



# ULTIMATE NURSING BRAIN SHEET BUNDLE

7 Specialty-Specific Brain Sheets for Every Unit

01	■ ICU Brain Sheet	ICU • 1–2 Patient Focus
02	■ Med-Surg Report Sheet	Medical-Surgical • Up to 6 Patients
03	■ Emergency Department Sheet	Emergency / Trauma
04	■ Cardiac Brain Sheet	Cardiac / Telemetry
05	■ Postpartum / OB Brain Sheet	Labor & Delivery / OB
06	■ Charge Nurse Report Sheet	Charge RN / Supervisor
07	■ Float Pool Shift Planner	Float Pool / PRN / All Units

✓ Printable PDF

✓ Letter & A4 Ready

✓ All Specialties

✓ Print & Reuse

# HOW TO USE YOUR BRAIN SHEET BUNDLE

Tips from Bobcat Medical™ — Built by Medical Professionals, for Medical Professionals

## 01 PRINT YOUR SHEET

Print on standard 8.5" x 11" letter paper. For best results use laser or inkjet at 100% scale — do not "fit to page". Cardstock (24–32 lb) is recommended for durability during long shifts.

## 02 SELECT YOUR SPECIALTY

This bundle includes 7 specialty-specific sheets. Choose the one that matches your unit each shift, or mix and match. Float nurses can use the Float Pool Shift Planner for any unit.

## 03 FILL IN AT SHIFT START

Complete the patient info, vitals, and key assessment fields during morning/evening report. Circle abnormalities as you go so they stand out at a glance throughout your shift.

## 04 CARRY IT WITH YOU

Fold in half and slide into your scrub pocket, nurse fanny pack, or clipboard. Pair it with Bobcat Medical's Nurse Fanny Pack for the ultimate shift organization system!

## 05 PRINT & REUSE

These sheets are designed to be printed repeatedly. Keep a stack at home and grab a fresh one every shift. Store them digitally on your phone or tablet for on-demand printing.

## 06 HIPAA REMINDER

At the end of your shift, shred or properly dispose of your brain sheet. Never leave patient information unattended. Your facility's HIPAA policies always apply.

### ■ SHEET INDEX — WHAT'S INSIDE

SHEET	NAME	BEST FOR	PATIENTS
01	ICU Brain Sheet	ICU, SICU, MICU, CVICU, Neuro ICU	1–2
02	Med-Surg Report Sheet	Med-Surg, General Floor	Up to 6
03	Emergency Dept Sheet	ER, Trauma, Urgent Care	1
04	Cardiac Brain Sheet	Cardiac, Telemetry, Cath Lab	Comprehensive
05	Postpartum / OB Sheet	L&D, Mother-Baby, Antepartum	1
06	Charge Nurse Report	Charge RN, House Supervisor	Unit-wide
07	Float Pool Shift Planner	Float Pool, PRN Staff, All Units	Varies

■ Visit [www.bobcatmedicalstore.com](http://www.bobcatmedicalstore.com) for nurse fanny packs, stethoscope holders, and more gear built for your shifts!

# ICU BRAIN SHEET

Intensive Care Unit • 1–2 Patient Focus

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<b>PATIENT</b> NAME / MRN: _____ ROOM: _____ CODE: _____ PROVIDER: _____ <b>T A</b> ALLERGIES: _____ ADMIT DATE: _____ PRIMARY DX: _____												
TIME	HR	BP	RR	TEMP	SpO <sub>2</sub>	MAP	GCS	PAIN	UO mL	BG	VENT Mode	

LINES & DRIPS	
A-line (site/date):	
CVL / PICC (site):	
PIV x (gauge):	
Foley (date):	
Drip 1:	
Drip 2:	
Drip 3:	

SYSTEMS ASSESSMENT	
<b>NEURO</b>	GCS: ___ A&Ox: ___ Pupils: ___ Sedation scale: ___ Pain scale: ___
<b>RESP</b>	Vent: <input type="checkbox"/> Y <input type="checkbox"/> N Mode: ___ FiO <sub>2</sub> : ___ % PEEP: ___ TV: ___ SpO <sub>2</sub> : ___
<b>CARDIA</b>	Rhythm: _____ HR: ___ BP: ___ / ___ MAP: ___ Edema: ___
<b>GI/GU</b>	Diet: ___ BS: ___ UO: ___ mL/hr Foley: <input type="checkbox"/> Y <input type="checkbox"/> N BUN: ___ Cr: ___
<b>SKIN</b>	Intact: <input type="checkbox"/> Y <input type="checkbox"/> N Wounds/PI: _____
<b>LABS</b>	Na: ___ K: ___ Cl: ___ CO <sub>2</sub> : ___ Gluc: ___ Hgb: ___ Plt: ___ Lac: ___ INR: ___
<b>PLAN</b>	

