Nursing Admission Note

Patient Information

- **Name**: [Patient Name]
- **Age**: [Age]
- **Gender**: [Gender]
- **Admission Date/Time**: [MM/DD/YYYY - HH:MM AM/PM]
- **Reason for Admission**: [Chief Complaint or Diagnosis]

Subjective Data

- **Patient's History**: [Summary of medical, surgical, and family history]
- **Current Symptoms**: [What the patient reports]
- **Allergies**: [List any known allergies]

Objective Data

- **Vital Signs**:
  - Blood Pressure (BP): [Value]
  - Heart Rate (HR): [Value]
  - Respiratory Rate (RR): [Value]
  - Temperature (Temp): [Value]
  - Oxygen Saturation (SpO2): [Value]
- **Initial Physical Examination Findings**: [Brief summary]

Assessment

- **Initial Impression**: [Initial clinical impression based on available data]

Plan

- **Interventions Planned**:
  - [Medications Prescribed]
  - [Diagnostic Tests Ordered]
  - [Patient Education Provided]
- **Immediate Goals**: [Short-term objectives for care]

Sign-Off

- **Nurse's Name and Designation**: [Full Name, RN/LPN, etc.]
- **Signature**: [Nurse's Signature]
- **Date and Time**: [MM/DD/YYYY - HH:MM AM/PM]