



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/palpitations

☐ 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: