SKILLED NURSING VISIT NOTE

PATIENT NAME - Last, First, Middle Initial | ID#

DATE OF VISIT ____
TIME IN ____ AM PM OUT ____ AM PM
TYPE OF VISIT: ☐ SN ☐ SN & Super. ☐ Super. Only ☐ Other

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Requires assistance to ambulate ☐ Residual weakness ☐ Contusion, unable to go of home alone ☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion ☐ Dependent upon adaptive device(s) ☐ Medical restrictions ☐ Other (specify)____

NURSING DIAGNOSIS/PROBLEM ____

MARK ALL APPLICABLE WITH AN X. CIRCLE APPROPRIATE ITEM MEDICARE ☐ MEDICAID ☐ MX ☐ OTHER ☐

VITALS

T ____ Wt ____ BS ____
Resp. ____ ☐ Reg. ☐ Irregular
Pulse: A ____ R ____
☐ Reg. ☐ Irregular

B/P	LYING	SITTING	STANDING
RIGHT			
LEFT			

Denote Location/Site of Wounds/Pressure Sores Measure Ext. Edema Bil,

Anterior Posterior

	#1	#2	#3	#4
Length				
Width				
Depth				
Drainage				
Tunneling				
Odor				
Sur. Tissue				
Edema				
Stoma				

CARDIOVASCULAR

Fluid Retention
Chest Pain
Neck Vein Distension
Edema (specify): ☐ RUE ☐ LUE ☐ RLE ☐ LLE
Ascites
Peripheral Pulses
Arrhythmia
Other:
No deficit

RESPIRATORY

Rales / Ronchi / Wheeze
☐ R. Lung ☐ L. Lung
Cough / Sputum
Dyspnea / SOB
Orthopnea
02. LPM: VIA:
No deficit

DIGESTIVE

Bowel Sound
Nausea / Vomiting
Anorexia / NPO
Epigastric Distress
Difficulty Swallowing
Abdominal Distention
Colostomy / Ileostomy
Bowel Incontinence
Constipation / Impaction / Diarrhea
Diet: **Appetite:**
Fluid Intake:
Enteral Feeding Route:
Type:
Amount:
Via:
Flushing:
No Deficit

GENITOURINARY

Burning / Dysuria
Distension / Retention
Frequency / Urgency / Hesitancy
Hematuria
Bladder Incontinence
Catheter / Ileoconduit
Suprapubic Catheter
Foley Catheter
Size Fr. cc.
Last Changed:
Irrigation cc / nsa
Urine
Output cc / hr.
Color
Consistency
Odor
Pain / Discharge
Cath. Leakage / Dislodge
Other
No Deficit

SKIN

Warm / Dry
Cold / Clammy
Jaundice / Pallor / Cyanosis
Integrity
Chills
Decubitus / Wound / ...
Rash / Itching / Discoloration
Turgor / Hydration
Tube Insertion Site
Other
No Deficit

MUSCULOSKELETAL

Balance / Unsteady gait / Endurance
Weakness / Ambulates with Assistance
Limited Movement / Rom
☐ Chair Bound ☐ Bed Bound
☐ Contracture ☐ Paralysis
No Deficit

NEUROSENSORY

Syncope
Headache
Grasp ☐ Equal ☐ Unequal
Right: ____
Left: ____
Movement ☐ RUE ☐ LUE ☐ RLE ☐ LLE
Pupil Reaction
Right Left
Hand Tremors
Poor Hand-Eye Coordination
Poor Manual Dexterity
Speech impairment
Hearing Impairment
Visual Impairment / Blindness
Tactile Sensation
No deficit

EMOTIONAL STATUS

Oriented ☐ T ☐ P ☐ P
Forgetful / Confused
Disoriented ☐ T ☐ P ☐ P
Lethargic / Semi Lethargic
Comatose
Restless /Agitated
Anxious / Depressed
Other
No Deficit

PAIN

Frequency of pain interfering with patients Activity or movement
☐ 0 - Patient has no pain or pain does not interfere with activity or movement
☐ 1 - Less often than daily
☐ 2 - Daily, but not constantly
☐ 3 - All of the time

PAIN PROFILE
Primary Site ____
Intensity 0 1 2 3 4 5 6 7 8 9 10
Low High

Current pain management & effectiveness ____
☐ Pain Management Teaching to patient / family (document below)
Patient's pain goal: ____
Progress toward pain goal: ____
☐ No deficit

INTERVENTIONS / INSTRUCTIONS

☐ **Skilled Observation / Assessment**
☐ **Foley Change** ☐ **Foley irrigation**
☐ **Wound Care / Dressing Change**
☐ **Venipuncture / Lab:**____
☐ **Prep. / Admin. Insulin**
☐ **Im Injection / SQ Injection**
☐ **Diabetic Observation / Care**
☐ Observation / Inst Med. (N or C) effects / Side Effects____
☐ Inst. Safety Precaution / Emergency Prep.
☐ Inst. Disease Process____
☐ Diet. Teaching____
☐ Safety Factors Management Conducted
☐ Teach Infant / Childcare
☐ Peg / GT Tube Site Care
☐ Trache. Care / Suctioning

TECHNIQUES USED
☐ Universal Precautions Followed
☐ Aseptic Tech. Used.
☐ Quality Control of Glucometer Performed as per Agency P & P
☐ Glucometer Calib. on____
☐ Soiled Dressings Double Bagged
☐ Sharps Discarded Inside Sharps Container

INFUSION / IV SITE:____
☐ IV Tubing Change
☐ Cap Change
☐ Central Line Dressing Change
☐ IV Site Dressing Change
☐ IV Site Change
☐ Infusion by____ Pump
☐ Infusion Med:____
☐ Infusion Rate:____
Comments:____
☐ Infusion Well Tol. by Pt.

SKILLED INTERVENTION - TEACHING - PT. RESPONSE

PLAN FOR NEXT VISIT

☐ PT / S.O. / CG verbalized understanding of inst. given ☐ No S/O pr C/G able / willing for Inj. Adm. at this time ☐ Tx well tolerated by PT.
☐ PT / S.O. / CG able to return correct demonstration of Tech. / procedure Inst. on ☐ No S/O or C/G able / willing for wound care at this time.

☐ Patient unable to perform own W/C due to____

CARE PLAN: ☐ Reviewed / Revised with patient / client involvement. ☐ Outcome achieved ☐ PRN Order Obtained:____
MEDICATION STATUS ☐ No Change ☐ Order Obtained:____
DISCHARGE PLANNING DISCUSSED? Yes☐ No ☐ N/A ☐
SUPPLIES USED:____

CARE COORDINATION: Physician ☐ PT ☐ OT ☐ ST ☐ SS ☐ SN ☐ CM ☐
☐ Other:____

APPROXIMATE NEXT VISIT DATE

NURSE SIGNATURE / PRINT NAME **RN / LN** **DATE**

Signature / Date -Complete TIME OUT (above) prior to signing below (circle title) ___/___/___

SAMPLE