

NAME:	
DATE:	

HOSPITAL NUMBER:	
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TIME	INPUT					OUTPUT						
	ORAL	ENTERAL	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):