Head-to-Toe Checklist

(For use with Body Condition Diagram)

Name: _____ Date: _____ Time:_____

This form must be completed when any injury is noted and/or following any fall.

Direction (X) appropriate column. If "yes" describe assessment findings and follow up in the COMMENT section below.

		Problem				Problem	
		Yes	No			Yes	No
Head:	Face			Back:	Upper		
	Eyes				Lower		
	Ears				Buttocks		
	Mouth			Lower Body:	Waist		
	Scalp						
If yes, **include** neurological check form.					Abdomen		
Heck:	Front				Upper Legs		
	Back				Knees		
Upper Body:	Shoulders				Ankles		
					Feet		
	Upper Arms				Toes		
	Elbows						
	Lower Arms						
	Wrists						
	Hands						
	Fingers						
	Chest						

Signature/Title: _____Date/Time: _____

RN Review: _____ Date/Time: _____

Admin Review: _____Date/Time:_____

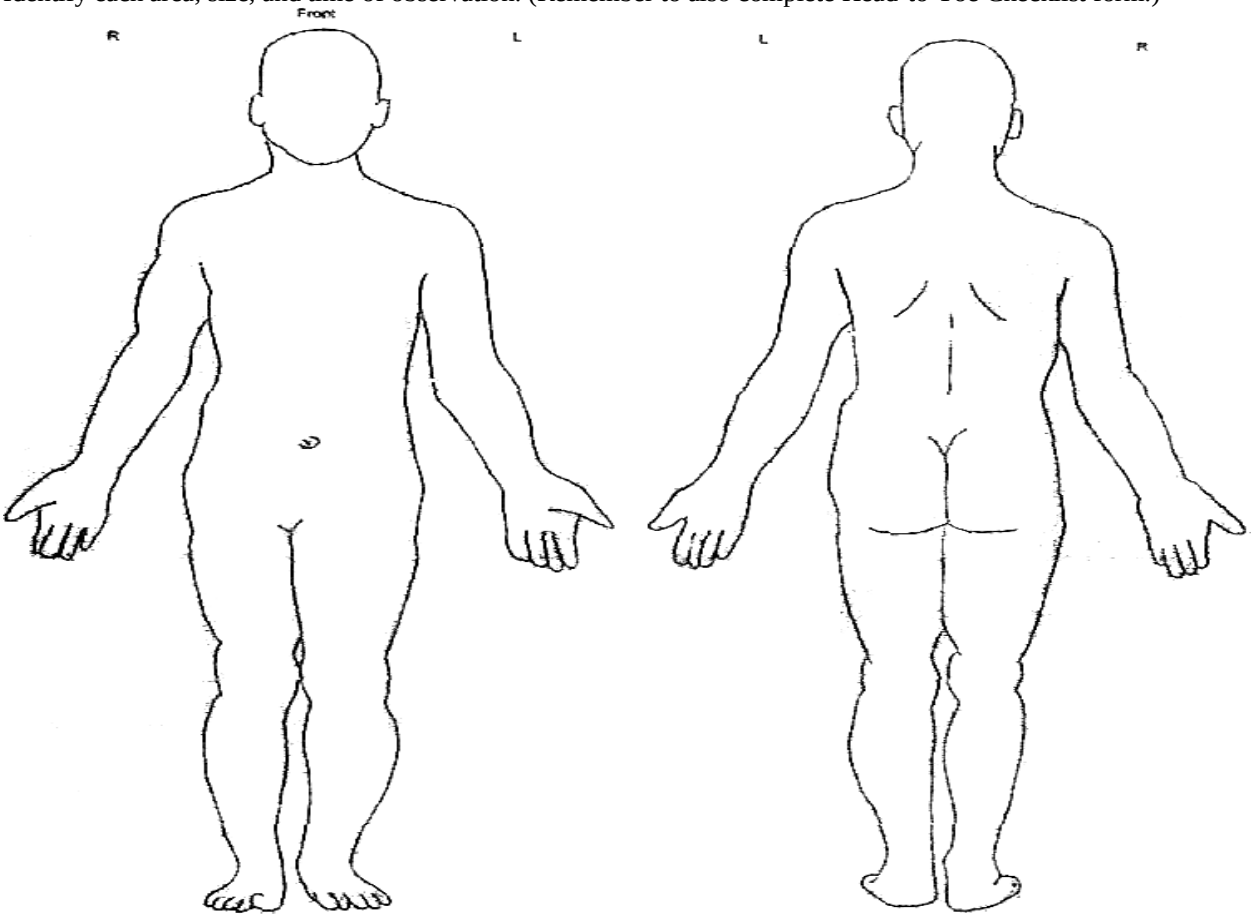
Please complete both sides

Head-toechecklist 4/14/20 LD

BODY CONDITION DIAGRAM

Name:_____
Date:_____
Time:_____
Staff:_____

Identify each area, size, and time of observation. (Remember to also complete Head-to-Toe Checklist form.)



Is there a breakdown of skin integrity, (i.e.: scrape, cut, bruise, redness, warmth, swelling, rash, etc) Describe size of wound and specific location. Is there pain, tenderness, weakness, loss of use or deformity? Is there bleeding or drainage? Describe type and amount.

Comments: _____
_____
_____
_____

RN Review: _____ Date:_____

Please complete both sides
Head-toechecklist 4/14/20 LD