. No subjective complaints of GI related symptoms.

NOTE: Diarrhea is defined as 3 or more loose/watery stools in a 24 hour period with no use of bowel stimulants OR is different from normal bowel movements.

GU Urinary Assessment

Parameters

WDS: Continent of urine, adequate urinary output greater than 30 mL/hr, and bladder not distended. Urine is odourless, yellow in colour and clear. No subjective reports of urinary related symptoms including frequency, urgency, urine odor, dysuria, hematuria or cloudy urine. No subjective reports of pain/burning on voiding and no retention. Unmeasured voids are captured on IO intervention.

Reproductive System

Reproductive Assessment

WDS: No subjective reports or evidence of reproductive issues

Integumentary Assessment

Integumentary Assessment Parameters

WDS: Skin dry and intact. No rashes, lumps, sores, lacerations, draining areas or bruises. No skin discoloration.
No subjective reports of integumentary related symptoms including itching.

Musculoskeletal Assessment

Musculoskeletal Assessment Parameters

WDS: No joint swelling or reported tenderness/pain and weakness.
Full ROM. Patient is ambulatory without joint discomfort or instability.
Stance and gait pattern are normal.
Postural adjustments are made without compensatory movements or aids.
ADLs are completed without undue fatigue or pain.