

NAME: \_\_\_\_\_  
 DATE: \_\_\_\_\_

HOSPITAL NUMBER: \_\_\_\_\_

TIME	INPUT				OUTPUT						
	ORAL	PARENTERAL		HOUR TOTAL	TOTAL INPUT	URINE	GASTRIC LOSSES	BOWELS	DRAINS	HOUR TOTAL	TOTAL OUTPUT
0800											
0900											
1000											
1100											
1200											
1300											
1400											
1500											
1600											
1700											
1800											
1900											
2000											
2100											
2200											
2300											
0000											
0100											
0200											
0300											
0400											
0500											
0600											
0700											
PRINT NAME OF NURSE COMPLETING THE FLUID BALANCE CHART:					TOTAL BALANCE:						
SIGNATURE OF NURSE COMPLETING THE FLUID BALANCE CHART:					(NEGATIVE/POSITIVE):						