<b>PATIENT</b> NAME / MRN: _____ ROOM: _____ CODE: _____ PROVIDER: _____ <b>T P</b> ALLERGIES: _____ ADMIT DATE: _____ PRIMARY DX: _____												
TIME	HR	BP	RR	TEMP	SpO <sub>2</sub>	MAP	GCS	PAIN	UO mL	BG	VENT Mode	

LINES & DRIPS	
A-line (site/date):	
CVL / PICC (site):	
PIV x (gauge):	
Foley (date):	
Drip 1:	
Drip 2:	
Drip 3:	

SYSTEMS ASSESSMENT	
<b>NEURO</b>	GCS: ___ A&Ox: ___ Pupils: ___ Sedation scale: ___ Pain scale: ___
<b>RESP</b>	Vent: <input type="checkbox"/> Y <input type="checkbox"/> N Mode: ___ FiO <sub>2</sub> : ___ % PEEP: ___ TV: ___ SpO <sub>2</sub> : ___
<b>CARDIA</b>	Rhythm: _____ HR: ___ BP: ___ / ___ MAP: ___ Edema: ___
<b>GI/GU</b>	Diet: ___ BS: ___ UO: ___ mL/hr Foley: <input type="checkbox"/> Y <input type="checkbox"/> N BUN: ___ Cr: ___
<b>SKIN</b>	Intact: <input type="checkbox"/> Y <input type="checkbox"/> N Wounds/PI: _____
<b>LABS</b>	Na: ___ K: ___ Cl: ___ CO <sub>2</sub> : ___ Gluc: ___ Hgb: ___ Plt: ___ Lac: ___ INR: ___
<b>PLAN</b>	

# MED-SURG REPORT SHEET

Medical-Surgical Floor • Up to 6 Patients

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DATE: \_\_\_\_\_

NURSE: \_\_\_\_\_

SHIFT:  Days  Nights

UNIT: \_\_\_\_\_

RM	PATIENT / MRN	DX	MD	CODE	DIET	IV/ACCESS
Pt 1						
Pt 2						
Pt 3						
Pt 4						
Pt 5						
Pt 6						

## PRIORITY TASKS & TO-DOS

TIME	ROOM	TASK / ACTION	

# EMERGENCY DEPARTMENT SHEET

ER / Trauma • Rapid Assessment Focus

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DATE/TIME IN: _____		TRIAGE LEVEL: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		ARRIVAL: <input type="checkbox"/> Walk-in <input type="checkbox"/> EMS <input type="checkbox"/> Air		NURSE: _____	
PATIENT NAME / MRN		ROOM #		PROVIDER		ADMIT DATE	

## CHIEF COMPLAINT & TRIAGE VITALS

CHIEF COMPLAINT	PAIN SCALE (0-10)						
	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10						
HR	BP	RR	TEMP	SpO <sub>2</sub>	GCS	WEIGHT	Emt (if applicable)
_____	_____	_____	_____	_____	_____	_____	_____

## SAMPLE HISTORY

<b>S</b>	SIGNS & SYMPTOMS	
<b>A</b>	ALLERGIES	<input type="checkbox"/> NKDA
<b>M</b>	MEDICATIONS	
<b>P</b>	PAST MEDICAL / SURGICAL HX	
<b>L</b>	LAST ORAL INTAKE	
<b>E</b>	EVENTS LEADING TO VISIT	

## INTERVENTIONS & ORDERS

<input type="checkbox"/> IV Access (site/gauge/time):	
<input type="checkbox"/> O <sub>2</sub> therapy (type/rate):	
<input type="checkbox"/> Monitor placed:	
<input type="checkbox"/> EKG ordered/done:	
<input type="checkbox"/> Labs drawn (type):	
<input type="checkbox"/> Imaging ordered:	
<input type="checkbox"/> Medications given:	
<input type="checkbox"/> Foley / NGT placed:	
<input type="checkbox"/> Consults called:	

## DISPOSITION

<input type="checkbox"/> Admit to floor
<input type="checkbox"/> Admit to ICU
<input type="checkbox"/> Admit to telemetry
<input type="checkbox"/> Transfer to OR
<input type="checkbox"/> Discharge home
<input type="checkbox"/> Discharge with home health
<input type="checkbox"/> AMA
<input type="checkbox"/> Expired
<input type="checkbox"/> Observation status

