Assessment Record

Date: / /

Name: _____ **Phone:** _____

Age: _____ **Weight:** _____ **Height (if required):** _____

Pulse: _____ **BP:** _____ **Fluid mls/hr,first 4hrs:** _____

HOURLY

TIME						
Temperature						
Pulse						
Respiratory Rate						
Dehydration Status Nil/mild/mod/severe						

FLUID BALANCE **INPUT** **OUTPUT**

TIME	Type	Amount	Running TOTAL	Urine	Vomit	Stool

Guideline of Normal Values by Age

AGE	Newborn	1-6 weeks	6 months	1 year	3 years	6 years	10 years
WEIGHT (kg)	03	04	07	10	15	20	30
HEART RATE	100 - 160	100 - 160	90 - 120	90 - 120	80 - 120	70 - 100	60 - 90
SYSTOLIC BLOOD PRESSURE	50 - 70	70 - 95	80 - 100	80 - 100	80 - 110	80 - 110	90 - 120

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New Traditions

FLUID BALANCE **INPUT** **OUTPUT**

TIME	Type	Amount	Running TOTAL	Urine	Vomit	Stool