WEEKLY EVALUATIONS

Date	Intake: Lowest Highest
	Output: Lowest Highest
	Urine Color: Consistency:
	Check if Present: ☐ Hematuria ☐ UTI ☐ Edema ☐ Dry Lips ☐ Dry Mouth ☐ Dry Skin ☐ Frequent Perspiration ☐ Change in Body Weight ☐ Odor of Urine Foley Size:
	Comments/Adequacy
	Signature:
Date	Intake: Lowest Highest
	Output: Lowest Highest
	Urine Color: Consistency:
	Check if Present: ☐ Hematuria ☐ UTI ☐ Edema ☐ Dry Lips ☐ Dry Mouth ☐ Dry Skin ☐ Frequent Perspiration ☐ Change in Body Weight ☐ Odor of Urine Foley Size:
	Comments/Adequacy
	Signature:
Date	Intake: Lowest Highest
	Output: Lowest Highest
	Urine Color: Consistency:
	Check if Present: ☐ Hematuria ☐ UTI ☐ Edema ☐ Dry Lips ☐ Dry Mouth ☐ Dry Skin ☐ Frequent Perspiration ☐ Change in Body Weight ☐ Odor of Urine Foley Size:
	Comments/Adequacy
	Signature:
Date	Intake: Lowest Highest
	Output: Lowest Highest
	Urine Color: Consistency:
	Check if Present: ☐ Hematuria ☐ UTI ☐ Edema ☐ Dry Lips ☐ Dry Mouth ☐ Dry Skin ☐ Frequent Perspiration ☐ Change in Body Weight ☐ Odor of Urine Foley Size:
	Comments/Adequacy
	Signature:

30 DAY EVALUATION

Date	Recording of Intake & Output shall be: ☐ Continued ☐ Discontinued Due To:
	Doctor's Approval to DC ☐ Yes ☐ No Signature:

Last Name	First Name	Attending Physician	Room No.	Med. Rec. No.

"INTAKE & OUTPUT EVALUATION"

SNF FORMS - P.O. Box 4390, Garden Grove, CA 92642

INITIAL **EACH** ENTRY REASON _____ MONTH_____ YEAR_____

	EXAMPLE		1		2		3		4		5		6		7	
	I	O	I	O	I	O	I	O	I	O	I	O	I	O	I	O
NOC	480 KL	250 KL														
AM	1000 jw	800 jw														
PM	600 AG	400 AG														
TOTAL	2080 KL	1450 KL														

	8		9		10		11		12		13		14		15	
	I	O	I	O	I	O	I	O	I	O	I	O	I	O	I	O
NOC																
AM																
PM																
TOTAL																

	16		17		18		19		20		21		22		23	
	I	O	I	O	I	O	I	O	I	O	I	O	I	O	I	O
NOC																
AM																
PM																
TOTAL																

	24		25		26		27		28		29		30		31	
	I	O	I	O	I	O	I	O	I	O	I	O	I	O	I	O
NOC																
AM																
PM																
TOTAL																

INITIAL	SIGNATURE	INITIAL	SIGNATURE	INITIAL	SIGNATURE

Last Name	First Name	Attending Physician	Room No.	Med. Rec. No.

CM-1001

INTAKE - OUTPUT FLOW SHEET (For Health Record)

SNF FORMS