NEAR EAST UNIVERSITY FACULTY OF NURSING
NUR201 MEDICAL NURSING

STUDENT CLINICAL FILE

STUDENT'S NAME AND SURNAME:
NUMBER:

INFORMATION ABOUT THE APPLICATION AREA

HOSPITAL NAME:

NAME OF THE CLINIC:

TABLE OF CONTENTS

1. **PATIENT DATA COLLECTION FORM**
2. **PATIENT CARE PLAN**
3. **DAILY CLINICAL PRACTICE REPORT**
4. **STUDENT EVALUATION FORM**
5. **CLINICAL ATTENDANCE/ATTENDANCE SCHEDULE**

DELIVERY DATE: **SIGNATURE:**

NEAR EAST UNIVERSITY FACULTY OF NURSING NUR 201 MEDICAL NURSING
PATIENT DATA COLLECTION FORM

Student's Name Surname: ……. **History:** …….
/……./…….

INTRODUCTORY INFORMATION ABOUT THE PATIENT

Name Surname: …….. **Hospital/department…**….....

Age: ..... **Date hospitalization:** .....

Gender: ……..... **Medical diagnosis:** .....

Marital status: …… **Blood type…**…….....

Number of children, their ages: .....

Job/profession: ..... ( ) Quit his job ( ) On report ( ) Retired

Social security: ( )Yes ( )None.

Infectious disease: (Hbs(hb)HCV (hc)HIV () Other.....

Hospital infection requiring isolation; ( )Yes ( )None

If there is a hospital infection that requires isolation, the type of isolation is:

( ) Contact isolation ( ) Tight Contact isolation ( ) Respiratory Isolation ( ) Droplet Isolation

Height: ..... **Weight:** ..... **B.M.I. :** .....

Pulse: ...../min ( ) strong ( ) weak ( ) regular ( ) irregular

Blood pressure: ..... mmHg ( ) right arm ( ) left arm ( ) sitting ( ) lying down

Respiratory rate: ...../min Quality: ( ) Normal ( ) Superficial ( ) Fast

Body temperature: ...../°C

Menstrual problems : ( ) No ( ) Yes

( ) Menopause

Monthly breast/testicular self-examination : ( ) No ( ) Yes

Place of Arrival : ( ) Polyclinic ( ) Intensive Care ( ) Service ( ) Emergency Unit ( ) Other .....

COMPLAINT/STORY:

HEALTH HISTORY

Chronic Diseases Yes( ) None( )

( ) Diabetes Mellitus ( ) Kidney problems (.....) ( ) Paralysis

( ) Congestive Heart Failure ( ) Migraine/headache ( ) Anemia

( ) Coronary Artery Disease ( ) Cancer ( ) Other

( ) Hypertension ( ) Ulcer (.....)

( ) Hypo/Hyperthyroidism ( ) Arthritis

Smoking: ( ) No ( ) Quit (date)..... ( ) Yes (..... amount/ duration)

Alcohol: ( ) No ( ) Quit (date)..... ( ) Yes (..... quantity/day)

Previous hospitalization ( ) Yes ( ) None

Reasons for hospitalization: .....

Surgical Intervention ( ) Yes ( ) None

Initiative carried out : .....

Allergy: ( ) Yes ( ) None

Allergen: ( ) drug..... ( ) food ( ) contact allergen (fabric, metal) ( ) Environmental agents : ( ) Smoke ( ) Pollen ( ) Other.....

EVALUATION OF SYSTEMS

SKIN

Color: ( ) Normal ( ) Pale ( ) Cyanotic ( ) Jaundice Location:.....

Temperature: ( ) Normal ( ) Hot ( ) Cold Place :.....

Turgor: ( ) Normal ( ) poor

Edema: ( ) None ( ) Yes .....+ Location :.....

Pressure ulcer: ( ) None ( ) Location :.....

Petechiae, Purpura, Ecchymoses: ( ) None ( ) Yes Location: .....

Itching: ( ) None ( ) Yes Location: .....

Vascular Access: ( ) None ( ) Yes Location: .....

MOUTH

Teeth

Alt ( ) Missing.... ( ) Full

Top ( ) Missing.... ( ) Full

Gums: ( ) Normal ( ) Lesion ( ) Other.....

Language: ( ) Normal ( ) Other.....

Intraoral: ( ) Normal ( ) Plaque ( ) Bleeding ( ) Other

RESPIRATION

Dyspnea: ( ) None ( ) Yes

Cough: ( ) None ( ) Yes (Define).....

Secretion: ( ) None ( ) Yes (Define).....

