

Skilled Nursing Visit

Cheat Sheet - RN/LVN

Pt's Name _____

Date/Time _____

PAIN:

Y

N

Pain Scale: _____/10

Location: _____

Quality: _____

Management: _____

Aggravating Factor: _____

MEDICATIONS:

☐ CHANGES SINCE LAST VISIT?

☐ YES ☐ NO

☐ MED COMPLIANT?

☐ YES ☐ NO

VITALS:

TEMP

HR

BP

RESP

O2

SUGAR

CARDIOVASCULAR:

☐ WNL

☐ CHEST PAIN: Y / N

☐ HEART SOUNDS:

☐ MURMUR

☐ GALLOP

☐ CLICK

☐ IRREGULAR

☐ PERIPHERAL PULSES: _____

☐ CAP REFILL:

☐ <3 SECS / >3 SECS

☐ DIZZINESS

☐ EDEMA: Y / N

☐ +1 ☐ +3

☐ +2 ☐ +4

☐ NECK VEIN DISTENTION: Y / N

GU:

☐ WNL

☐ INCONTINENCE

☐ DISTENTION

☐ BURNING

☐ FREQUENCY

☐ DYSURIA

☐ RETENTION

☐ URGENCY

☐ UROSTOMY _____

☐ CATHETER: FOLEY / SUP.

Size: ____ F ____ cc

Last changed: _____

URINE:

☐ CLOUDY

☐ ODOROUS

☐ SEDIMENT

☐ HEMATURIA

☐ OTHER: _____

EXTERNAL GENITALIA:

☐ NORMAL

☐ ABNORMAL: _____

MUSCULOSKELETAL:

☐ WNL

☐ WEAKNESS

☐ AMBULATION DIFFICULTY

☐ LIMITED MOBILITY _____

☐ JOINT PAIN _____

☐ POOR BALANCE

☐ GRIP STRENGTH

☐ EQUAL ☐ UNEQUAL

☐ BEDBOUND

☐ CHAIRBOUND

☐ CONTRACTURE _____

☐ PARALYSIS _____

RESPIRATORY:

☐ LUNG SOUNDS:

☐ CTA

☐ RHONCI

☐ CRACKLES

☐ DIMINISHED

☐ RALES

☐ WHEEZES

☐ ABSENT

☐ STRIDOR

☐ COUGH: Y / N

☐ PRODUCTIVE

☐ NONPRODUCTIVE

☐ SPUTUM: Y / N

☐ OXYGEN: Y / N

☐ ____ LPM / _____

☐ INT / CONTINUOUS

☐ NEBULIZER: Y / N

DIGESTIVE / GI:

☐ WNL

☐ NAUSEA/VOMITING

☐ NPO

☐ REFLUX/INDIGESTION

☐ DIARRHEA

☐ CONSTIPATION

☐ ____ CHRONIC

☐ ____ ACUTE

☐ ____ OCCASIONAL

☐ INCONTINENCE

☐ BOWEL SOUNDS:

☐ ____ HYPERACTIVE

☐ ____ HYPOACTIVE

☐ ____ NORMAL

☐ LAST BM: _____

STOOL:

☐ WNL

☐ ABNORMAL

☐ GRAY

☐ TARRY

☐ FRESH BLOOD

☐ BLACK

OSTOMY:

☐ STOMA APPEARANCE _____

☐ STOOL APPEARANCE _____

☐ SURROUNDING SKIN _____

INTEGUMENTARY:

☐ WNL

☐ DRY

☐ CLAMMY

☐ WARM

☐ COOL

☐ PALLOR

TURGOR:

☐ GOOD/ELASTIC

☐ DECREASED

☐ POOR

ORIENTATION:

☐ PERSON

☐ DISORIENTED

☐ LETHARGIC

☐ PLACE

☐ FORGETFUL

☐ SEIZURES

☐ TIME

☐ PERRL

☐ TREMORS

SENSORY:

☐ WNL

☐ HEARING IMPAIRED

☐ LEFT ☐ RIGHT ☐ DEAF

☐ SPEECH IMPAIRED

☐ VISION

☐ WNL

☐ CONTACTS L / R

☐ CATARACTS.

☐ BLIND

☐ GLASSES

☐ BLURRED

☐ GLAUCOMA

☐ MAC. DEGEN.

☐ DECREASED SENSATION: _____

NUTRITION:

☐ WNL

☐ DYSPHAGIA

☐ DECREASED APPETITE

☐ WEIGHT LOSS/GAIN _____

☐ MEALS PREPARED APPROPRIATELY

☐ DIET

☐ ADEQUATE

☐ INADEQUATE

☐ DECREASED APPETITE

☐ NG / DOBHOFF / PEG:

☐ PLACEMENT CHECKED

☐ RESIDUAL CHECKED

☐ DENTURES

☐ THOAT PROBLEMS

☐ DENTAL PROBLEMS

☐ HOARSENESS

☐ PROBLEMS CHEWING

DIET: _____

☐ TUBE FEEDING

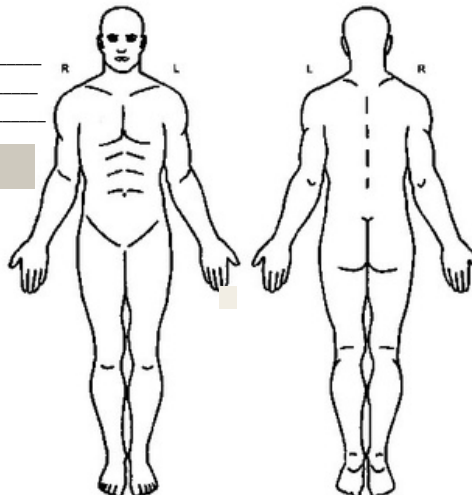
☐ FORMULA: _____

☐ BOLUS

☐ CONTINUOUS @ ____ cc/hr

☐ PUMP / GRAVITY

☐ PLACEMENT CHECKED



PSYCHOSOCIAL:

☐ POOR. HOME ENVIRONMENT

☐ POOR COPING SKILLS

☐ AGITATED

☐ DEPRESSED MOOD

☐ IMPAIRED DECISION-MAKING

☐ EXPRESSED ANXIETY

☐ INAPPROPRIATE BEHAVIOR

☐ IRRITABILITY

PROBLEMS / ISSUES DURING VISIT?

