Patient Name: _____ **Date:** _____

Skilled Nurse Visit

Type of Visit: ( ) Initial ( ) Skilled Nursing Revisit ( ) Skilled Nursing s/p hospitalization ( ) Change in patient status

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

( ) 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 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: