CLINICAL PREPARATION, WORKSHEET TEMPLATE

Student Name: ________________________________________ Date ____________________ Patient Initials: _______ Rm# ________

Admitting Diagnosis: ___________________________________________

Presenting S&S: __________________________________________________

Other Identified Disease Processes: __________________________________________

Pertinent History or Identified Risk Factors:

____________________________________________________________________________________

Provide a detailed description of patient’s primary disease process/illness. (Include expected signs and symptoms, abnormal lab values or diagnostic tests from your reference sources). Think! What is happening at the cellular level that is causing the S&S you see? (This may be completed throughout the day or after the first clinical day with the patient. Use the back or additional paper prn.)

____________________________________________________________________________________

List the actual result studies that were performed on your patient. Are the “abnormal” labs different than expected? (If so, why?)

Laboratory Studies: (DATE) - (Indicate if the result is high or low and consider why it is abnormal based on the disease process)

<table>
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<tr>
<th>WBC</th>
<th>RBC</th>
<th>HGB</th>
<th>HCT</th>
<th>PLATELETS</th>
<th>PT/INR</th>
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<tr>
<td>Na</td>
<td>K+</td>
<td>Cl</td>
<td>Mg</td>
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<td>Troponin</td>
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NOTES (list any other pertinent lab results)

Ordered Treatments:____________________________________________________________________________________
Diagnostic Tests and Results:

**Medications:** (make drug cards for 10 new* medications ordered for this patient). If pre-printed drug cards are utilized, pertinent information MUST be highlighted! (* Do not use the same medications each week. Learn about different / new ones!)

Clinical Plan of Care  Student Name:  Pt. Initials:
What is the most important **focus of my PHYSICAL ASSESSMENT** and Why? (What possible abnormalities am I looking for?)

Nursing Diagnosis: *(Priority concern based on what I have learned (from report/EMR, etc.) **before** seeing the patient)*:

*Think: What can I do to improve this condition? How will it help? (Expected outcome?)* Use your resources, EBP, know rationale.

Nursing Interventions planned for **clinical day 1**: (Must be specific and measurable)
1.
2.
3.

Clinical Day 1: *(Did my assessment reveal the expected signs and symptoms? If not, what was different? How did that change my plan of care?)*

Evaluation of Clinical Day 1. *(Did I accomplish my goal with the above interventions? If not, what will I do differently tomorrow?)*
Clinical Day 2:

**Nursing Diagnosis:** (Priority concern based on what I have learned, after assessing and providing care for the patient on day 1). What can I do to improve this condition? How will it help? (Expected outcome?)

**Nursing Interventions** planned for clinical day 2: (Must be specific and measurable)

1. 
2. 
3. 

**Evaluation of Clinical Day 2.** (Did I accomplish my goal with the above interventions? If not, what will I do differently tomorrow?)

Laboratory Studies: (DATE)- (Indicate if the result is high or low and consider why it is abnormal based on the disease process)

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**Clinical Reflections (Evaluation):**

What did I learn about this disease process or about providing quality care today? What do I need to learn more about? What evidence-based information did I use to guide my care? Was the patient safe in my care? What clinical skills did I or should I review? (These reflections may be used to guide you in your reflective journal entries).