NAME _____

Acute Pain

Date	Problem	Goal/Outcome	Interventions	Date	Evaluation	NOTES
	Related To: □Pain due to (state) □Location (state) AEB: □Last complaint of pain _____ (description) • Location • Characteristic • Onset • Duration • Frequency • Quality • Severity • Precipitating factors • Signs/ • symptoms • 0-10 scale □ guarding behavior □ moaning/crying □ pacing □ facial mask of pain □ VS not WNL □ sweating □ nausea/vomiting □ pale	1. No complaint of pain > 3 on pain scale 2. Verbalizes effective pain relief/ intervention	**NURSING** 1. Initial and ongoing pain assessment including VS _____ (freq) 2. Assess for probable cause 3. Evaluate response to pain med 4. Assess ability/motivation to perform ADLs 5. Monitor weight **DELEGATE** 1.Assist with meds as ordered/directed Take VS with each complaint of pain 2.Monitor for nonverbal cues of pain (state) 3. Inform MAS Nurse of responsive pain med 4. Other (list)		***(Address all items listed circled in "goal/ outcome" column. If goal not met, revise plan)***	
RN SIGNATURE:					**DATE:**	

Acute Pain