

**Division of Developmental Disabilities
Nursing Support Unit Input & Output Form**

Name: _____

DOB: _____

Month/Year: _____

Location: _____

**Please document any significant changes in the note section and contact the Primary Care Physician as needed.*

Date	Day Shift		Staff Initials	Evening Shift		Staff Initials	Overnight Shift		Staff Initials
	Input/Intake	Output		Input/Intake	Output		Input/Intake	Output	
Ex:	1500 ml	800ml	DK	800 ml	450 ml	LC	0 ml	250 ml	HP
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
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25									
26									
27									
28									
29									
30									
31									

Staff Signatures:

If a life-threatening emergency is present always call 911 as per Danielle's Law.

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Name	Staff Initials	Name	Staff Initials	Name	Staff Initials

Note Section:
