

NURSING NOTES TEMPLATE

CATEGORY	DESCRIPTION	NOTES
Subjective:	Patient's reported symptoms and experiences	[Patient's subjective complaints and concerns]
	Relevant medical, family, and social history	[Patient's Medical, family and social history]
	Patient's concerns or questions	[Patient's questions and concerns]
Objective:	Vital signs and physical assessment findings	[Vital signs and physical assessment findings]
	Results of diagnostic tests or lab work	[Diagnostic test results and lab work]
	Observations of patient behavior or appearance	[Patient's appearance and behavior]
Assessment:	Analysis of patient's condition and needs	[Assessment of Patient's condition and needs]
	Potential problems or complications	[Potential problems or complications]
Plan:	Interventions to address patient's needs	[Intentions to address Patient's needs]
	Patient education or referrals	[Patient's education or referrals as need]
	Evaluation and follow-up	[Evaluation and follow-up plan]

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ML Morrison



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