



YOUR FAMILY HOME HEALTH CARE SERVICES, INC.

12963 W. Okeechobee Rd. Ste #5 Hialeah Gardens, FL 33018 Ph 305-558-4111 Fx. 305-558-8811

Nursing Clinical Note

TYPE OF VISIT: SN SUP

PATIENT: _____ DATE: _____ AM PM MR# _____

HOMEBOUND STATUS: Weakness Bed Bound Unsteady Gait Requires Assist SOB

OTHER: _____

CARDIOVASCULAR	PULMONARY	INTEGUMENTARY	MUSCULOSKELETAL	VITAL SIGNS & WOUND ASSESS.																																																		
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Warm <input type="checkbox"/> Dry <input type="checkbox"/> Cool <input type="checkbox"/> Chills	<input type="checkbox"/> Poor balance	T _____ HT _____ WT _____																																																		
<input type="checkbox"/> Edema _____	<input type="checkbox"/> SOB <input type="checkbox"/> Dyspnea	<input type="checkbox"/> Intact	<input type="checkbox"/> Limited Movement	RESP <input type="checkbox"/> REG <input type="checkbox"/> IRR																																																		
<input type="checkbox"/> Abnormal Rhythmn	<input type="checkbox"/> Cough _____	<input type="checkbox"/> Wound <input type="checkbox"/> Ulcer <input type="checkbox"/> Incision	<input type="checkbox"/> Chair <input type="checkbox"/> Bed Bound	PULSE A R <input type="checkbox"/> REG <input type="checkbox"/> IRR																																																		
<input type="checkbox"/> Pulses _____	<input type="checkbox"/> Sputum _____	<input type="checkbox"/> Rash <input type="checkbox"/> Itching	<input type="checkbox"/> Walks with _____	B/P _____ LYING _____ SIT/STAND _____																																																		
<input type="checkbox"/> Anticoagulant Therapy	<input type="checkbox"/> Oxygen _____	<input type="checkbox"/> Turgor _____	<input type="checkbox"/> Contracture <input type="checkbox"/> Paralysis	RIGHT _____																																																		
<input type="checkbox"/> OTHER _____	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> OTHER _____	LEFT _____																																																		
<input type="checkbox"/> NO DEFICIT	<input type="checkbox"/> NO DEFICIT	<input type="checkbox"/> NO DEFICIT	<input type="checkbox"/> NO DEFICIT	<input type="checkbox"/> FBS/RBS _____ via glucomter																																																		
GASTROINTESTINAL	GENITOURINARY	NEUROLOGICAL	MENTAL	Denote Location / Size of Wounds / Pressure Sores / Measure Ext. Edema Bil. 																																																		
<input type="checkbox"/> Bowel Sounds x _____	<input type="checkbox"/> Burning <input type="checkbox"/> Dysuria <input type="checkbox"/> Odor	<input type="checkbox"/> Headache	<input type="checkbox"/> ORIENTED <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time																																																			
<input type="checkbox"/> Abdomen <input type="checkbox"/> Soft <input type="checkbox"/> Tender	<input type="checkbox"/> Distention <input type="checkbox"/> Retention	<input type="checkbox"/> Syncope <input type="checkbox"/> Vertigo	<input type="checkbox"/> Forgetful <input type="checkbox"/> Confused																																																			
<input type="checkbox"/> Distended	<input type="checkbox"/> Frequency <input type="checkbox"/> Urgency	<input type="checkbox"/> Grasp <input type="checkbox"/> Strong <input type="checkbox"/> Weak	<input type="checkbox"/> Disoriented																																																			
<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> NPO	<input type="checkbox"/> Incontinence <input type="checkbox"/> Hesitancy	<input type="checkbox"/> Movement _____	<input type="checkbox"/> Lethargic <input type="checkbox"/> Comatose																																																			
<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation	<input type="checkbox"/> Hesitancy <input type="checkbox"/> Itching	<input type="checkbox"/> Pupils <input type="checkbox"/> R _____ <input type="checkbox"/> L _____	<input type="checkbox"/> Restless <input type="checkbox"/> Agitated																																																			
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Color _____	<input type="checkbox"/> Hand tremors	<input type="checkbox"/> Anxious <input type="checkbox"/> Depressed																																																			
<input type="checkbox"/> Ostomy _____	<input type="checkbox"/> Catheter _____	<input type="checkbox"/> Aphasia <input type="checkbox"/> Dysphagia	<input type="checkbox"/> Altered LOC																																																			
<input type="checkbox"/> PEG _____	<input type="checkbox"/> FR _____ / _____ CC	<input type="checkbox"/> Speech Impairment	<input type="checkbox"/> Nervous																																																			
<input type="checkbox"/> Feeding _____	<input type="checkbox"/> Last Changed _____	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Impaired Memory																																																			
<input type="checkbox"/> Flushing _____	<input type="checkbox"/> Irrigation _____	<input type="checkbox"/> Visual Impairment	<input type="checkbox"/> Psych HX																																																			
<input type="checkbox"/> OTHER _____	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> OTHER _____																																																			
<input type="checkbox"/> DIET: _____	<input type="checkbox"/> NO DEFICIT	<input type="checkbox"/> NO DEFICIT	<input type="checkbox"/> NO DEFICIT	<table border="1"> <tr><td></td><td>1</td><td>2</td><td>3</td><td>4</td></tr> <tr><td>Length</td><td></td><td></td><td></td><td></td></tr> <tr><td>Width</td><td></td><td></td><td></td><td></td></tr> <tr><td>Depth</td><td></td><td></td><td></td><td></td></tr> <tr><td>Drainage</td><td></td><td></td><td></td><td></td></tr> <tr><td>Tunneling</td><td></td><td></td><td></td><td></td></tr> <tr><td>Odor</td><td></td><td></td><td></td><td></td></tr> <tr><td>Sur. Tissue</td><td></td><td></td><td></td><td></td></tr> <tr><td>Edema</td><td></td><td></td><td></td><td></td></tr> <tr><td>Stoma</td><td></td><td></td><td></td><td></td></tr> </table>		1	2	3	4	Length					Width					Depth					Drainage					Tunneling					Odor					Sur. Tissue					Edema					Stoma				
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Edema																																																						
Stoma																																																						
PAIN	INTERVENTIONS	TECHNIQUES USED	INFUSION/IV SITE																																																			
<input type="checkbox"/> No pain	<input type="checkbox"/> Skilled Assessment	<input type="checkbox"/> Universal Precaution	<input type="checkbox"/> IV tubing changed																																																			
<input type="checkbox"/> Less often than daily	<input type="checkbox"/> Foley Change <input type="checkbox"/> Irrigation	<input type="checkbox"/> Aseptic Technique	<input type="checkbox"/> Cap change																																																			
<input type="checkbox"/> Daily but not constant	<input type="checkbox"/> Wound <input type="checkbox"/> Ulcer <input type="checkbox"/> Incision	<input type="checkbox"/> Proper Sharps Disp.	<input type="checkbox"/> Catheter Site Care																																																			
<input type="checkbox"/> All of the time	<input type="checkbox"/> Prep/Admin Insulin	<input type="checkbox"/> Proper Waste Disp.	<input type="checkbox"/> IV site change																																																			
<input type="checkbox"/> Pain level (1-10) _____	<input type="checkbox"/> IM <input type="checkbox"/> SQ Injection	<input type="checkbox"/> QC of glucometer	<input type="checkbox"/> Med _____																																																			
<input type="checkbox"/> Site _____	<input type="checkbox"/> PEG/GT Site Care	<input type="checkbox"/> Glucomter Calib. On	<input type="checkbox"/> Rate _____																																																			
<input type="checkbox"/> Relieved with Med <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> VIA _____																																																			
SKILLED INTERVENTION & TEACHINGS				SUPERVISORY VISIT (CIRCLE Y/N)																																																		
				<input type="checkbox"/> Supervisory Visit LPN/HHA <input type="checkbox"/> Y <input type="checkbox"/> N																																																		
				<input type="checkbox"/> Following Care Plan <input type="checkbox"/> Y <input type="checkbox"/> N																																																		
				<input type="checkbox"/> Patient Needs Met <input type="checkbox"/> Y <input type="checkbox"/> N																																																		
				<input type="checkbox"/> Assignment Updated <input type="checkbox"/> Y <input type="checkbox"/> N																																																		
				<input type="checkbox"/> Service Change Requested <input type="checkbox"/> Y <input type="checkbox"/> N																																																		
				<input type="checkbox"/> Univ. & Safety Prec. Followed <input type="checkbox"/> Y <input type="checkbox"/> N																																																		
				<input type="checkbox"/> Employee Present <input type="checkbox"/> Y <input type="checkbox"/> N																																																		
				<input type="checkbox"/> Patient Satisfied with Service <input type="checkbox"/> Y <input type="checkbox"/> N																																																		
NEXT VISIT DATE: _____ MD NEXT VISIT: _____				<input type="checkbox"/> Comments: _____																																																		
<input type="checkbox"/> PT/CG verbalized understanding of instructions given				ABNORMAL FINDINGS/CHANGES																																																		
<input type="checkbox"/> PT/CG able to demonstrate correct Technique/Procedure Instruction				<input type="checkbox"/> MD notified-Name: _____																																																		
<input type="checkbox"/> PT unable to perform/administer <input type="checkbox"/> woundcare <input type="checkbox"/> injection due to: _____				<input type="checkbox"/> New Order: _____																																																		
<input type="checkbox"/> CG unable to perform/administer <input type="checkbox"/> woundcare <input type="checkbox"/> injection due to: _____				<input type="checkbox"/> New Order: _____																																																		
<input type="checkbox"/> No able or Willing CG available at this time to assist with: _____				<input type="checkbox"/> Discharge Planning Discussed																																																		
<input type="checkbox"/> Treatment/injection tolerated well by patient				<input type="checkbox"/> Case Manager Informed																																																		

NURSE NAME: _____
EMPLOYEE# _____

SIGNATURE: _____ RN/LPN

MR# _____ PATIENT NAME: _____ DATE: _____
 Time in: AM PM - out _____ AM PM Visit Type: Routine SV PRN Psych. High Tech

T _____ WT _____ BS _____
 Resp: _____ Pulse: _____ Reg Irreg
 Pain: yes no/ Scale _____ /10
 Site: _____
 B/P _____ Lying _____ Sitting _____ Standing _____
 Right _____
 Left _____

PSYCHOLOGICAL WNL
 Disoriented x _____ A&O x _____
 Forgetful Anxious
 Confused Fatigue
 Depressed Agitated
 Other _____

NEUROLOGICAL WNL
 Syncope / Vertigo
 Hearing Impairment / Speech impairment
 Visual impairment
 Hand tremors
 Poor hand-eye coordination
 Poor manual dexterity

HOME HEALTH AIDE SV VISIT:
 HHA Name: _____
 Patient's hygiene needs being met
 Respectful of rights, property & confidentiality
 Following Care Plan
 Environment clean and safe
 Patient satisfied with care giver
 Documents on the ICR on each visit
 Follow Universal Precautions (i.e. hand washing, etc.)

CARDIOVASCULAR WNL
 Ascites
 Chest pain/pressure
 Fluid retention
 Edema site _____
 Arrhythmia
 Other _____

RESPIRATORY WNL
 Dyspnea: At rest / On exertion
 Cough / Sputum
 O2 @ _____
 Breath sounds R _____ L _____
 Other _____

Denote Location / Size of Wounds / Measure Ext. Edema Bil.

MUSCULOSKELETAL WNL
 Weakness / Paralysis
 Limited ROM / Atrophy
 Assistance device _____
 Altered gait / Balance
 Prosthesis _____
 Chair bound Bed bound
 Bone/ joint pain NWB _____

GASTROINTESTINAL WNL
 Appetite: Good Fair Poor NPO
 Diet: _____
 Fluid intake _____
 Bowel sounds _____
 Stoma _____
 Last BM: _____
 Nausea/vomiting Diarrhea/constipation
 Colostomy / Ileostomy

	#1	#2	#3	#4	#5
Length					
Width					
Depth					
Drainage Type:					
Drainage Amount:					
Tunneling					
Undermining					
Odor					
Surr Tissue					
Edema					
Stoma					

GENITOURINARY WNL
 Frequencies / Urgency / Pain /
 Burning / Hematuria
 Incontinence
 Anuria / Oliguria / Polyuria
 Catheter (type & size) _____
 last changed _____
 Dialysis Freq. _____
 AV Shunt: Bruit _____ Thrill _____
 Tesio /Quinton _____

INTEGUMENTARY WNL
 Warm / Dry / Intact
 Jaundice / Cyanotic
 Cool / Clammy / Chills
 Poor turgor
 Pale / Flushed / Clammy
 Staples / Stitches
 Decubitus Wound / ulcer / surgical
 Stage I II III
 Other _____

Communication: Phone conf. to Dr. _____
 Dr. will return call. Message given to Dr. office
 _____ spoke with _____
 No new orders New order: _____

PROFESSIONAL SERVICES/INTERVENTIONS: (see comments) **

<input type="checkbox"/> Universal precaution observed	<input type="checkbox"/> Med. Changes (updated med sheet) *	<input type="checkbox"/> Glucometer calibrated
<input type="checkbox"/> Catheter insert / change	<input type="checkbox"/> Tube feedings	<input type="checkbox"/> Wound care
<input type="checkbox"/> Infection control	<input type="checkbox"/> Sharp discarded in biohazard box	
<input type="checkbox"/> Med. Administration	<input type="checkbox"/> Diabetic care	<input type="checkbox"/> Ostomy care
<input type="checkbox"/> Picc line care	<input type="checkbox"/> Biomedical Waste	
<input type="checkbox"/> Skilled observation & assessment	<input type="checkbox"/> IV therapy	<input type="checkbox"/> O2 therapy
<input type="checkbox"/> Peg/GT tube site care	<input type="checkbox"/> Other _____	

INSTRUCTED IN: (see comments)**

<input type="checkbox"/> Meds / Action S/E _____	<input type="checkbox"/> Wound care	<input type="checkbox"/> Safety
<input type="checkbox"/> Diet / hydration _____	<input type="checkbox"/> Pain management	Factor
<input type="checkbox"/> Universal precautions	<input type="checkbox"/> O2 therapy	
<input type="checkbox"/> Infection control	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Disease process _____		
<input type="checkbox"/> Patient: <input type="checkbox"/> Caregiver: <input type="checkbox"/> Return Demo: _____		
<input type="checkbox"/> Demo _____	<input type="checkbox"/> Verbalizes understanding	
<input type="checkbox"/> Requires further instruction	<input type="checkbox"/> written material supplied	