MD NOTIFICATION:

EDUCATION GIVEN:

SOURCE OF EDUCATION:

WOUND CARE:

LOCATION: _____

ONSET DATE: _____

SIZE: _____

DRAINAGE: _____

ODOR: _____

ETIOLOGY: _____

STAGE: _____

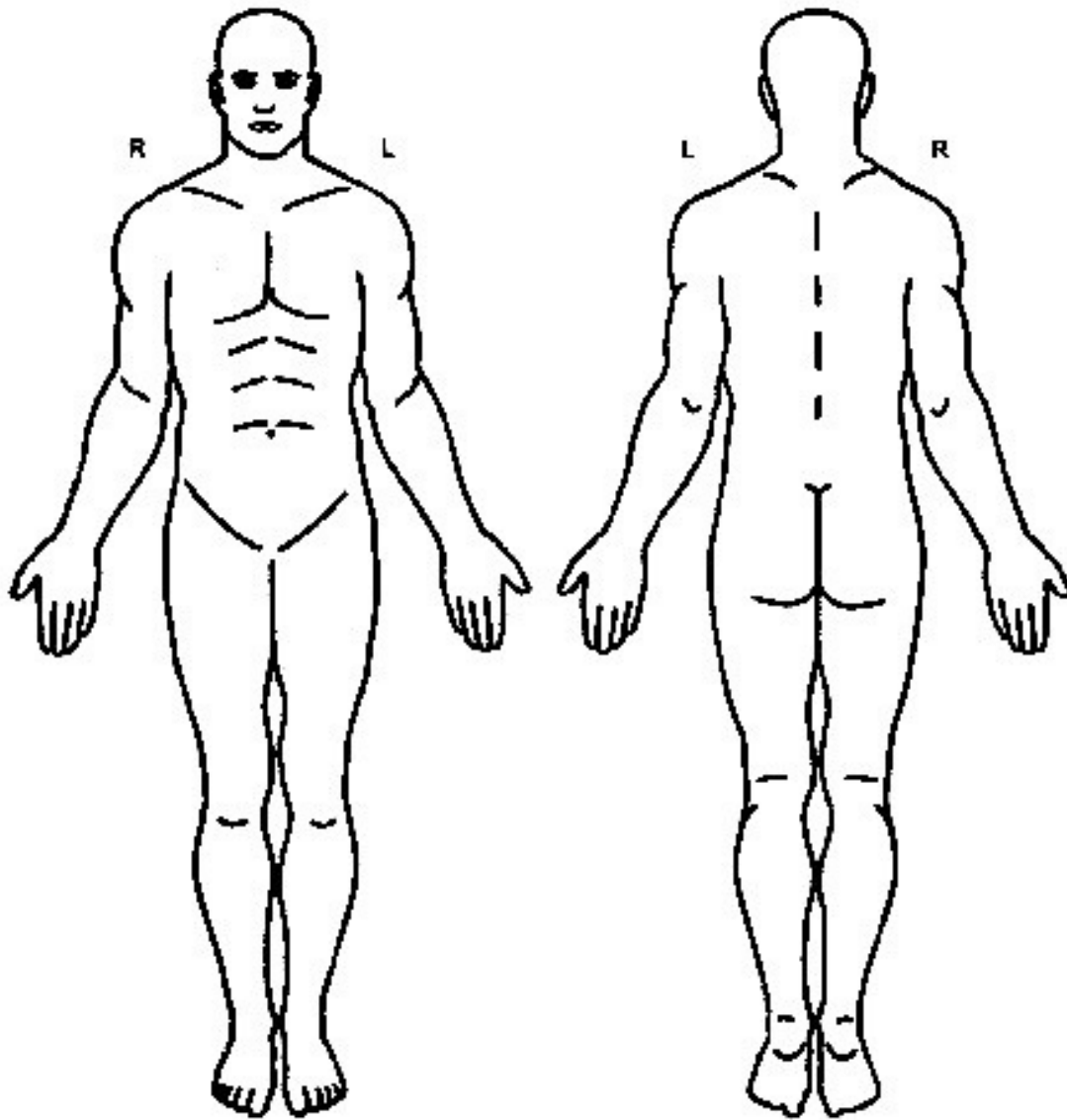
UNDERMINING: Y / N

INFLAMMATION: Y / N

TREATMENT: _____

☐ WOUND PHOTO OBTAINED?

WOUND CARE WORKSHEET



LOCATION: _____
ONSET DATE: _____
SIZE: _____
DRAINAGE: _____
ODOR: _____
ETIOLOGY: _____
STAGE: _____
UNDERMINING: Y / N
INFLAMMATION: Y / N

COMMENTS:

LOCATION: _____
ONSET DATE: _____
SIZE: _____
DRAINAGE: _____
ODOR: _____
ETIOLOGY: _____
STAGE: _____
UNDERMINING: Y / N
INFLAMMATION: Y / N

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ODOR: _____
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STAGE: _____
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INFLAMMATION: Y / N

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STAGE: _____
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INFLAMMATION: Y / N

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STAGE: _____
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INFLAMMATION: Y / N

COMMENTS: