

# INTAKE / OUTPUT RECORD

Month: \_\_\_\_\_

Year: \_\_\_\_\_

Reason for I/O: Foley  G-tube  Fluid restriction  TPN  IV FLUIDS   
 Elevated BUN/CR  Other:  Specify: \_\_\_\_\_

DAY OF MONTH		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
I N T A K E	11-7.	ORAL														
		Tube feeding														
		Water flush														
		Other														
	7-3.	ORAL														
		Tube feeding														
		Water flush														
		Other														
	3-11.	ORAL														
		Tube feeding														
		Water flush														
		Other														
<b>TOTAL INTAKE</b>																

DAY OF MONTH		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
O U T P U T	11-7.	Voided														
		Foley														
		Emesis														
		Other														
	7-3.	Voided														
		Foley														
		Emesis														
		Other														
	3-11.	Voided														
		Foley														
		Emesis														
		Other														
<b>TOTAL OUTPUT</b>																

Resident Name: \_\_\_\_\_ Room Number: \_\_\_\_\_ Doctor Name: \_\_\_\_\_ Health Rec. #: \_\_\_\_\_

# INTAKE / OUTPUT RECORD

Month: \_\_\_\_\_

Year: \_\_\_\_\_

DAY OF MONTH		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
I N T A K E	11-7.	ORAL															
		Tube feeding															
		Water flush															
		Other															
	7-3.	ORAL															
		Tube feeding															
		Water flush															
		Other															
	3-11.	ORAL															
		Tube feeding															
		Water flush															
		Other															
<b>TOTAL INTAKE</b>																	

DAY OF MONTH		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
O U T P U T	11-7.	Voided															
		Foley															
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		Foley															
		Emesis															
		Other															
	3-11.	Voided															
		Foley															
		Emesis															
		Other															
<b>TOTAL OUTPUT</b>																	

Resident Name: _____	Room Number: _____	Doctor Name: _____	Health Rec. #: _____
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