HOMEBOUND DUE TO:

<input type="checkbox"/> Taxing effort to leave home
<input type="checkbox"/> Require use of assistive device
<input type="checkbox"/> Dyspneic / Reqs. use of O2
<input type="checkbox"/> Needs assistance for all activities
<input type="checkbox"/> Gait instability
<input type="checkbox"/> Unable to leave home alone
<input type="checkbox"/> Other: _____

WOUND CARE: 1) Cleanse wound # _____ with: Normal Saline Acetic acid Other: _____ & pat dry
 2) Applied: Vaseline gauze Xeroform Betadine Wet dry _____ Aquacel Ag Silvasorb gel Duoderm Panafil Other: _____
 3) Covered with: Telfa Dry gauze Adaptic Other: _____
 4) Secured with: Kling Stretch bandage Unna Boot Other: _____ & tape

****Comments required****

Approximate next visit date ____ / ____ / ____ Plan for next visit: _____
 Nurse (LPN / RN) _____ Initials _____

VISIT DATE: _____

SKILLED NURSING VISIT NOTE

TIME IN: _____ TIME OUT: _____

PATIENTS NAME:		MED. REC. NUMBER:		HOMEBOUND STATUS: <input type="checkbox"/> Needs assistance with all activities <input type="checkbox"/> Residual weakness <input type="checkbox"/> Requires assistance to ambulate <input type="checkbox"/> Confusion, unable to go out of home alone <input type="checkbox"/> Unable to safely leave home unassisted <input type="checkbox"/> Severe SOB, SOB upon exertion <input type="checkbox"/> Depends upon adaptive device(s) <input type="checkbox"/> Medical restrictions <input type="checkbox"/> Other (specify) _____			
NURSES NAME:		EMP. NO.:					
TYPE OF VISIT: <input type="checkbox"/> SN <input type="checkbox"/> SN & SUPERVISORY <input type="checkbox"/> SUPERVISORY ONLY <input type="checkbox"/> OTHER _____							
DAIGNOSIS:		APPETITE: <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> GOOD HYDRATION: <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> GOOD		NUTRITION/HYDRATION: <input type="checkbox"/> WNL DIET: <input type="checkbox"/> NAS <input type="checkbox"/> NCS <input type="checkbox"/> REGULAR <input type="checkbox"/> 1800 CALORIE ADA <input type="checkbox"/> OTHER _____			
B/P	LYING	SITTING	STANDING	TEMP: _____	PULSE: _____	RESP.: _____	CIRCULATORY: <input type="checkbox"/> WNL <input type="checkbox"/> EDEMA: <input type="checkbox"/> Pitting
RIGHT				WEIGHT: _____ LBS	APICAL: _____	<input type="checkbox"/> REGULAR	<input type="checkbox"/> Non Pitting Location _____
LEFT					RADIAL: _____	<input type="checkbox"/> IREGULAR	GRADE: <input type="checkbox"/> Trace <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+
				PAIN: <input type="checkbox"/> YES <input type="checkbox"/> NO LOCATION(S): _____ TYPE: <input type="checkbox"/> ACHING <input type="checkbox"/> RADIATING <input type="checkbox"/> THROBBING <input type="checkbox"/> OTHER _____ <input type="checkbox"/> DOES NOT INTERFERE WITH ACTIVITY / MOVEMENT <input type="checkbox"/> LESS OFTEN THAN DAILY <input type="checkbox"/> DAILY BUT NOT CONSTANTLY <input type="checkbox"/> ALL OF THE TIME PAIN RELIEVING MEASURES USED: _____ FREQ: _____ RELIEF: <input type="checkbox"/> COMPLETE <input type="checkbox"/> MODERATE <input type="checkbox"/> NONE			
HEART SOUNDS: <input type="checkbox"/> WNL IRREG: _____ FAINT: _____ BOUNDING: _____ CHEST PAIN: _____ FREQ: _____ RELIEF: _____ PACEMAKER: _____ RATE: _____ OTHER: _____		RESPIRATORY: RALES/RHONCHI/WHEEZE <input type="checkbox"/> R. LUNG <input type="checkbox"/> L. LUNG <input type="checkbox"/> COUGH/SPUTUM <input type="checkbox"/> DYSPNEA/SOB <input type="checkbox"/> ORTHOPNIA <input type="checkbox"/> O2: LPM: _____ VIA: _____ <input type="checkbox"/> NO DEFICIT		NEUROSENSORY: <input type="checkbox"/> SYNCOPE/VERTIGO/DIZZINESS <input type="checkbox"/> HEADACHE <input type="checkbox"/> HAND TREMORS <input type="checkbox"/> POOR HAND-EYE COORDINATION <input type="checkbox"/> POOR MANUAL DEXTERITY <input type="checkbox"/> SPEECH IMPAIRMENT <input type="checkbox"/> VISUAL IMPAIRMENT/BLINDNESS <input type="checkbox"/> TACTILE SENSATION <input type="checkbox"/> NO DEFICIT OTHER: _____		ENDOCRINE STATUS: <input type="checkbox"/> WNL ABNORMAL FINDINGS: _____ BS PER GLUCOMETER: <input type="checkbox"/> FASTING <input type="checkbox"/> NON FASTING BY: <input type="checkbox"/> SN <input type="checkbox"/> PT <input type="checkbox"/> PCG INSULIN _____ U. HUMULIN R _____ U. HUMULIN N _____ U. LANTUS _____ U. HUMALOG _____ U. OTHER _____ SITE _____ # _____ ADMINISTERED BY: <input type="checkbox"/> SN <input type="checkbox"/> PT <input type="checkbox"/> PCG	
GENTOURINARY STATUS: <input type="checkbox"/> WNL URINE (DESCRIBE): _____ INDWELLING CATH (SIZE): _____ LAST CATH CHANGE: _____ URINARY INCONTINENCE: <input type="checkbox"/> YES <input type="checkbox"/> NO OTHER: _____		GASTROINTESTINAL STSTUS: <input type="checkbox"/> WNL LAST BM (DATE): _____ <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> DIARRHEA <input type="checkbox"/> NAUSEA <input type="checkbox"/> VOMITING BOWEL INCONTINENCE: <input type="checkbox"/> YES <input type="checkbox"/> NO OTHER: _____					
Denote Location / Size of Wounds / Measure Ext. Edema Bil. (L) (R) (L) (L) (R) (R) Anterior: (L) (R) (R) (L) (R) (L) Posterior: (L) (R) (L) (R) (L) (L)		<input type="checkbox"/> NO S/O OR CG. ABLE/WILLING FOR: <input type="checkbox"/> W/C <input type="checkbox"/> INSULIN ADMINISTRATION AT THIS TIME <input type="checkbox"/> PATIENT UNABLE TO PERFORM OWN: <input type="checkbox"/> W/C <input type="checkbox"/> INSULIN DUE TO: <input type="checkbox"/> SEE NEUROSENSORY <input type="checkbox"/> OTHER: _____					
		SKIN INTEGRITY: <input type="checkbox"/> INTACT <input type="checkbox"/> COMPROMISED TURGOR: <input type="checkbox"/> BRISK <input type="checkbox"/> SLUGGISH					
		ABNORMAL FUNDINGS: _____ WOUND DESCRIPTION: LOCATION: _____ SIZE (IN CM): _____ COLOR: _____ DRAINAGE: _____ SURROUNDING AREA: _____ WOUND CARE PROVIDED: _____					
		EXTREMITIES: COLOR: _____		TEMP: _____		PERIPHERAL PULSES: _____	
MENTAL STATUS: <input type="checkbox"/> ALERT <input type="checkbox"/> ORIENTED TO T P PL <input type="checkbox"/> DISORIENTED <input type="checkbox"/> FORGETFUL <input type="checkbox"/> CONFUSED <input type="checkbox"/> AGITATED <input type="checkbox"/> ANXIOUS <input type="checkbox"/> DEPRESSED <input type="checkbox"/> LETHARGIC <input type="checkbox"/> ABLE TO FOLLOW COMMANDS <input type="checkbox"/> RESPONDS TO PAIN/VERBAL STIMULI <input type="checkbox"/> OTHER _____							
SKILLED CARE PROVIDED/TEACHING/PERTINENT OBSERVATION/TREATMENT: _____ _____ _____							
PHYSICIAN CONTACT: <input type="checkbox"/> YES <input type="checkbox"/> NO RE: _____ DISCHARGE PLANING/PROGRESS TOWARD GOALS: _____ PATIEND AND/OR SIGNIFICANT OTHER FEEDBACK (VERBAL OR NONVERBAL): _____							
TEACHING: PROVIDED TO: <input type="checkbox"/> PT <input type="checkbox"/> S.O. <input type="checkbox"/> CG UNDERSTANDING <input type="checkbox"/> YES, VERBALIZED _____% UNDERSTANDING <input type="checkbox"/> NO <input type="checkbox"/> NEEDS FURTHER SUPERVISION IN: _____ <input type="checkbox"/> NEEDS FURTHER INSTRUCTION IN: _____ <input type="checkbox"/> PROBLEM-TEACHING RESOLVED FOR: _____							
SUPERVISORY VISIT: LPN PRESENT <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> FOLLOW PLAN OF CARE <input type="checkbox"/> DEMONSTRATES COMPETENT SKILLS <input type="checkbox"/> COMMUNICATES EFFECTIVLY <input type="checkbox"/> NOTIFIES SUPERVISOR OF PATIENTS NEEDS/PROBLEMS COMMENTS: _____ HHA CARE PLAN: <input type="checkbox"/> REVIEWED <input type="checkbox"/> REVISED <input type="checkbox"/> PT INSTRUCTED IN CHANGES COMMENTS: _____							
<input type="checkbox"/> UNIVERSAL PRECAUTIONS <input type="checkbox"/> ASCEPTIC TECNIQUES <input type="checkbox"/> SOILED DRESSING BAGGED <input type="checkbox"/> SHARPS DISCARDED INSIDE SHARP CONTAINER							
NURSE'S SIGNATURE: _____ RN / LPN				PATIENT'S SIGNATURE: _____			

PATIENT/CLIENT NAME _____ MR # _____ DATE _____

TYPE OF VISIT: SN SUPV Medicare Medicaid Other _____ TIME IN _____ AM PM
 TIME OUT _____ AM PM

HOME BOUND REASON: _____ Needs Assistance for all activities _____ Requires Assistance ambulate _____ Dependent upon adaptive device(s)
 _____ Confusion, unable to go out of home alone _____ Unable to safely leave home unassisted _____ Severe SOB, SOB upon exertion
 Residual Weakness _____ Medical Restrictions _____ Other (specify) _____

CARDIOVASCULAR	PULMONARY	INTEGUMENTARY	MUSCOSKELETAL	VITAL SIGNS & WOUND ASSESS																					
<input type="checkbox"/> Chest <input type="checkbox"/> Edema _____ <input type="checkbox"/> Abnormal Rhythm <input type="checkbox"/> Pulses _____ <input type="checkbox"/> Anticoagulant Therapy <input type="checkbox"/> OTHER _____ <input type="checkbox"/> WNL	<input type="checkbox"/> Lungs <input type="checkbox"/> SOB/Dizzy <input type="checkbox"/> Cough <input type="checkbox"/> Sputum <input type="checkbox"/> Oxygen _____ <input type="checkbox"/> OTHER _____ <input type="checkbox"/> WNL	<input type="checkbox"/> Warm/Dry/Cool/Chilis <input type="checkbox"/> Intact <input type="checkbox"/> Wound/Ulcer/incision <input type="checkbox"/> Rash/Itching <input type="checkbox"/> Turgor <input type="checkbox"/> OTHER _____ <input type="checkbox"/> WNL	<input type="checkbox"/> Poor balance <input type="checkbox"/> Limited Movement <input type="checkbox"/> Chair/Bed Bound <input type="checkbox"/> Walks with _____ <input type="checkbox"/> Contracture/Paralysis <input type="checkbox"/> OTHER _____ <input type="checkbox"/> WNL	<table border="1"> <tr> <td>T</td> <td>HT</td> <td>WT</td> </tr> <tr> <td colspan="3">RESP _____ (REG / IRR)</td> </tr> <tr> <td colspan="3">PULSE A _____ R _____ (REG / IRR)</td> </tr> <tr> <td colspan="3">B/P LYING SIT / STAND</td> </tr> <tr> <td colspan="3">RIGHT /</td> </tr> <tr> <td colspan="3">LEFT /</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> FBS/RBS _____ via glucometer</td> </tr> </table>	T	HT	WT	RESP _____ (REG / IRR)			PULSE A _____ R _____ (REG / IRR)			B/P LYING SIT / STAND			RIGHT /			LEFT /			<input type="checkbox"/> FBS/RBS _____ via glucometer		
T	HT	WT																							
RESP _____ (REG / IRR)																									
PULSE A _____ R _____ (REG / IRR)																									
B/P LYING SIT / STAND																									
RIGHT /																									
LEFT /																									
<input type="checkbox"/> FBS/RBS _____ via glucometer																									

GASTROINTESTINAL	GENITOURINARY	NEUROLOGICAL	MENTAL
<input type="checkbox"/> Bowel Sounds X _____ <input type="checkbox"/> Abdomen Soft/Tender <input type="checkbox"/> Distended <input type="checkbox"/> Nausea/Vomiting/NPO <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Incontinence <input type="checkbox"/> Ostomy _____ <input type="checkbox"/> PEG _____ <input type="checkbox"/> Feeding _____ <input type="checkbox"/> Flushing _____ <input type="checkbox"/> Last BM _____ <input type="checkbox"/> WNL <input type="checkbox"/> Diet	<input type="checkbox"/> Burning/Dysuria/Odor <input type="checkbox"/> Distention/Retention <input type="checkbox"/> Frequency/Urgency <input type="checkbox"/> Incontinence/Hesitancy <input type="checkbox"/> Itching <input type="checkbox"/> Color _____ <input type="checkbox"/> Catheter _____ <input type="checkbox"/> FR _____ / _____ CC <input type="checkbox"/> Last Changed _____ <input type="checkbox"/> Irrigation _____ <input type="checkbox"/> OTHER _____ <input type="checkbox"/> WNL	<input type="checkbox"/> Headache <input type="checkbox"/> Syncope/Vertigo <input type="checkbox"/> Grasp equal/unequal <input type="checkbox"/> Movement _____ <input type="checkbox"/> Pupils equal/unequal <input type="checkbox"/> Hand tremors <input type="checkbox"/> Aphasia/Dysphagia <input type="checkbox"/> Speech Impairment <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Visual Impairment <input type="checkbox"/> OTHER _____ <input type="checkbox"/> WNL	<input type="checkbox"/> Oriented X _____ <input type="checkbox"/> Forgetful/Confused <input type="checkbox"/> Disoriented <input type="checkbox"/> Lethargic/Comatose <input type="checkbox"/> Restless/Agitated <input type="checkbox"/> Anxious/Depressed <input type="checkbox"/> Altered LOC <input type="checkbox"/> Impaired Memory <input type="checkbox"/> Psych HX <input type="checkbox"/> OTHER _____ <input type="checkbox"/> WNL

Denote Location / Size of Wounds / Measure Ext. Edema Bil.