SO2: **PO2:** **PCO2:** **O2 Treatment:** ( ) None ( ) Yes (.....lt/min)

NEUROLOGICAL

Mental state: ( ) Orient ( ) Confused ( ) Agitated ( ) Emotional blunt

Speaking: ( ) Normal ( ) Lisping ( ) Impaired ( ) Motor aphasia

Pupillary: ( ) Isochoric ( ) Anisochoric ( ) Miotic ( ) Mydriatic

Right/Left

Light reflex (IR) ...../.....

Eyes : ( ) Clean ( ) Discharge ( ) Redness ( ) Other.....

Corneal reflex : ( ) None ( ) Yes

GLASKOW COMA SCLA

Ability to open eyes	Can open spontaneously Can open with verbal orders It can open with painful stimuli It doesn't turn on	4 3 2 1
Motor response	Obeying orders Localized to pain Tensile (exst. Trying to pull the nerve from the painful stimulus Flexion Excessiveness No reaction	6 5 4 3 2 1
Verbal response	Orientation (place, person, time) Confused (makes sentences but answers are wrong) Inappropriate sentences (one or more wrong answers) Meaningless sounds No reaction	5 4 3 2 1
RESULT		

MUSCULOSKELETAL

Muscle atrophy: ( ) None ( ) Presence Location: .....
Contracture: ( ) None ( ) Yes Location: .....
Gait and balance:
Hand grip : ( ) equal ( ) strong ( ) weak/paralysis (right left)
Leg muscles :() equal ( ) strong ( ) weak/paralysis (right left)

ACTIVITY/EXERCISE

	(0) Standalone	(1) By auxiliary vehicle	(2) With the help of others	(3) Fully dependent
Food/drink				
Bathing				
Dressing/sprucing up				
Going to the toilet				

In-bed mobility				
Walking/strolling				

NUTRITIONAL/METABOLIC STATUS

Diet: ( )Oral ( )Enteral ( )Parenteral **Diet:**
Diet information : ( )Yes ( )None
Appetite : ( ) normal ( ) Increased ( ) Decreased ( ) Decreased sense of taste ( ) Nausea ( ) Vomiting
Weight change in the last 6 months : ( ) Yes ( ) None
Difficulty swallowing (dysphagia): ( )Yes ( )solid foods ( ) liquid foods) ( )None

ABDOMEN/EXCRETION

Bowel sounds: ( ) None ( ) Present ..... **Bowel habits: frequency:** ...../Day ...../Week ( ) Normal ( ) Constipation ( ) Diarrhea ( ) Fecal Impakshin
Bladder habits: ..... ( ) Normal ( ) Dysuria ( ) Nocturia ( ) Hematuria ( ) Retention ( )Other.....
Incontinence: ( )None ( )Yes **Urine:** ( )None ( )Yes **Stool** : ( )None ( )Yes

SLEEP

Duration: .....hour/night **Nap:** ( ) In the morning..... ( )Afternoon..... **Feeling rested after sleep**:.....
Insomnia:.....

Hearing: ( )Normal ( )Insufficient (( )Right ( )Left) ( )Deafness((right) (Left)) ( )Hearing aid
Vision: ( )Normal ( )Right..... ( )Left.....
( )Glasses
( )Contact lenses
( )Myopia
( )Hyperopia
( )Astigmatism
( )Blindness
( ) Cataract ( )Prosthesis

Pain : ( )None ( )Yes ( )Acute ( )Chronic

Place:..... Time:.....
Frequency:.....Severity:.....
Feature : ( ) Common ( ) Local ( ) Stinging ( ) Throbbing ( ) Burning ( ) Sharp

Management of pain:.....

LABORATORY FINDINGS

HISTORY	RESULTS	NORMAL VALUES	CURRENT VALUES	REASON

EXAMINATIONS PERFORMED AT THE LAST HOSPITALIZATION	HISTORY	RESULT

Medications Given in the Clinic	Dosage/Route of Administration	Effect	Side Effect

THERAPY

Previous medications: ( ) None ( ) Yes (Explain).....
……
……...

FLUID INTAKE AND REMOVAL TRACKING

History		08-16	16-24	24-08	Sum	Result
	Receive					○ On Balance ○ Hypovolemia ○ Hypervolemia ○ Other.....
	Issued					
	Receive					○ On Balance ○ Hypovolemia ○ Hypervolemia

	Issued					○ Other.....
	Receive					○ On Balance ○ Hypovolemia ○ Hypervolemia ○ Other.....
	Issued					
	Receive					○ On Balance ○ Hypovolemia ○ Hypervolemia ○ Other.....
	Issued					

FAMILY STORY

1. **Family structure :** ( ) Lives alone ( ) Nuclear Family ( ) Extended Family
2. **Patient's source of income** : ( )Himself ( )Spouse ( )Other.....
3. **How to deal with problems:**
   .....
4. **Patient/Family's stress in the last 1 year :**
   ( )Yes (explain) ( ) None
   ……
   ……
5. **The most important sources of support in case of stress/crisis** :
   .....
   ……
   ……..
6. **Disease in family members** : ( ) None ( ) Yes.....
7. **Concerns about illness or hospitalization**:.....
   .....
   .....
   .....
8. **Status of being informed about his/her disease/treatment/diet**:
   .....
   .....
   .....
   .....
   .....

