Patient Name: xxvxbvb Date: cvbcbcvbcvb xxvxbvb

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
Weight: ☐Actual,☐Reported Blood Sugar: ☐
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

(☐)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: False
TV: False
PEEP: False

Neuromuscular

(☐) 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:

False
False
False

O2 :

Gastrointestinal

( ) Anorexia ( ) Nausea/Vomiting ( ) Difficulty Swallowing
( ) Tube Feeding (specify) _____
( )Continuous ( ) Intermittent
Comments: _____
_____
_____

Genitourinary

( )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 ca
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: