



Osakidetza
Servicio vasco de Salud

DONOSTIA OSPITALEA
HOSPITAL DONOSTIA

ERIZAINZA ERREGISTRO
REGISTRO DE ENFERMERIA

DEITURAK / APELLIDOS

Nº Urgencia

IZENA / NOMBRE

JAIOTZE DATA / FECHA DE NACIMIENTO

HELBIAEA / DOMICILIO

Tfno:

GIZARTE SEGURANTZA ZK. / Nº S. SOCIAL

HISTORIA ZK. / Nº HISTORIA

ZERBITZUA / SERVICIO DE URGENCIAS GENERALES

Enf.

Er.

SARRERA DATA / FECHA DE INGRESO

ALTA DATA / FECHA DE ALTA

| DATOS PREVIOS | ACUDE: ANDANDO <input type="checkbox"/> EN SILLA <input type="checkbox"/> CAMILLA <input type="checkbox"/> SOLO <input type="checkbox"/> ACOMPAÑADO <input type="checkbox"/> MOTIVO POR EL QUE ACUDE: _____ MEDICO RESPONSABLE: _____ INFORMACION RECIBIDA DE: _____ ALERGIAS: _____ RETIRADA DE OBJETOS PERSONALES: _____ ENTREGADO A: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|------|------|----|----------|--------|---------|--------|--|--|------|------|------|------|----|----------|--------|---------|--------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">HORA</th> <th style="width: 10%;">P.A.</th> <th style="width: 10%;">F.C.</th> <th style="width: 10%;">F.R.</th> <th style="width: 10%;">T°</th> <th style="width: 10%;">DIURESIS</th> <th style="width: 10%;">DEPOS.</th> <th style="width: 10%;">SAT. O2</th> <th style="width: 10%;">P.V.C.</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> | | | | | | | | | | HORA | P.A. | F.C. | F.R. | T° | DIURESIS | DEPOS. | SAT. O2 | P.V.C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HORA | P.A. | F.C. | F.R. | T° | DIURESIS | DEPOS. | SAT. O2 | P.V.C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| P. DIAG. | <input type="checkbox"/> <input type="checkbox"/> BIOQUIMICA <input type="checkbox"/> <input type="checkbox"/> HEMOGRAMA <input type="checkbox"/> <input type="checkbox"/> E. COAGULACION <input type="checkbox"/> <input type="checkbox"/> P. CRUZADAS <input type="checkbox"/> E.C.G. <input type="checkbox"/> <input type="checkbox"/> GASOMETRIA <input type="checkbox"/> <input type="checkbox"/> S. ORINA <input type="checkbox"/> <input type="checkbox"/> RX. TORAX <input type="checkbox"/> <input type="checkbox"/> R.X. ABDOMEN OTRAS: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | PROCEDIMIENTOS <input type="checkbox"/> SONDAJE VESICAL _____ ASPECTO _____ CANTIDAD _____ <input type="checkbox"/> SONDAJE NASOGASTRICO <input type="checkbox"/> LAVADO GASTRICO HORA _____ CANTIDAD _____ ASPECTO (limpio, hemático, posos de café, otros) <input type="checkbox"/> GLUCEMIA CAPILAR Hora ____ / ____ Mgrs. Hora ____ / ____ Mgrs. Hora ____ / ____ Mgrs. <input type="checkbox"/> OXIGENOTERAPIA TIPO _____ <input type="checkbox"/> ASPIRACION SECRECIONES <input type="checkbox"/> VENOCLISIS: HORA _____ TIPO _____ ZONA DE INSERCIÓN _____ <input type="checkbox"/> CURA <input type="checkbox"/> VENDAJE <input type="checkbox"/> OTROS _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HORA ULTIMA INGESTA: SOLIDO _____ LIQUIDO _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TOLERANCIA: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

COLEGIADO

FIRMADO:

Fecha:
Hora:
Pagina: 1

15/1



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Servicio vasco de Salud

DONOSTIA OSPITALEA
HOSPITAL DONOSTIA

ERIZAINZA ERREGISTRO
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Enf.

Er.

SARRERA DATA / FECHA DE INGRESO

ALTA DATA / FECHA DE ALTA

| MEDICACION | HORA | VIA | FIRMA |
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VALORACION Y CUIDADOS

- DOLOR _____
- DETERIORO INTEGRIDAD CUTANEA R/C _____
- PATRON RESPIRACION INEFICAZ R/C _____
- POTENCIAL ASPIRACION _____
- LIMPIEZA INEFICAZ VIAS AEREAS _____
- ALTERACION ELIMINACION URINARIA R/C _____
- LESION POTENCIAL R/C _____
- VIOLENCIA POTENCIAL R/C _____
- ANSIEDAD _____
- EXTREÑIMIENTO DIARREA
- INCONTINENCIA FECAL R/C _____
- DEFICIT AUTOCUIDADO WC _____
- DEFICIT AUTOCUIDADO VESTIDO/ACICAL _____
- DETERIORO COMUNICACION VERBAL R/C _____
- ALTERACION SENSO PERCEPTIVA R/C _____
- DETERIORO MOVILIDAD FISICA R/C _____
- INTOLERANCIA A LA ACTIVIDAD R/C _____
- HIPERTERMIA HIPOTERMIA
- DESESPERANZA _____
- TEMOR _____
- DUELO DISFUNCIONAL _____
- AFRONTAMIENTO INDIVIDUAL INEFICAZ _____

CUIDADOS SEGUN PROTOCOLOS

OTRAS OBSERVACIONES Y/O CUIDADOS _____

COLEGIADO

FIRMADO:

Fecha:
Hora:
Pagina: 2

15/1