Patient Name: Date:
Skilled Nurse Visit
Type of Visit: () Initial () Skilled Nursing Revisit () Skilled Nursing s/p hospitalization () Patient status change
Homebound Status: () Needs assistance for all activities () Residual weakness () Requires assistance to ambulate () Confusion, unable to go out of home alone () Severe SOB, SOB upon exertion () Dependent upon adaptive device(s) () Medical restrictions () Other (specify)
Skilled Observation/Assessment
(Circle all applicable)
Mental:No Change,Alert & Oriented,Confused/Forgetful,Disoriented,Agitated
Vitals: Temperature Oral,axillary,tympanic,rectal Pulse:
Radial,Apical,Brachial,regular,irregular
Respirations:regular,irregular
Blood Pressure: Right /Left /Lying,standing,sitting
Weight:Actual,Reported Blood Sugar:Actual/Reported
Skin; (Temperature, Color, Turgor)
Breath Sounds:Clear,Crackles/Rales,Rhonchi/Wheeze Other:
O2 Saturation %
Bowel Sounds:Active/absent/hypoactive/hyperactive x quadrants
Last BM incontinence,diarrhea,constipation,Impaction
Pain:None,Same,improved,worse Origin:Location(s)
Hearing:Vision:
Relief measures
Cardiopulmonary Neuromuscular
()No problem
())Chest pain/palpations
()) Pedal Edema:)LUE +1/+2/+3/+4)LLE +1/+2/+3/+4
)RUE +1/+2/+3/+4)RLE +1/+2/+3/+4
Other:
() Pedal Pulses present/absent
() Cough: () Nonproductive () Productive
Color:Character:
() Dyspnea () Orthopnea () Cyanosis
() O2 liters/minute via NC/mask/trach
() PRN (Continuous)
Comments:
Trach Type:Size
Ventilator Settings
RR:
TV:
PEEP:
() No problem
Pupils; () PERRLA () Other:
() Decreased Sensation ()Tremors ()Headache
Grasp: Right () Equal () Unequal () Other
Left () Equal () Unequal () Other
() Numbness/Tingling () Vertigo/Ataxia
() Syncope
()ambulates: ()independent, () Assist x1, () Equipment
Balance: () WNL () Unsteady Gait
() Weakness
() Adaptive Equipment

Comments:

O2 :
Gastrointestinal Genitourinary
( ) Anorexia ( ) Nausea/Vomiting ( ) Difficulty Swallowing
( ) Tube Feeding (specify) _____
( )Continuous ( ) Intermittent
Comments: _____
_____
_____
( )Burning ( ) Frequency/Urgency ( ) Retention/Hesitancy
( ) Odor ( )Hematuria ( ) Incontinence
( ) Catheter (specify) type _____French____ml/balloon
Bulb inflated _____ml ( )Changed ( ) Inserted ( )Removed
Irrigated with (specify)_____
Comments: _____
Wound Care
( ) Not applicable/ostomy care
Wound care/dressing change performed by ( )Self ( )Nurse
( ) Caregiver/family member
( ) Soiled dressing removed/disposed of properly
( )Wound cleaned (specify) _____
( ) Wound irrigated (specify) _____
( ) Type of dressing(s) used _____
( ) Wound debridement
( ) Drainage collection container emptied. Volume _____
( ) Patient tolerated procedure well
( ) Medicated prior to wound care
( ) Patient/family/caregiver instructed on wound
care/ostomy/disposal of soiled dressing
( ) Patient/family/caregiver to perform wound care/ostomy/dressing
change
Wound
1
2
3
Location
Length
Width
Depth
Drainage
Tunneling
Odor
Stoma
Comments: _____
_____
_____
_____
Interventions/Instructions
( ) Observe/Teach:
( ) Disease Process (specify) _____
( ) Diet: _____
( ) Safety: ( )Fall ( ) Medications ( ) Fire

( ) Other: _____
( ) Pain Management
( ) Care of: ( ) Terminally Ill, ( ) Ventilator Dependent,
( ) Tracheostomy Care ( )s/p CVA
( ) wound care, ( ) Diabetes management, _____
_____
_____
Teach/Administer:
( ) Tube feedings/Special diet: _____
_____
( ) Medication Administration: ( ) injections, ( ) GT/GJ,
( ) nebulizer treatment ( ) infusion
( ) medication purpose & Side effects:
( ) Ambu bag use
( ) Oxygen tank use
( ) Ventilator settings and alarms
( ) Miscellaneous equipment_____
_____
Summary Checklist
Care Plan: ( ) Reviewed/Revised with patient involvement
( ) Outcome achieved ( ) PRN order obtained
( )Discharge Planning Discussed
Plan for next visit: _____
_____
_____
Approximate next visit date: _____/_____/_____
Next physician Date: _____/_____/_____
Care coordination: ( ) MD, ( ) SN ( )PT ( ) OT ( ) ST ( )MSW ( ) LPN/PDN ( )
Billable services recorded? ( ) yes ( ) No
Nurses Signature/Title: _____ Date: / / Time In:
Time Out: