**Clinical Check Sheet**

Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident/Room#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Resident/Room#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vital Signs- Vital Signs-

Mental Status/Mood- Mental Status/Mood

Speech- Speech-

Bathing- Bathing-

Dressing/Grooming- Dressing/Grooming-

Dentures/Oral Care- Dentures/Oral Care-

Nail Care- Nail Care-

Shave- Shave-

Bed- Bed-

Activity- Activity-

Mobility- Mobility-

Vision- Vision-

Hearing- Hearing-

Fluids- Fluids-

Bladder/Urine Bladder/Urine

Bowel- Bowel-

Nutrition- Nutrition-

Resident/Room#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vital Signs-

Mental Status/Mood-

Speech-

Bathing-

Dressing/Grooming-

Dentures/Oral Care-

Nail Care-

Shave-

Bed-

Activity-

Mobility-

Vision-

Hearing-

Fluids-

Bladder/Urine

Bowel-

Nutrition-

Resident/Room#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vital Signs-

Mental Status/Mood-

Speech-

Bathing-

Dressing/Grooming-

Dentures/Oral Care-

Nail Care-

Shave-

Bed-

Activity-

Mobility-

Vision-

Hearing-

Fluids-

Bladder/Urine

Bowel-

Nutrition-