

# NURSING NOTES TEMPLATE

| CATEGORY           | DESCRIPTION                                    | NOTES  |
|--------------------|--|--|
| <b>Subjective:</b> | 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]             |
| <b>Objective:</b>  | 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]            |
| <b>Assessment:</b> | Analysis of patient's condition and needs      | [Assessment of Patient's condition and needs]  |
|                    | Potential problems or complications            | [Potential problems or complications]          |
| <b>Plan:</b>       | Interventions to address patient's needs       | [Inventions 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]                |

# Example Nursing Documentation

**J Rink**



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