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| Date: Time Precautions:  Yes  No Type  From: To: For:  Vital Signs: P \_\_\_\_\_\_\_\_\_\_ R \_\_\_\_\_\_\_\_\_\_ BP \_\_\_\_\_\_\_\_\_\_ Pain Scale \_\_\_\_\_\_\_\_\_\_ Code Status:  Fall Risk:  Yes  No Restraints:  Yes  No  Level of Consciousness:  Oriented  Anxious  Confused  Nurse Signature: Phone:  (Send copy of current MAR and actual chart including Medication Reconciliation) |
| Post Procedure / Treatment Status Return time:  Tolerated well  See progress note or:  Staff Signature: Phone: |
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