Nursing notes template

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NURSING NOTE

Patient

Date and time of entry

Nurse

Ward or unit

REASON FOR ENTRY

Routine shift note, change in condition, procedure, or event:

ASSESSMENT

Vital signs:

Pain (score, location, character):

Relevant body systems (for example breathing, circulation, wound, mobility, skin, elimination):

Mental state and behavior:

What the patient says, in their own words:

INTERVENTIONS

Care given and when (medications as prescribed, dressings, positioning, mobility):

Tests or samples taken:

RESPONSE

How the patient responded, with times and repeat measures:

COMMUNICATION

Who was informed (doctor, charge nurse, family), when, and what was agreed:

EDUCATION

What the patient or family was taught, and their understanding:

PLAN AND HANDOVER

Ongoing care, observations due, and points for the next shift:

Signature and credentials:

Educational template, not medical or legal advice. Follow your employer and regulator rules.