Anterior Posterior

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

PAIN	INTERVENTIONS	TECHNIQUE(S) USED	INFUSION/IV SITE
<input type="checkbox"/> No pain <input type="checkbox"/> Less often than daily <input type="checkbox"/> Daily but not constant <input type="checkbox"/> Constant <input type="checkbox"/> Pain level (1-10) _____ <input type="checkbox"/> Site _____ Relieved with Med <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Skilled Assessment <input type="checkbox"/> Foley Change/Irrigation <input type="checkbox"/> Wound/Ulcer/Incision <input type="checkbox"/> Prep/Admin Insulin <input type="checkbox"/> IM/SQ Injection <input type="checkbox"/> PEG/GT Site Care <input type="checkbox"/> Diet / Meds Instruction <input type="checkbox"/> S/S Disease Process <input type="checkbox"/> OTHER _____	<input type="checkbox"/> Universal Precautions <input type="checkbox"/> Aseptic Technique <input type="checkbox"/> Proper Sharps Disp. <input type="checkbox"/> Proper Waste Disp. <input type="checkbox"/> QC of Glucometer <input type="checkbox"/> Glucometer Calib. <input type="checkbox"/> On _____ <input type="checkbox"/> OTHER _____	<input type="checkbox"/> IV tubing change <input type="checkbox"/> Cap change <input type="checkbox"/> Catheter Site Care <input type="checkbox"/> IV Site Change From: _____ To: _____ <input type="checkbox"/> Med _____ <input type="checkbox"/> Rate _____ <input type="checkbox"/> VIA _____

SKILLED INTERVENTION & TEACHING

SN ADMINISTERED _____ IM/SQ _____

CONTINUE TO VISIT FOR: OBSERVATION/ASSESS, INSTRUCTIONS, FOLEY/WOUND CARE, LABS/PREP/ADMIN INJECTION, MAX TEACHING ATTAINED, REINSTRUCT UNATTAINED

WEEKLY QUALITY CONTROL / GLUCOSE CONTROL SOLUTION

<input type="checkbox"/> N/A	RANGE	EXPIRATION DATE	DATE OPENED	CONTROL INDICATOR
High				
Low				

CHANGES IN PATIENT CONDITION

N/A
 MD Notified: _____
 New Order(s): _____

Supervisor Notified Y N N/A

COMMENTS: _____

SUPERVISORY VISIT (CIRCLE ONE)

PT/CG verbalized understanding of instructions given Compliant with Present/Prior Instruction
 PT/CG able to demonstrate correct Technique/Procedure Instruction
 PT unable to perform/administer wound care/injection due to: _____
 CG unable to perform/administer wound care/injection due to: _____
 No able CG available at this time to assist with: _____
 Treatment/injection tolerated well by patient Compliant with Diet Compliant with Medication Regimen
 PT ability with Oral Meds Unable Able Demonstrates Understanding
 Supplies Used: Syringes Lancets N/S Gloves Alcohol Pads Glucometer Strips 4x4 Other _____
 Discharge Planning Discussed

N/A
 Supervisory Visit LPN/HHA Y N
 Following Care Plan Y N
 Patient Needs Met Y N
 Assignment Updated Y N N/A
 Service Change Requested Y N
 Univ. & Safety Prec. Followed Y N
 Employee Present Y N
 Patient Satisfied with Service Y N
 Comments: _____

NURSE PRINTED NAME _____
 NURSE SIGNATURE _____ RN LPN



NURSING PROGRESS NOTE

CHECK TYPE OF VISIT: SCHEDULED
 UNSCHEDULED
 SUPERVISORY



PATIENT _____ MR# _____

BP L Sit _____ Stand _____ Lie _____	TEMP _____	Pulse Radial _____	Resp _____	Weight: _____	Last MD visit: _____
R Sit _____ Stand _____ Lie _____	OAR _____	Apical _____		Height: _____	

MENTAL STATUS: Alert Oriented to: T P PL Forgetful Confused Able to follow commands Agitated Anxious
 Depressed Lethargic Responds to: Pain / Verbal Stimuli Comments: _____

CARDIO-CIRCULATORY: Reg / Irreg HR Palpitations Neck Vein Distention Pacemaker Chest Pain (See Comments Sec.)
 RLE: Warm Cold Mottled Edema: Trace 1+ 2+ 3+ 4+ Pitting / Nonpitting Pulse: Strong Weak Absent
 LLE: Warm Cold Mottled Edema: Trace 1+ 2+ 3+ 4+ Pitting/ Nonpitting Pulse: Strong Weak Absent
 Capillary refill: _____ Sec Cyanosis _____ Claudication Comments: _____

RESPIRATORY: SOB: At rest Min. exertion (eating, talking) Mod. exertion (dressing, walkin ↓ 20 ft) When walk. ↑ 20 ft/stairs
 Cough: Dry Productive Sputum Color: _____ Amount: _____ Hemoptysis Suctioning Required
 Lung Sounds: Left: Clear Decreased Rales Rhonchi Wheezes Orthopnea _____ pillows Tracheostomy
 Right: Clear Decreased Rales Rhonchi Wheezes
 O₂ _____ l/m via _____ Frequency of use: Cont PRN (Describe when): _____
 SAN (med/freq.): _____ Effectiveness of O₂/SAN Tx: _____

GI: Appetite: _____ Inadequate: Nutrition Hydration Cachexia Bleeding Gums Nausea Vomiting (Freq.)
 Dentures: Partial Upper Lower Edentulous Dysphagia ABD Distention Girth: _____ cm
 Constipation Diarrhea Incontinence Rectal Bleeding GT Feedings _____ Pump Gravity
 Colostomy Ileostomy Bowel Sounds: _____ Diet: _____

GENITOURINARY: Frequency Urgency Burning Nocturia Dysuria Oliguria Incontinence Retention Anuria
 Vaginal Bleeding/Discharge Penile Discharge Indwelling Catheter (size) _____ Suprapubic Catheter (size) _____
 Date last changed: _____ External Catheter Irrigation Sediment Hematuria Foul Odor Diapers used
 Character of Urine: Clear Cloudy Color: _____ Comments: _____

ENDOCRINE: WNL Sweating Polyuria Polydipsia Heat/Cold Intolerance Sharps box at home Meter cleaned/calibrated
 Blood Glucose Meter BS Results: _____ Fasting/Random/Venous/Fingerstick Done by: _____

SKIN: Intact Pale Jaundice Warm Hot Cool Dry Moist Pruritus Rash Blisters Bruises Erythema
 Lesions Incision Staples/Sutures Turgor: Good Fair Poor Wound Decubitus Ulcers (See Weekly Addendum)
 Other (describe): _____