# CARDIAC BRAIN SHEET

Cardiac / Telemetry Unit • Rhythm & Hemodynamic Focus

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PATIENT NAME / MRN	ROOM #	PROVIDER	CODE STATUS	ALLERGIES	ADMIT DATE

## CARDIAC HISTORY & BASELINE

CARDIAC HX:	<input type="checkbox"/> CAD <input type="checkbox"/> CHF <input type="checkbox"/> A-Fib <input type="checkbox"/> HTN <input type="checkbox"/> Valve Dz <input type="checkbox"/> Post-CABG <input type="checkbox"/> PCI <input type="checkbox"/> ICD/PPM <input type="checkbox"/> <input type="checkbox"/> HFrEF <input type="checkbox"/> HFpEF	
BASELINE RHYTHM:		EF: _____ BNP/NT-proBNP: _____ Troponin: _____

## SERIAL VITALS & HEMODYNAMICS

TIME	HR	RHYTHM	BP	MAP	CVP	SpO <sub>2</sub>	TEMP	PAIN	BG	WEIGHT

### CARDIAC MEDICATIONS

<input type="checkbox"/> Metoprolol:	Dose: _____ Time: _____
<input type="checkbox"/> Lisinopril/Losartan:	Dose: _____ Time: _____
<input type="checkbox"/> Furosemide (Lasix):	Dose: _____ Time: _____
<input type="checkbox"/> Digoxin:	Dose: _____ Time: _____
<input type="checkbox"/> Amiodarone:	Dose: _____ Time: _____
<input type="checkbox"/> Heparin/Lovenox:	Dose: _____ Time: _____
<input type="checkbox"/> Aspirin/Plavix:	Dose: _____ Time: _____
<input type="checkbox"/> Nitroglycerin:	Dose: _____ Time: _____
<input type="checkbox"/> Other::	Dose: _____ Time: _____

### RHYTHM STRIP / EKG NOTES

Rhythm:	
Rate:	
PR interval:	
QRS duration:	
QT/QTc:	
ST changes (lead):	
T-wave changes:	
Interpretation:	
Notified MD:	

## FLUID BALANCE & I&O;

INTAKE SOURCE	AMOUNT	OUTPUT SOURCE	AMOUNT
IV Fluids		Urine output	
PO Fluids		Emesis	
Blood products		Drainage	
TPN/Feeds		Stool/Other	
<b>TOTAL INTAKE:</b>		<b>TOTAL OUTPUT:</b>	

# POSTPARTUM / OB BRAIN SHEET

Labor & Delivery • Mother & Baby Assessment

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## MOTHER INFORMATION

PATIENT NAME / MRN	ROOM	DOB / AGE	OB PROVIDER	CODE STATUS
G ___ P ___ A ___	EGA / DELIVERY DATE	DELIVERY TYPE	GBS STATUS	ALLERGIES
	<input type="checkbox"/> SVD <input type="checkbox"/> C/S (1°/repeat)	<input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum	<input type="checkbox"/> + <input type="checkbox"/> - <input type="checkbox"/> Unknown	

## BUBBLE-HE POSTPARTUM ASSESSMENT

<b>B</b>	<b>BREASTS</b>	Soft/Filling/Engorged <input type="checkbox"/> BF <input type="checkbox"/> Bottle <input type="checkbox"/> Pumping Nipple condition: _____
<b>U</b>	<b>UTERUS</b>	Fundal height:___ Firmness: <input type="checkbox"/> Firm <input type="checkbox"/> Boggy Midline: <input type="checkbox"/> Y <input type="checkbox"/> N Diastasis:___
<b>B</b>	<b>BLADDER</b>	Voided: <input type="checkbox"/> Y <input type="checkbox"/> N UO:___mL Foley: <input type="checkbox"/> Y <input type="checkbox"/> N Distension: <input type="checkbox"/> Y <input type="checkbox"/> N
<b>B</b>	<b>BOWEL</b>	BS: <input type="checkbox"/> Present <input type="checkbox"/> Absent Passed gas: <input type="checkbox"/> Y <input type="checkbox"/> N BM: <input type="checkbox"/> Y <input type="checkbox"/> N Constipation: <input type="checkbox"/> Y <input type="checkbox"/> N
<b>L</b>	<b>LOCHIA</b>	Amount: <input type="checkbox"/> Scant <input type="checkbox"/> Light <input type="checkbox"/> Mod <input type="checkbox"/> Heavy Color: <input type="checkbox"/> Rubra <input type="checkbox"/> Serosa <input type="checkbox"/> Alba Odor: <input type="checkbox"/> Y <input type="checkbox"/> N
<b>E</b>	<b>EPISIOTOMY/INCISION</b>	REEDA: R___ E___ E___ D___ A___ Staples: <input type="checkbox"/> Y <input type="checkbox"/> N Dressing: <input type="checkbox"/> Intact <input type="checkbox"/> Changed
<b>H</b>	<b>HOMAN'S SIGN / DVT</b>	Lower extremity edema: <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ Homan's: <input type="checkbox"/> Neg <input type="checkbox"/> Pos TED hose: <input type="checkbox"/> Y <input type="checkbox"/> N
<b>E</b>	<b>EMOTIONAL STATUS</b>	Mood: <input type="checkbox"/> Stable <input type="checkbox"/> Anxious <input type="checkbox"/> Tearful Edinburgh score:___ Support system: ___

