

RECORDING MEASUREMENT FORM

RESPIRATIONS FORM:

Resident's Name: *(Do not need to complete for test)*

Date: *(Do not need to complete for test)*

RECORD RESPIRATIONS

_____ /minute

Candidate's Signature

RECORDING MEASUREMENT FORM

PULSE FORM:

Resident's Name: *(Do not need to complete for test)*

Date: *(Do not need to complete for test)*

RECORD PULSE

_____ /minute

Candidate's Signature

RECORDING MEASUREMENT FORM

MANUAL BLOOD PRESSURE FORM:

Resident's Name: *(Do not need to complete for test)*

Date: *(Do not need to complete for test)*

RECORD BLOOD PRESSURE

_____/____ mm Hg

Candidate's Signature

RECORDING MEASUREMENT FORM

INTAKE AND OUTPUT (I & O) FORM:

Resident's Name: *(Do not need to complete for test)*

Date: *(Do not need to complete for test)*

INTAKE			
Time	Type (oral, IV or tube feeding)	Amount in ml (or cc's)	Initials

OUTPUT			
Time	Type (urine, emesis, drainage or diarrhea)	Amount in ml (or cc's)	Initials

Candidate's Signature

RECORDING MEASUREMENT FORM

FOOD & FLUID INTAKE FORM

Resident's Name: *(Do not need to complete for test)*

Date: *(Do not need to complete for test)*

Intake	Amount of Food Eaten	Amount of Fluid Intake
Check one: <input type="checkbox"/> MEAL <input type="checkbox"/> SNACK	Check one: <input type="checkbox"/> 0% <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%	Check one: <input type="checkbox"/> 0% <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%

Candidate's Signature