NEURO: Headaches Tinnitus Seizures Tremor Numbness Tingling Area: _____ Paralysis: _____
 Sensory Loss: _____ Aphasia Impaired Vision Glasses Blind Lt. Eye Rt. Eye Impaired Hearing Rt. Ear Lt. Ear
 Aid Slurred/Garbled Speech Pupils: _____ Hand grips: _____ Other: _____

MUSCULOSKELETAL: Arthritis Pain Swelling Rigidity Contractures Amputation Fracture Location: _____
 Motor Deficit: Decreased: ROM Strength: _____ Poor Balance/Coordination Gait: _____ Prosthesis Cast: _____
 Bedfast Able / Unable to turn Unable to transfer self: Can / Cannot bear weight/pivot during transfer process
 Transfers with: Human assistance Assistive device Hoyer lift Chairfast/unable to ambulate Able / Unable to wheel self
 Ambulates with: Supv/asst of another person at all times Device: Cane/Walker Requires human supv/asst to go ↓ stairs/steps

PAIN: Intensity: (1-10 scale): _____ Location(s): _____ Radiating to: _____ Type: _____
 Does not interfere with activity/movement Less often than daily Daily but not constantly All of the time

HOMEBOUND STATUS _____

SKILLED CARE: Assem/Obs Wound Care IV Therapy Catheter change Injection Administration Teaching/Instructions
 Narrate procedures performed/instructions given/patient tolerance: _____

Instructions given to: Patient Caregiver Response to instructions: Verbalizes Demonstrates Needs further instructions

COMMUNICATION WITH: MD Case Manager Status report given New orders: Yes (see Mod. Orders) No

PLANS FOR DISCHARGE: Discussed with Patient MD SO Case Manager Other: _____

Nurse Name/Title (Print) _____

Nurse Signature _____

Date _____

Visit Time In _____

Time Out _____



Patient's Name (Last)			(First)	(M.I.)	(MR#)	Month	Day	Year	Employee Number	Initials
B/P LYING (R) _____ (L) _____	SITTING _____	STANDING _____	T _____ O, Ax, R AP _____ Reg/Irreg R _____ Wgt _____	Finger glucose time: _____ Fasting: _____ Random: _____	VISIT TIME: _____ AM: _____ PM: _____		____ RV-Regular Visit ____ EV- Emergency Visit Due To: _____			

MENTAL STATUS: ALERT, ORIENTED TO TIME/PERSON/PLACE, FORGETFUL, CONFUSED, SAD, ANXIOUS, AGITATED. HOSTILE, _____

EENT: BLURRED VISION, INFLAMMATION _____ DISCHARGE _____ PAIN _____ OTHER: _____

NEURO: H/A, DIZZINESS, TREMORS _____ WEAKNESS _____ NUMBNESS _____ TINGLING _____ OTHER: _____

RESPIRATORY: BS (CLEAR, DECREASED _____ WHEEZES _____ RALES _____ RHONCHI _____) COUGH (DRY, PROD), SPUTUM (SM, MOD, LG, WHITE, YELLOW, GREEN, BLOODY), O₂, SAN, SOB, ORTHOPNEA x _____ PILLOWS, _____

CARDIAC: CHEST PAIN/PRESSURE (LAST EPISODE) _____ x _____ MIN., RADIATED TO _____ RELIEVED BY _____
PALPITATIONS, NO COMPLAINTS, _____

PERIPHERAL CIRCULATION: EXTREMITIES (WARM, COOL, PINK, PALE, MOTTLED, CYANOTIC), CAPILLARY REFILL (GOOD, FAIR, POOR), NAILBEDS (PINK, PALE, CYANOTIC), EDEMA (NONE, TR, 1+, 2+, 3+, 4+): LOCATION _____
PULSES (UPPER, LOWER, R+L) _____

GI/ABD: APPETITE (GOOD, FAIR, POOR), NAUSEA, VOMITING, NG/GT, BOWEL SOUNDS (PRESENT, HYPOACTIVE, HYPERACTIVE, ABSENT), TENDERNESS, PAIN, OSTOMY _____ LBM _____ (INCONTINENT, SOFT, HARD, LOOSE, BROWN, BLACK, TARRY, BLOODY), CONSTIPATION, DIARRHEA

GU: INCONTINENT, DIAPERS, FOLEY, URINE (CLEAR, DARK, SEDIMENT, CLOUDY, MUCOUS, ODOR, BLOODY), PAIN, RETENTION, ILEAL CONDUIT _____

I&O: INTAKE: _____ CUPS/DAY, OUTPUT _____ cc or _____ VOIDS/24 HOURS, FOLLOWS DIET (YES, NO) _____

MUSCULOSKEL: COORDINATION _____ ROM _____ PAIN _____ LIMITED MOBILITY DUE TO _____

ACTIVITY: BEDBOUND, CHAIR, ASSIST TO TRANSFER, GAIT (SLOW, UNSTEADY, NEEDS ASSIST OF- WALKER, CANE, 1, 2 PERSON, WALLS & FURNITURE), WHEELCHAIR, HOYER LIFT, _____

SKIN: TURGOR (GOOD, FAIR, POOR), WARM, COOL, DRY, DIAPHORETIC, PINK, PALE, FLUSHED, ICTERIC, GRAY, CYANOTIC, ITCHING _____
RASH _____ BRUISES _____ PETECHIAE _____ WOUNDS (INCISION, ABRASION, ULCER) L _____ W _____ D _____ (cm).
STERISTRIPS, SUTURES, STAPLES, DRAINAGE (SM, MOD, LG, SEROUS, SANGUINEOUS, PURULENT), LOCATION _____
SURROUNDING SKIN _____

PAIN: LOCATION _____ INTENSITY (SCALE OF 0-10) _____ RESPONSE TO INTERVENTION _____

ADDITIONAL INFORMATION: (SPECIFIC INFO, NEW PROBLEMS, ENVIRONMENTAL/SOCIAL/SAFETY FACTORS IDENTIFIED) _____

SKILLED NURSING: ASSESSMENT/OBSERVATION, REVIEWED CARE PLAN WITH PATIENT/CAREGIVER, DISCUSSED DISCHARGE PLAN

PROCEDURE*: LAB: _____ INJECTION _____ NG/GT # _____ Fr. INSERTED, FEEDING GIVEN.
FOLEY: REMOVED, INSERTED # _____ Fr. _____ cc. (BALLOON INFLATED E _____ ccNS, _____ cc URINE RETURNED), IRRIGATED with _____ ccNS
DIGITAL RECTAL EXAM, MANUAL DISIMPACT FIU ENEMA, WOUND CARE, OSTOMY/ILEAL CONDUIT CARE, O₂/SAN TREATMENT GIVEN,
• SPECIFY _____

INSTRUCTIONS: TOLERATED WELL, DIFFICULTY ENCOUNTERED _____
MEDICATION _____ DISEASE PROCESS /COMPLICATIONS _____ S/S OF _____ ILEAL CONDUIT/ OSTOMY / SKIN
FOLEY/WOUND CARE. DIET, FLUIDS, NG/GT FEEDING, EQUIP USE/CARE (PUMP, O₂, SAN), INJECTION /FINGERSTICK TECHNIQUE, SAFETY,
ACTIVITY LIMITATIONS, EMERGENCY MANAGEMENT 911, UNIVERSAL PRECAUTIONS, BIOMEDICAL WASTE MANAGEMENT, PRINTED INFO GIVEN,
• SPECIFY _____

TEAM CONFERENCE: PATIENT/CAREGIVER: DEMONSTRATES UNDERSTANDING OF TEACHING, NEEDS FURTHER TEACHING, GOOD RETURN DEMO

PHYSICIAN CONTACT: STATUS REPORT, UNSTABLE CONDITION, MOD ORDER- _____

DISCHARGE PLANNING: CONTINUE TO VISIT FOR: OBSERVATION/ ASSESS, FOLEY/WOUND CARE, LABS, PREP/ADM INJECTION, INSTRUCTIONS _____
D/C EXPECTED IN _____ WEEKS, OR _____ VISITS LAST PHYSICIAN VISIT _____

NURSE NAME (Print): _____ SIGNATURE _____

Patient's name _____ Medical Record _____

BP L Sit _____ Stand _____ Lie _____ Temp. _____ Pulse Radial _____ Resp _____ Height: _____
 R Sit _____ Stand _____ Lie _____ OAR _____ Apical _____ Weight: _____ Last MD Visit _____

MENTAL STATUS Alert Oriented to: T P PL Forgetful Confused Able to follow commands Agitated Anxious Depressed Lethargic
 Respond to: Pain/Verbal Stimuli Comments: _____

CARDIO CIRCULATORY Reg / Irreg HR Palpitations Neck Vein Distention Pacemaker Chest pain
 RLE: Warm Cold Mottled Edema: Trace 1+ 2+ 3+ 4+ Pitting/Nonpitting Pulse: Strong Weak Absent
 LLE: Warm Cold Mottled Edema: Trace 1+ 2+ 3+ 4+ Pitting/Nonpitting Pulse: Strong Weak Absent
 Capillary refill _____ Sec Cyanosis _____ Claudication Comments: _____

RESPIRATORY SOB At rest Min. exertion (eating, talking) Mod. exertion (dressing, walking 20 ft) When walk. 20 ft. stair
 Cough Dry Productive sputum Color: _____ Amount: _____ Hemoptysis Suctioning required
 Lung Sounds: Left: Clear Decreased Rales Rhonchi Wheezes Orthopnea Pillows _____ Tracheostomy
 Right: Clear Decreased Rales Rhonchi Wheezes

GI Appetite _____ Inadequate: Nutrition Hydration Cachexia Bleeding gums Nausea Vomiting (freq)
 Dentures: Partial Upper Lower Edentulous Dysphagia ABD Distention Girth: _____ cm Constipation Diarrhea
 Incontinence Rectal Bleeding GT feedings _____ Pump Gravity Colostomy Ileostomy
 Bowel sounds: _____ Diet: _____

GENITOURINARY Frequency Urgency Burning Nocturia Dysuria Oliguria Incontinence Retention Anuria
 Vaginal Bleeding / Discharge Penile Discharge Indwelling catheter (size) _____ Suprapubic catheter (size) _____
 Date last changed _____ External catheter Irrigation Sediment Hematuria Foul odor Diapers used
 Character of urine: Clear Cloudy Color: _____ Comments: _____

ENDOCRINE WNL Sweating Polyuria Polydipsia Heat/Cold intolerance Sharps box at home Meter cleaned/calibrated
 BS Results: _____ Fasting / Random / Venous / Fingerstick Done by: _____

NEURO Headaches Tinnitis Seizures Tremor Numbness Tingling Area: _____ Paralysis: _____
 Sensory loss: _____ Aphasia Impaired vision Glasses Blind Lt. eye Rt. eye Impaired hearing Rt. Ear Lt. Ear
 Aid Slurred / Garbled Speech Pulpis: _____ Hand grips: _____ Other: _____

MUSCOSKELETAL Arthritis Swelling Rigidity Contractures Amputation Fracture location: _____
 Motor Deficit: Decreased: ROM Strength: _____ Poor Balance/Coordination Gait: _____ Prosthesis Cast: _____
 Bedfast Able / Unable to transfer self. Can / Cannot bear weight/pivot during transfer process
 Transfer with: Human assistance Assistive device Hoyer lift Chairfast/unable to ambulate Able / Unable to wheel self
 Ambulates with: Supv/asst of another person at all times Device: Cane / Walker Requires human assistance to go stairs/steps.

PAIN Absence of pain Complaint of pain Location: _____ Severity: 1 2 3 4 5 6 7 8 9 10
 What makes pain worse? Movement Ambulation Increased pain with activity Others: _____
 What makes pain better? Medication Heat/Ice Massage Rest/Relaxation Others: _____

HOMEBOUND STATUS <input type="checkbox"/> Need assist. for all activity <input type="checkbox"/> Residual weakness <input type="checkbox"/> Non ambulatory <input type="checkbox"/> Confusion <input type="checkbox"/> Severe dyspnea <input type="checkbox"/> Leaving home requires a considerable taxing effort <input type="checkbox"/> Severe pain <input type="checkbox"/> Other _____	SKIN <input type="checkbox"/> Intact <input type="checkbox"/> Dry <input type="checkbox"/> Cold <input type="checkbox"/> Warm <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Color _____ <input type="checkbox"/> Tugor _____ <input type="checkbox"/> Wound <input type="checkbox"/> Lesions <input type="checkbox"/> Rash <input type="checkbox"/> Incision <input type="checkbox"/> Location _____	MEASURE (Every two weeks)				HHA / LPN / SV <input type="checkbox"/> Present <input type="checkbox"/> Not present <input type="checkbox"/> Following plan <input type="checkbox"/> PT's needs met <input type="checkbox"/> Universal prec. & safety followed <input type="checkbox"/> PT / SO satisfied Assignment updated SN done by: _____
		#1	#2	#3	#4	
		Length				
		Width				
		Depth				
		Drainage				
		Tunneling				
		Undermining				
		Odor/Color/Consist				
		Sur.Tissue				

SKILL CARE Assessment and observation of all systems Monitor vital signs Wound care Ostomy care Tracheostomy care
 Administration: O2 _____ lpm Cont. PRN SAN Med _____
 Injection administration IM SC IV Medication: _____ Dosage: _____ Site: _____
 Lab specimen obtained Catheter type _____ Size _____ Insertion Irrigation Change _____
 Procedure: _____

Procedure well tolerated Difficulty encountered Universal precautions Aseptic technique followed

TEACHING/INSTRUCTIONS Given to PT SO Medication side effects, safe and effective use: _____
 Universal precautions Safety Measures Emergency prep. Waste disposal Disease Process Crisis intervention Pain management
 Wound care Skin care Insulin administration Use of glucometer Record own BP Diet Diabetic care S/S of infection Catheter management Safe and effective use of equipment
 Other: _____

RESPONSE No SO Available Refuse Willing for Wound care Injection adm. Verbalize Demonstrates procedure PT SO unable to perform procedure due to Complexity of procedure Poor hand dexterity Contamination of supplies Location of wound Needs further teaching

LEARNING BARRIES None Emotional/Psychological Cognitive deficit Seems disinterested Impaired thought process Impaired hearing
 Impaired vision Language barriers **COMMUNICATION WITH** MD Case Manager Status given New orders **CASE PLAN CHANGES**
 Discussed with PT/SO Visit frequency changed **PLANS FOR D/C DISCUSSED** PT SO MD Case Manager

