Faith Health Care, Inc.

NURSE
DATA BASE/ASSESSMENT NOTE

PATIENT NAME LAST	FIRST	PT. NUMBER	DATE MO.	DAY	YR.	EMP INITIALS	EMP. #

PRESENT COMPLAINTS AND ILLNESS

DATE OF BIRTH:

EMERGENCY CONTACT/NEXT OF KIN:

Name:

Phone:

NURSING VISITS CODE

IV - Initial Visit
RI - Reinstatement Visit

Medical Supplies related to Diagnosis were left with patient per MD order ..... ☐ Yes ☐ No

B/P **LYING** **SITTING** **STANDING**

(R) | | |

(L) | | |

T _____ AP _____ RP _____ _____

ABD GIRTH _____ cm HT _____ WT _____ GLUCOSE _____

MENTAL STATUS ☐ Alert ☐ Disoriented ☐ Forgetful ☐ Communication ☐ Depressed ☐ Anxious ☐ Agitated
☐ Hostile ☐ Lethargic ☐ Other _____

EENT ☐ Pupils: R____mm. L____mm. REACTION: ☐ R ☐ L ☐ Blind ☐ Glasses ☐ Glaucoma ☐ Cataracts
☐ Blurring ☐ Watering ☐ Discharge ____ ☐ Inflammation ____ ☐ Hearing Aid ☐ H.O.H. ☐ Aid ☐ Tinnitus
☐ Ear Pain ☐ Dentures ☐ Missing Teeth ☐ Bleeding Gums ☐ Epistaxis ☐ Sinus Pain ☐ Nasal Discharge
☐ Sore Throat ☐ Hoarse ☐ Other _____

NEURO ☐ H/A ☐ Vertigo ☐ Syncope ☐ Tremors ☐ Seizures ☐ Dysphagia ☐ Aphasia ☐ Herniparesis ____
☐ Paralysis ____ ☐ Grasp: R____ L____ ☐ Numbness ☐ Tingling ☐ Pain ☐ Other _____

PULMONARY ☐ SOB ☐ Orthopnea ☐ Rales ____ ☐ Rhonchi ____ ☐ Wheezes _____ ☐ BS _____ ☐ Hemoptysis
☐ Cough (Non-Prod.) (Prod.) Sputum Color _____ Amt. _____ ☐ O2 _____L/min freq. _____
☐ SAN _____ ☐ Smokes ☐ Other _____

CARDIAC ☐ RATE: ☐ Regular ☐ Irregular ☐ Palpitations ☐ Pacer ☐ Neck Vein Distension ☐ Murmur
☐ Chest Pain Freq. _____ Duration _____ Last Episode _____
Radiates to _____ Relief with _____
☐ Other _____

PERIPHERAL CIRCULATION ☐ Pulses: ☐ Present ☐ Absent ☐ Weak ☐ Strong ☐ Equal ☐ Unequal
☐ Extremities: ☐ Cool ☐ Warm ☐ Ruddy ☐ Pale ☐ Cyanotic ☐ Mottled ☐ Varicosities ☐ Claudication
☐ Edema: ☐ None ☐ Pitting ☐ TR ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ Location._____ ☐ Anasarca
☐ Capillary Refill: ☐ Poor ☐ Fair ☐ Good ☐ Nailbeds: ☐ Pink ☐ Pale ☐ Cyanotic
☐ Other _____

GI/ABD ☐ Bowel Sounds ☐ Absent ☐ Present ☐ Hypoactive ☐ Hyperactive LBM: _____
☐ Nausea ☐ Emesis ☐ Diarrhea ☐ Constipation ☐ Laxative/Enemas Use Freq _____
☐ Indigestion ☐ Gas ☐ Tenderness ☐ Pain ☐ Hematemesis ☐ Melena ☐ Ascites ☐ Hernia
☐ Masses _____ ☐ Ostomy _____ ☐ Weight Loss/Gain _____ ☐ Appetite: ☐ Good ☐ Poor ☐ Fair
☐ NG ☐ GT ☐ Other _____ ☐ Diet: _____

G.U. ☐ Incontinent ☐ Foley Size _____ Last Changed _____ ☐ Frequency ☐ Urgency ☐ Pain
☐ Burning ☐ Hematuria ☐ Retention Urine: Color _____ ☐ Cloudy ☐ Odor ☐ Bloody
☐ Intake: _____ cups/day Output: Voids _____ x/day or _____cc ☐ Nocturia x _____
☐ Ileoconduit ☐ Nephrostomy ☐ Prostate Problems ☐ Hesitency ☐ Vaginal Bleeding ☐ Discharge
☐ Other _____

M/S ☐ Dec. ROM ☐ Stiffness ☐ Swollen Joints ☐ Pain ☐ Weakness ☐ Contractures ☐ Amputation
☐ Coordination: ☐ Good ☐ Fair ☐ Poor ☐ Arthritis ☐ Other _____

ACTIVITIES ☐ Bedbound ☐ WC ☐ Assist to Transfer ☐ Need of Assist of: ☐ Walker ☐ Cane ☐ _____ Person(s)

