DAILY MEDICARE NOTES

Medicare Condition: _____

Date: _____ Shift: _____

INSTRUCTIONS: Complete the information in the left column by describing the quality and response of the resident. Document any further skilled assessment/nursing interventions in the column to the right.
Note: This daily licensed nurse's notes, together with the daily medication and treatment records, therapy notes, IV records, Decubitus records, pain management, nursing rehab notes, resident/family teaching, flow sheets, etc, comprise the daily skilled notes for Medicare.

GENERAL: DESCRIPTION	NARRATIVE NOTES/SIGNATURE
Able to make needs known: ☐ Yes, ☐ No, ☐ At times	
Able to follow instructions: ☐ Yes, ☐ No, ☐ At times	
Aware of safety precautions: ☐ Yes, ☐ No, ☐ At times	
Cooperative with care and tx plan: ☐ Yes, ☐ No, ☐ At times	
Response to stimuli:	
1. Pulse:_____ Regular, Irregular, Strong, Weak	
2. Temp:_____ Chills/Fever	
3. B/P:_____ Dizziness/Faintness	
4. Resp:_____Labored, Deep, Swallow, Rapid, SOB, Normal 02: ☐ Yes, ☐ No	
5. Lung Sounds: Rales, Rhonchi, Wheezes, Coughs, Congestion	
6. Suctioning:	
7. Skin color: Cyanosis, Pallor-normal	
8. Skin Turgor/Hydration:	
9. Fluid Restrictions:	
10. Urine Color/Consistency:	
11. Circulation (CWM)	
12. Edema:	
13. Pain: Site:_____ Severity:_____ Relief Measures: Massage, Hot/Cold Packs, Elevation/Support, Repositioning, Other:	
14. Difficulty in Swallowing, Chewing:	
15. Nausea/Vomiting (Type, Amt):	
16. Diarrhea (Type, Amt):	
17. Paralysis/Paresis:	
18. Gait: Shuffling, Scissoring, Leaning, Buckling, Stable	
19. Activity Tolerance: Bedrest, Bedridden, Fatigues easily, Able to tolerate ADL, Up in chair – how long:	
20. Precautions: Orthopedic, Cardiac, Decubitus, Seizures	
21. Rehab Services: ☐ OT, ☐ PT, ☐ SLP	
22. Infection (ATB):	
23. Isolation:	
24. Chemotherapy, Radiation, Dialysis:	
25. Lab/X-ray:	
26. MD notification:	
27. Family notification:	
28. Other:	
Nurse signature:	

Resident: _____ Hospital #: _____ Room #: _____