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Nursing Needs Assessment Decision Record Form- this serves as a document wherein the nurse will state what form of procedure that the doctor decided in line with the assessment records. The patient's needed medicine and facilities are also stated in this form.

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A nursing assessment form gathers all the information of a patient's physiological, spiritual, sociological and physiological stages and conditions. A nursing assessment forms contain the basic and personal information about the patient such as his/ her name, address, contact number and so on.

Nursing assessment is an important step of the whole nursing process. Assessment can be called the "base or foundation" of the nursing process. With a weak or incorrect assessment, nurses can create an incorrect nursing diagnosis and plans therefore creating wrong interventions and evaluation. To prevent those kind of scenarios, we have created a cheat sheet that you can print and use to ...

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