

Daily Fluid Balance & Prescription Chart

Write in CAPITAL LETTERS or use addressograph

Surname: _____

First names: _____

Consultant: _____ Ward: _____

Hospital no: _____ DOB: _____

Health and Care no: _____

Check identity

Hospital _____

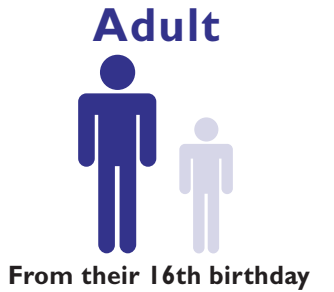
Ward _____

Date _____

June 2014

Special Instructions: _____

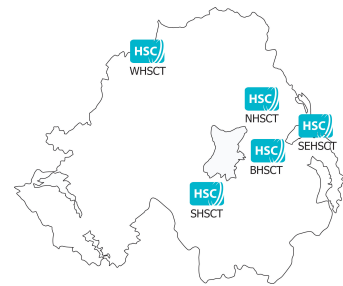
For Hourly, Cumulative fluid recording today Yes



FLUID INPUT (ml)

FLUID OUTPUT (ml)

	ORAL FLUID				INTRAVENOUS FLUID & MEDICINES*								URINE		BOWEL		COMMENTS		Hourly Amount OUT	Grand Total OUT	Overall Balance	Initials		
	ORAL		ENTERAL		No.1 Site		No.2 Site		No.3 Site		No.4 Site		Hourly Amount IN	Grand Total IN	Amount	Total	Amount	Total					Amount	Total
	Fluid Type		Fluid Type		Fluid Type		Fluid Type		Fluid Type		Fluid Type													
	Amount	Total	Amount	Total	Amount	Total	Amount	Total	Amount	Total	Amount	Total	Amount	Total	Amount	Total	Amount	Total						
08.00																								
09.00																								
10.00																								
11.00																								
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06.00																								
07.00																								



INTAKE	8am	Day	8pm	Night	8am	Total
Oral						
Enteral						
Intravenous						
Grand Total IN						

OUTPUT	8am	Day	8pm	Night	8am	Total
Urine						
Bowel						
Other						
Other						
Grand Total OUT						

24 hour Fluid Balance (ml)

Balance