ADL ☐ Gait: ☐ Slow ☐ Unsteady ☐ Uses walls and furniture for support
☐ Personal Care: ☐ Independent ☐ Moderate Assistance ☐ Maximum Assistance
☐ Prior level of function: _____

SKIN INTACT ☐ YES ☐ NO

☐ Icteric ☐ Pale ☐ Cyanotic ☐ Flushed ☐ Grey

☐ Warm ☐ Cool ☐ Clammy ☐ Dry ☐ Diaphoretic

• Turgor: ☐ Good ☐ Fair ☐ Poor

☐ Itching ☐ Rash ☐ Petechiae ☐ Bruises

Other Skin Details: _____

_____

_____

_____

Caregiver: _____

Relation to patient: _____

Caregiver Limitations: ☐ Work ☐ Physical ☐ Age ☐ Illness

☐ I Knowledge ☐ Other Responsibilities

SKIN ASSESSMENT (ASSIGN GRADE)

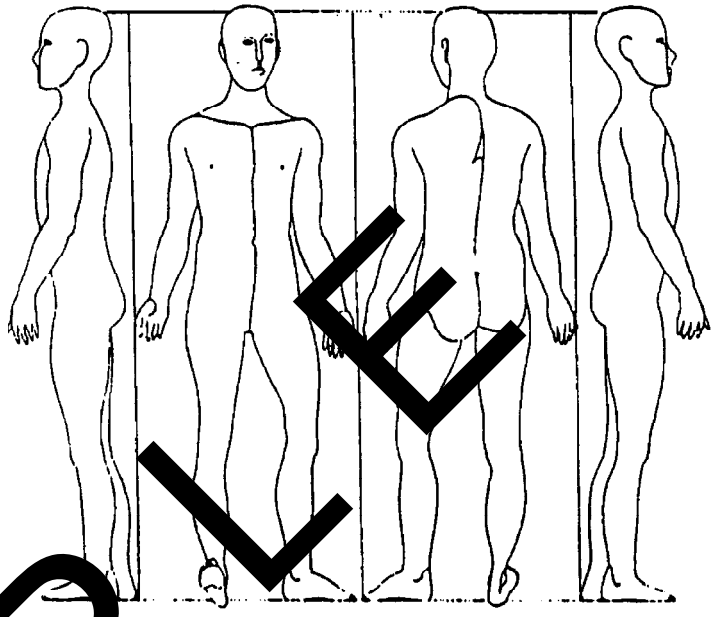
GR I SKIN REDDENED - DISAPPEARS ON PRESSURE

GR II REDNESS, EDEMA & INDURATION WITH BLISTERING

GR III SKIN NECROTIC WITH FAT EXPOSURE

GR IV - NECROSIS THROUGH SKIN AND FAT TO MUSCLE

GR V - EXTENDED FAT AND MUSCLE NECROSIS



SOCIO CULTURAL:

S M W D Language _____ Religion: _____

PT/SO Knowledge of Illness: ☐ Good ☐ Fair ☐ Poor

Motivation for Rehab: ☐ Good ☐ Fair ☐ Poor

Income Stability: ☐ Adequate ☐ Inadequate

Home Environment: ☐ Apartment ☐ House ☐ Electricity

☐ Running Water ☐ Hygienic ☐ Non-Hygienic

☐ Barrier Free ☐ Barriers: _____

PREVIOUS MEDICAL HISTORY

☐ D.M. _____ (☐ Insulin ☐ Oral Agent ☐ Diet Controlled) ☐ Asthma___ ☐ COPD___ ☐ HPT___

☐ Cardiac _____ (☐ CHF ☐ Arrythmias ☐ CAD ☐ M.I. ☐ Angina) ☐ Ulcers _____

☐ Cancer _____ ☐ ETO H Use ☐ Other _____

HOSPITALIZATION/SURGERIES (REASONS, DATE) _____

_____

HISTORY OF PRESENT ILLNESS: _____

REASON FOR HOMEBOUND: _____

_____

_____

SKILLED NURSING PERFORMED (SPECIFIC INSTRUCTIONS/PROCEDURES)

☐ Assessment/Observations ☐ Written Med. Schedule ☐ Instructed on Home Care Services & Bill of Rights

☐ Wound Care _____ ☐ Other _____

Narrative _____

_____

_____

_____

_____

PATIENT/SIGNIFICANT OTHER ATTITUDE AND RESPONSE TO INSTRUCTIONS:

☐ Able To Repeat Instructions ☐ Able To Demonstrate ☐ Needs Further Teaching

☐ Unable To Understand/ Demonst rate Due To: _____

PLAN: (SEE CARE PLANS)

☐ SN to visit for Assessment/Observations, Instructions and Treatments

☐ Aide to visit for: ☐ Personal Care and ADLs ☐ Other _____

☐ MSS: Assessment of Home Situation

☐ P.T. ☐ S.T. ☐ O.T.: Evaluation and Treatment program

Physician Communication for: _____

_____ _____

Print Nurse Name RN Signature