Nurse name _____	Signature _____	Title RN / LPN _____	Date _____
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Patient's Name (Last)			(First)	(M.I.)	Month	Day	Year	Employee Number	Initials
B/P LYING (R) (L)	SITTING	STANDING	T _____ O, Ax, R AP _____ Reg/Irreg R _____ Wgt _____	BS Level: _____ AM / PM Glucometer Cal: _____ Aseptic Tech: _____ Sharp Cont. _____	AIDE SUPERVISORY VISIT Plan discussed with patient Pt satisfied with care Yes, ___ No			RV- Regular Visit EV- Emergency Visit Due To: _____	

MENTAL STATUS: ALERT, ORIENTED TO TIME/PERSON/PLACE, FORGETFUL, CONFUSED, SAD, ANXIOUS, AGITATED. HOSTILE, _____

EENT: BLURRED VISION, INFLAMMATION _____ DISCHARGE _____ **PAIN** _____

NEURO: H/A, DIZZINESS. TREMORS _____ WEAKNESS _____ NUMBNESS _____ TINGLING _____

RESPIRATORY: BS (CLEAR, DECREASED _____ WHEEZES _____ RALES _____ RHONCHI _____) COUGH (DRY, PROD), SPUTUM (SM, MOD, LG, WHITE, YELLOW, GREEN, BLOODY), O₂, SAN, SOB, ORTHOPNEA x _____ PILLOWS, _____

CARDIAC: CHEST PAIN/PRESSURE (LAST EPISODE _____ x _____ MIN., RADIATED TO _____ RELIEVED BY _____), PALPITATIONS, NO COMPLAINTS, _____

PERIPHERAL CIRCULATION: EXTREMITIES (WARM, COOL, PINK, PALE, MOTTLED, CYANOTIC), CAPILLARY REFILL (GOOD, FAIR, POOR), NAILBEDS (PINK, PALE, CYANOTIC), EDEMA (NONE, TR, 1+, 2+, 3+, 4+): LOCATION _____ PULSES (UPPER, LOWER, R+L) _____

GI/ABD: APPETITE (GOOD, FAIR, POOR), NAUSEA, VOMITING, NG/GT, BOWEL SOUNDS (PRESENT, HYPOACTIVE, HYPERACTIVE, ABSENT), TENDERNESS, PAIN, OSTOMY _____ LBM _____ (INCONTINENT, SOFT, HARD, LOOSE, BROWN, BLACK TARRY, BLOODY), CONSTIPATION, DIARRHEA,

GU: INCONTINENT, DIAPERS, FOLEY, URINE (CLEAR, DARK, SEDIMENT, CLOUDY, MUCOUS, ODOR, BLOODY), PAIN, RETENTION, ILEAL CONDUIT _____

I&O: INTAKE: _____ CUPS/DAY, OUTPUT _____ cc or _____ VOIDS/24 HOURS, FOLLOWS DIET (YES, NO) _____

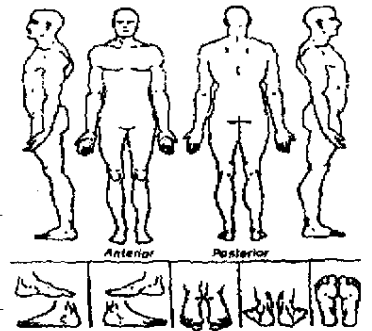
MUSCULOSKELTAL: COORDINATION _____ ROM _____ PAIN _____ LIMITED MOBILITY DUE TO _____

ACTIVITY: BEDBOUND, CHAIR, ASSIST TO TRANSFER, GAIT (SLOW, UNSTEADY, NEEDS ASSIST OF- WALKER, CANE, 1-2 PERSON, WALLS, FURNITURE, WHEELCHAIR, HOYER LIFT _____

SKIN: TURGOR (GOOD, FAIR, POOR), WARM, COOL, DRY, DIAPHORETIC, PINK, PALE, FLUSHED, ICTERIC, GRAY, CYANOTIC, ITCHING RASH _____ BRUISES _____ PETECHIAE _____ WOUNDS (INCISION, ABRASION, ULCER) L _____ W _____ D _____ (cm) STERISTRIPS, SUTURES, STAPLES, DRAINAGE (SM, MOD, LG, SEROUS, SANGUINEOUS, PURULENT), LOCATION _____ SURROUNDING SKIN: _____ WOUND BED APPEARANCE: _____

WOUNDS (INCISION, ABRASION, ULCER) L _____ W _____ D _____ (cm)

STERISTRIPS, SUTURES, STAPLES, DRAINAGE (SM, MOD, LG, SEROUS, SANGUINEOUS, PURULENT), LOCATION _____ SURROUNDING SKIN: _____ WOUND BED APPEARANCE: _____



PAIN: LOCATION _____ INTENSITY (SCALE OF 0-10) _____ RESPONSE TO INTERVENTION _____

ADDITIONAL INFORMATION: (SPECIFIC INFO, NEW PROBLEMS, ENVIRONMENTAL/SOCIAL/SAFETY FACTORS IDENTIFIED, TEAM CONFERENCES) _____

SKILLED NURSING: ASSESSMENT/OBSERVATION, REVIEWED CARE PLAN WITH PATIENT/CAREGIVER, DISCUSSED DISCHARGE PLAN

PROCEDURE: LABS _____ NG/GT # _____ Fr. INSERTED, FEEDING GIVEN. FOLEY: REMOVED, INSERTED # _____ Fr. _____ cc. (BALLOON INFLATED E _____ ccNS, _____ cc URINE RETURNED), IRRIGATED with _____ ccNS DIGITAL RECTAL EXAM, MANUAL DISIMPACT FIU ENEMA, WOUND CARE, OSTOMY/ILEAL CONDUIT CARE. O₂/SAN TREATMENT GIVEN, INJECTION ROUTE: _____ SITE: _____ MED. GIVEN: _____ DOSE: _____ REACTION: _____ TEACHING: _____ SPECIFY: _____

TOLERATED WELL, DIFFICULTY ENCOUNTERED _____

INSTRUCTIONS: MEDICATION _____ DISEASE PROCESS /COMPLICATIONS _____ S/S OF _____ ILEAL CONDUIT/ OSTOMY / SKIN FOLEY/WOUND CARE. DIET, FLUIDS, NG/GT FEEDING, EQUIP USE/CARE (PUMP, O₂, SAN), INJECTION /FINGERSTICK TECHNIQUE, SAFETY, ACTIVITY LIMITATIONS. EMERGENCY MANAGEMENT 911. UNIVERSAL PRECAUTIONS, BIOMEDICAL WASTE MANAGEMENT. PRINTED INFO GIVEN, • SPECIFY _____

PATIENT/CAREGIVER: DEMONSTRATES UNDERSTANDING OF TEACHING. NEEDS FURTHER TEACHING, GOOD RETURN DEMO STATUS REPORT, UNSTABLE CONDITION, MOD ORDER- _____

PHYSICIAN CONTACT: _____

DISCHARGE PLANNING: CONTINUE TO VISIT FOR: OBSERVATION/ ASSESS, FOLEY/WOUND CARE, LABS, PREP/ADM INJECTION. INSTRUCTIONS _____ D/C EXPECTED IN _____ WEEKS, OR _____ VISITS LAST PHYSICIAN VISIT _____

PATIENT SIGNATURE: _____ SIGNATURE _____ PRINT NAME: _____