Patient Name: sssssssssssss Date: ssssssssssssss

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	(▫) 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	Pupils; (▫) PERRLA (▫) Other: (▫) Decreased Sensation (▫)Tremors (▫)Headache
Other:	
(▫) Pedal Pulses present/ ▫ absent	Grasp: Right (▫) Equal (▫) Unequal (▫) Other
(▫) Cough: (▫) Nonproductive (▫) Productive	Left (▫) Equal (▫) Unequal (▫) Other
Color: Character:	
(▫) Dyspnea (▫) Orthopnea (▫) Cyanosis	(▫) Numbness/Tingling (▫) Vertigo/Ataxia
(▫) O2 liters/minute via ▫ NC/ ▫ mask/ ▫ trach	(▫) Syncope
(▫) PRN (Continuous)	(▫)ambulates: (▫)independent, (▫) Assist x1, (▫) Equipment
Comments:	Balance: (▫) WNL (▫) Unsteady Gait
Trach Type: Size	(▫) Weakness
Ventilator Settings	(▫) Adaptive Equipment
RR: False False	Comments:
TV: False	
PEEP: False False	

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 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: