

monitoring plan

DATE & TIME:	
NAME OF PATIENT:	
NAME OF CONSULTANT:	
PLAN PREPARED BY (NAME & SIGNATURE):	
CURRENT CLINICAL CONCERNS:	
MONITORING PLAN REVIEW DATE:	

OBSERVATION / ASSESSMENT	FREQUENCY (e.g. 6 HOURLY / DAILY)	DURATION (NUMBER OF DAYS)
CORE OBSERVATIONS		
Respiratory rate		
Heart rate		
Temperature		
Level of consciousness		
Oxygen saturation		
Blood pressure		
ADDITIONAL OBSERVATIONS / ASSESSMENTS		
Urine output		
Fluid balance		
Drain output		
Blood sugar level		
Weight		
Pain score		
Sedation score		
Neurovascular observations		
Blood tests (specify):		
Other (specify):		