## NEWBORN ASSESSMENT

BABY NAME / ID	DOB / TOB	SEX	WEIGHT / LENGTH	APGAR 1 MIN / 5 MIN
		<input type="checkbox"/> M <input type="checkbox"/> F		
<b>APPEARANCE</b>	Color: <input type="checkbox"/> Pink <input type="checkbox"/> Pale <input type="checkbox"/> Jaundiced <input type="checkbox"/> Mottled Skin: <input type="checkbox"/> WNL Vernix: <input type="checkbox"/> Y <input type="checkbox"/> N			
<b>RESP</b>	RR:___ Effort: <input type="checkbox"/> Unlabored <input type="checkbox"/> Grunting <input type="checkbox"/> Retracting O sats:___ Room air: <input type="checkbox"/> Y <input type="checkbox"/> N			
<b>CARDIAC</b>	HR:___ Rhythm: <input type="checkbox"/> Regular Murmur: <input type="checkbox"/> Y <input type="checkbox"/> N Cap refill:___ sec			
<b>NEURO</b>	Tone: <input type="checkbox"/> Normal <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper Cry: <input type="checkbox"/> Strong <input type="checkbox"/> Weak Reflexes: <input type="checkbox"/> WNL			
<b>FEEDING</b>	Method: <input type="checkbox"/> BF <input type="checkbox"/> Bottle Latch: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor Feeding #:___ Last fed:___			
<b>ELIMINATION</b>	Voided: <input type="checkbox"/> Y <input type="checkbox"/> N Stool: <input type="checkbox"/> Y <input type="checkbox"/> N Type: <input type="checkbox"/> Meconium <input type="checkbox"/> Transitional <input type="checkbox"/> Yellow			

# CHARGE NURSE REPORT SHEET

Charge RN / Supervisor • Unit Overview

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DATE: \_\_\_\_\_ SHIFT:  Days  Nights UNIT: \_\_\_\_\_ CENSUS: \_\_\_/\_\_\_ CHARGE RN: \_\_\_\_\_

## STAFF ASSIGNMENTS

STAFF NAME	CREDENTIALS	ASSIGNMENT / ROOMS	OVERTIME?	NOTES

## UNIT PATIENT OVERVIEW

BED/RM	PATIENT	DX	NURSE ASSIGNED	CODE	ISOLATION	PENDING	DISPO

### INCIDENTS / SAFETY EVENTS

- Patient fall
- Medication error
- HAPU identified
- Rapid Response called
- Code called
- Restraint applied
- Patient complaint
- Safety event reported

### SHIFT NOTES & FOLLOW-UPS

# ■ FLOAT POOL SHIFT PLANNER

Float Pool / All Units • 12-Hour Shift Organizer

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NURSE NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

UNIT: \_\_\_\_\_

SHIFT: ■ 7A-7P ■ 7P-7A

## ■ HOURLY SHIFT PLANNER

■ DAY SHIFT		■ NIGHT SHIFT	
HOUR	TASKS / NOTES	HOUR	TASKS / NOTES
0700		1900	
0800		2000	
0900		2100	
1000		2200	
1100		2300	
1200		0000	
1300		0100	
1400		0200	
1500		0300	
1600		0400	
1700		0500	
1800		0600	
1900		0700	

## PATIENT QUICK REFERENCE

RM	PATIENT	CODE	DX / NOTES

## SELF-CARE REMINDERS ■

■ Drank water (goal: 64 oz per shift)
■ Ate a meal / snack
■ Took a 15-min break
■ Used the restroom
■ Did a mental check-in
■ Completed end-of-shift documentation
■ Gave thorough handoff report