SEQUOIA
Integrative Medical Services

ROUNDING FORM

Date _____ Name _____ DOB _____ RM# _____

☐ DNR ☐ Full Code ☐ Own Decision Maker ☐ Guardian/APOA _____

☐ Hospice ☐ Home Health Provider/Disciplines _____

Vitals: Height _____ Weight _____lbs ☐ Stable ☐ Recent + Gain _____ lbs / - Loss _____ lbs

BP _____/_____ **HR** _____ **bpm** **SpO2** _____ **%** **RR** _____ **T** _____

Diabetes: ☐ None ☐ Insulin ☐ Oral Mgt Blood Sugar Range _____ Freq of Test _____

Anticoagulation ☐ None ☐ Warfarin/INR Monitored ☐ Eliquis ☐ Aspirin ☐ Plavix ☐ Xarelto

Recent Falls ☐ None ☐ Yes _____ ED Encounter/Hospitalization ☐ None ☐ Yes

Other _____

Nursing Concerns:	**Provider Orders:**
Mood: Appetite: Sleep: Pain: Bladder/Bowel: Hearing: Vision: Smoker: Mobility: ADLs: Other:	Signature: _____ Mary Kate Friess, DNP / Allison Brusewitz, APNP

**** FAX ALL COMPLETED ROUNDING FORMS AFTER VISIT TO 920 543 5288 ****