OTHER:

Nursing Diagnoses -Current Problems -Possible Problems -Educational Problems	**Causes Diagnostic Criteria**	**Goal**	**Planning** (Ex: $NaHCO_3$ oral care with 3/8 hours)	**Implementation** (The hours when the planned initiatives are implemented should be written.) **08-09-10-11-12-13-14-15-16**	**Assessment**

NEAR EAST UNIVERSITY FACULTY OF NURSING HEM201 INTERNAL MEDICINE NURSING
PATIENT DATA COLLECTION FORM
MAINTENANCE PLAN

Student's Name Surname:
Patient's Name Surname:

NEAR EAST UNIVERSITY FACULTY OF NURSING HEM201 INTERNAL MEDICINE NURSING
DAILY CLINICAL PRACTICE REPORT

STUDENT'S NAME AND SURNAME:.....
HOSPITAL:.....
CLINICAL:.....

HISTORY	APPLICATIONS TO HIS PATIENT	APPLICATIONS IN THE CLINIC	APPLICATION/OPERATIONS FOLLOWED

"NEAR EAST UNIVERSITY FACULTY OF NURSING HEM201 INTERNAL MEDICINE NURSING COURSE CLINICAL STUDENT EVALUATION FORM" WILL BE FILLED IN BY THE RESPONSIBLE NURSE AND PLACED IN THE FILE IN A SEALED ENVELOPE.

NEAR EAST UNIVERSITY FACULTY OF NURSING HEM201 INTERNAL MEDICINE NURSING
CLINICAL STUDENT EVALUATION FORM

Name of hospital:
Clinic/Unit Name:
Student's Name Surname:

EVALUATION CRITERIA	Very good (1)	Good (2)	Middle (3)	Bad (4)	Could not be evaluated (Reason)
1. Pay attention to the uniform layout					
2. Arriving at the clinic on time					
3. Receiving / giving the patient, participating in the patient delivery					
4. Using professional/appropriate communication techniques in communication with the patient and his/her family					
5. Using professional/appropriate communication techniques in communication with healthcare professionals					
6. Accurate data collection for the patient's disease process and influencing factors (education, socio-economic status, previous experiences, habits, etc.)					
7. Monitoring patient procedures/applications					
8. Determining the needs of the patient and his/her family for the care plan					
9. Explaining the procedures to be performed to the patient/family					
10. Making interventions/interventions (care, treatment, education, etc.) according to the patient's determined needs.					
11. Getting support from other members of the healthcare team in the interventions planned/to be made for the patient					
12. Evaluating the impact of planned/planned interventions for the patient					
13. Reporting patient-related problems and any changes to the relevant people					
14. Providing education in accordance with the needs of the patient/family, the characteristics of the patient (educational, socio-economic, cultural, etc.)					
15. Recording the patient/family the applications					
16. Fulfilling the assigned tasks in a timely and appropriate manner					
17. Complying with the principles of medical/surgical asepsia, Washing hands					
Other Opinions About the Student (clinical practice and compliance, etc.): - - -					

NOTE GIVEN:
NAME AND SURNAME OF THE RESPONSIBLE NURSE WHO MADE THE EVALUATION:
DATE/SIGNATURE:

NEAR EAST UNIVERSITY FACULTY OF NURSING HEM201 INTERNAL MEDICINE NURSING
PATIENT DATA COLLECTION FORM
CLINICAL PRACTICE PATIENT DISTRIBUTION SCHEDULE

Clinical:

History:

Student's Name and Surname	**Patient's Name and Surname**	**Patient Room Number**	**Diagnosed**	**Special Applications/Examinations**
1.				
2.				
3.				
4.				
5.				
6.				
7.				

	LUNCH BREAK PATIENT DELIVERY SCHEDULE GROUP 1: 11:30-12:30 GROUP 2: 12:30-13.30			
STUDENT'S NAME AND SURNAME	PATIENT'S NAME SURNAME / ROOM NUMBER		STUDENT'S NAME AND SURNAME	PATIENT'S NAME SURNAME / ROOM NUMBER

RESPONSIBLE STUDENT: