SKILLED NURSING VISIT NOTE

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS BEFORE SERVICE PROVIDED SG

SG Patient's Safety Goal

PATIENT NAME - Last, First, Middle Initial | ID#

DATE OF VISIT

TIME IN _____ AM/PM OUT _____ AM/PM

TYPE OF VISIT: ☐ SN ☐ SN & Super. ☐ Super. Only ☐ Other

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Requires assistance / device to ambulate ☐ Medical restrictions ☐ Contusion, unable to go out of home alone ☐ Unable to safely leave home unassisted ☐ Dyspnea on minimal exertion ☐ Bed / Chair bound ☐ Residual weakness ☐ Dependent upon adaptive device(s) ☐ Acute episodes of hyper/hypoglycemia yield unsafe ambulation ☐ Unable to drive ☐ Severe SOB, SOB upon exertion ☐ Other (specify) _____

MARK ALL APPLICABLE WITH AN X. CIRCLE APPROPRIATE ITEM MEDICARE ☐ MEDICAID ☐ MX ☐ OTHER ☐

VITALS

T _____ Wt _____ BS _____

Resp. _____ ☐ Reg. ☐ Irregular

Pulse: A _____ R _____

☐ Reg. ☐ Irregular

B/P	LYING	SITTING	STANDING
RIGHT			
LEFT			

CARDIOVASCULAR

- Fluid Retention
- Chest Pain
- Neck Vein Distension
- Edema (specify): ☐ RUE ☐ LUE ☐ RLE ☐ LLE
- Ascites
- Peripheral Pulses
- Arrhythmia
- Other:
- No deficit

RESPIRATORY

- Rales ☐ Ronchi ☐ Wheeze
- ☐ R. Lung ☐ L. Lung
- ☐ Cough ☐ Sputum
- ☐ Dyspnea ☐ SOB
- Orthopnea
- 02. LPM: VIA:
- No deficit ☐ Fire Prevention followed SG

DIGESTIVE

- Bowel Sound:
- ☐ Nausea ☐ Vomiting
- ☐ Anorexia ☐ NPO
- Epigastric Distress
- Difficulty Swallowing
- Abdominal Distention
- ☐ Colostomy ☐ Ileostomy
- Bowel Incontinence
- ☐ Constipation ☐ Impaction ☐ Diarrhea
- Diet:
- Fluid Intake:
- Enteral Feeding Route:
- Type: Amount:
- Via:
- Flushing:
- Appetite: ☐ Good ☐ Fair ☐ Poor
- LBM: ☐ No Deficit

GENITOURINARY

- ☐ Burning ☐ Dysuria
- ☐ Distension ☐ Retention
- ☐ Frequency ☐ Urgency ☐ Hesitancy
- Hematuria
- Bladder Incontinence
- ☐ Catheter ☐ Ileoconduit
- Suprapubic Catheter
- Foley Catheter
- Size Fr. cc.
- Last Changed:
- Irrigation cc / nsa
- Urine
- Output cc / hr.
- Color
- Consistency
- Odor
- ☐ Pain ☐ Discharge
- ☐ Cath. Leakage ☐ Dislodge
- Other
- No Deficit

SKIN

- ☐ Warm ☐ Dry ☐ No Deficit
- ☐ Cold ☐ Clammy
- ☐ Jaundice ☐ Pallor ☐ Cyanosis
- ☐ Turgor ☐ Hydration
- ☐ Rash ☐ Itching ☐ Discoloration
- ☐ Decubitus ☐ Wound ☐ Ulcer
- Chills
- Integrity
- Tube Insertion Site
- Other

ENDOCRINE

- ☐ Weakness ☐ Fatigue ☐ Tired ☐ No Deficit
- ☐ Sign/Symptoms of ☐ Polydipsia ☐ Polyphagia
- ☐ Sign/Symptoms of ☐ Hyperglycemia ☐ Hypoglycemia
- Other

MUSCULOSKELETAL

- Balance ☐ Unsteady gait ☐ Endurance
- Weakness ☐ Ambulates with Assistance
- Limited Movement ☐ Rom
- ☐ Chair Bound ☐ Bed Bound
- ☐ Contracture ☐ Paralysis
- No Deficit

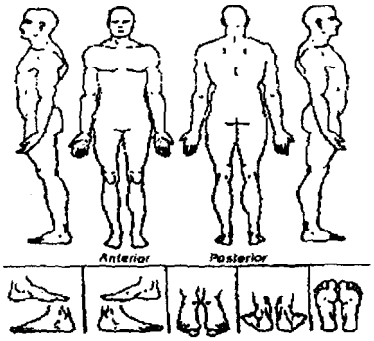
NEUROSENSORY

- Syncope
- Headache
- Grasp ☐ Equal ☐ Unequal
  - Right: _____
  - Left: _____
- Movement
  - ☐ RUE ☐ LUE
  - ☐ RLE ☐ LLE
- Pupil Reaction
  - ☐ Right ☐ Left
- Hand Tremors
- Poor Hand-Eye coordination
- Poor Manual Dexterity
- Speech impairment
- Hearing Impairment
- Visual Impairment ☐ Blindness
- Tactile Sensation
- No deficit

EMOTIONAL STATUS

- Oriented ☐ T ☐ P ☐ P
- Forgetful ☐ Confused
- Disoriented ☐ T ☐ P ☐ P
- Lethargic ☐ Semi Lethargic
- Comatose
- Restless ☐ Agitated
- Anxious ☐ Depressed
- Other

Denote Location / Size of Wounds / Measure Ext. Edema Bil.



	#1	#2	#3	#4
length				
Width				
Depth				
Drainage				
Tunneling				
Odor				
Surr Tissue				
Edema				
Stoma				

PAIN / FALL MANAGEMENT SG

Frequency of pain interfering with patients activity or movement:

☐ 0 - Patient has no pain
☐ 1- Pain does not interfere with activity or movement
☐ 2 - Less often than daily
☐ 3 - Daily, but not constantly
☐ 4 - All of the time
☐ Pain Management Teaching to patient / family

Intensity 0 1 2 3 4 5 6 7 8 9 10 (Low – High)

Current pain management & effectiveness: ☐ No deficit / Pain

Progress toward pain goal: _____ Patient's pain goal: _____

Primary Site(s): _____

Client is at risk for falls ☐ yes ☐ no **Fall assessment conducted** ☐ Yes ☐ N/A

Potential for falls: 0 1 2 3 4 5 6 7 8 9 10

Potential for falls has: Increased ☐ decreased ☐ SG

Compliant with fall prevention plan: ☐ Yes ☐ No ☐ N/A

SKILLED INTERVENTION - TEACHING - Pt. RESPONSE

DME/SUPPLIES: ☐ Gloves ☐ Thermometer ☐ BP cuff ☐ Glucometer ☐ Alcohol pads ☐ 4x4 ☐ Sharp container ☐ Other:

PLAN FOR NEXT VISIT:

OTHER PROGRESS TOWARDS GOALS: ☐ PT / S.O. / CG verbalized understanding of inst. given ☐ Other: _____

☐ PT / S.O. / CG able to return correct demonstration of Tech. / procedure Inst. on **DISCHARGE PLANNING DISCUSSED?** Yes ☐ No ☐ N/A ☐

☐ No S.O. or C/G able / willing for Inj. Adm. at this time ☐ Treatment well tolerated by Patient

☐ No S.O. or C/G able / willing for wound care at this time. ☐ Verification of Procedure Performed SG

CARE PLAN: ☐ Reviewed / Revised with patient / client involvement. ☐ Outcome achieved

☐ PRN Order Obtained: _____

☐ Verification of Medication Performed Prior to Admin. SG

MEDICATION STATUS ☐ No Change ☐ Order Obtained: _____

SUPPLIES USED: _____

INTERVENTIONS / INSTRUCTIONS

- ☐ Skilled Observation / Assessment
- ☐ Foley Change ☐ Foley irrigation
- ☐ Wound Care ☐ Dressing Change
- ☐ Prep. / Admin. Insulin: _____
- ☐ SQ Injection: _____ Site: _____
- ☐ IM Injection: _____ Site: _____
- ☐ Diabetic Observation / Care
- ☐ Observation / Inst Med. (N or C) effects / Side Effects _____
- ☐ Inst. Fall Prevention ☐ Emergency Prepar. SG
- ☐ Inst. Disease Process _____
- ☐ Diet. Teaching _____
- ☐ Safety Precautions/Factors Management Conducted
- ☐ Teach Infant / Childcare
- ☐ Peg / GT Tube Site Care
- ☐ Tracheostomy Care ☐ Suctioning

TECHNIQUES USED

- ☐ Universal Precautions/ Handwashing Tech. followed
- ☐ Aseptic Tech.used / Infection Control followed SG
- ☐ Quality Control of Glucometer Performed as per Agency P & P on: _____
- ☐ Glucometer Calib. on: _____
- ☐ Soiled Dressings Double Bagged
- ☐ Sharps Discarded Inside Sharps Container

INFUSION / IV SITE: _____

- ☐ IV Tubing Change
- ☐ Cap Change ☐ Venipuncture/Lab: _____
- ☐ Central Line Dressing Change
- ☐ IV Site Dressing Change
- ☐ IV Site Change
- ☐ Infusion by _____ Pump
- ☐ Infusion Med: _____
- ☐ Infusion Rate: _____
- Comments: _____
- ☐ Infusion Well Tol. by Pt.

☐ Patient unable to perform own W/C due to: _____

CARE COORDINATION: Physician ☐ PT ☐ OT ☐ ST ☐ MSW ☐ SN ☐ CM ☐ HHA ☐

☐ Other: _____

NURSE SIGNATURE / PRINT NAME **RN / LPN** **DATE**

Signature / Date -Complete TIME OUT (above) prior to signing below (circle title) ___/___/___

A&B Home Health, Inc.

SKILLED NURSING VISIT NOTE

PATIENT NAME - Last, First, Middle Initial | MR#

DATE OF VISIT _____

TIME IN _____ AM PM OUT _____ AM PM

TYPE OF VISIT: ☐ SN ☐ SN & Super. ☐ Super. Only ☐ Other

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Requires assistance to ambulate ☐ Residual weakness ☐ Contusion, unable to go of home alone ☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion ☐ Dependent upon adaptive device(s) ☐ Medical restrictions ☐ Other (specify) _____

MARK ALL APPLICABLE WITH AN X. CIRCLE APPROPRIATE ITEM **MEDICARE** ☐ MEDICAID ☐ MX ☐ **OTHER** ☐

VITALS

T _____ Wt _____ BS _____

Resp. _____ ☐ Reg. ☐ Irregular

Pulse: A _____ R _____

☐ Reg. ☐ Irregular

B/P	LYING	SITTING	STANDING
RIGHT			
LEFT			

CARDIOVASCULAR

- Fluid Retention
- Chest Pain
- Neck Vein Distension
- Edema (specify): ☐ RUE ☐ LUE ☐ RLE ☐ LLE
- Ascites
- Peripheral Pulses
- Arrhythmia
- Other:
- No deficit

RESPIRATORY

- Rales / Ronchi / Wheeze
- ☐ R. Lung ☐ L. Lung
- Cough / Sputum
- Dyspnea / SOB
- Orthopnea
- 02. LPM: VIA:
- No deficit

DIGESTIVE

- Bowel Sound
- Nausea / Vomiting
- Anorexia / NPO
- Epigastric Distress
- Difficulty Swallowing
- Abdominal Distention
- Colostomy / Ileostomy
- Bowel Incontinence
- Constipation / Impaction / Diarrhea
- Appetite:
- Fluid Intake:
- Enteral Feeding Route:
- Type:
- Amount:
- Via:
- Flushing:
- No Deficit

GENITOURINARY

- Burning / Dysuria
- Distension / Retention
- Frequency / Urgency / Hesitancy
- Hematuria
- Bladder Incontinence
- Catheter / Ileoconduit
- Suprapubic Catheter
- Foley Catheter
- Size Fr. cc.
- Last Changed:
- Irrigation cc / nsa
- Urine
- Output cc / hr.
- Color
- Consistency
- Odor
- Pain / Discharge
- Cath. Leakage / Dislodge
- Other

- No Deficit

SKIN

- Warm / Dry
- Cold / Clammy
- Jaundice / Pallor / Cyanosis
- Integrity
- Chills
- Decubitus / Wound / Ulcer
- Rash / Itching / Discoloration
- Turgor / Hydration
- Tube Insertion Site
- Other

- No Deficit

MUSCULOSKELETAL

- Balance / Unsteady gait / Endurance
- Weakness / Ambulates with Assistance
- Limited Movement / Rom
- ☐ Chair Bound ☐ Bed Bound
- ☐ Contracture ☐ Paralysis
- No Deficit

NEUROSENSORY

- Syncope
- Headache
- Grasp ☐ Equal ☐ Unequal Right: _____ Left: _____
- Movement ☐ RUE ☐ LUE ☐ RLE ☐ LLE
- Pupil Reaction Right Left
- Hand Tremors
- Poor Hand-Eye coordination
- Poor Manual Dexterity
- Speech impairment
- Hearing Impairment
- Visual Impairment / Blindness
- Tactile Sensation
- No deficit

EMOTIONAL STATUS

- Oriented ☐ T ☐ P ☐ P
- Forgetful / Confused
- Disoriented ☐ T ☐ P ☐ P
- Lethargic / Semi Lethargic
- Comatose
- Restless /Agitated
- Anxious / Depressed
- Other

- No Deficit

INTERVENTIONS / INSTRUCTIONS

- ☐ Skilled Observation / Assessment
- ☐ Foley Change ☐ Foley irrigation
- ☐ Wound Care / Dressing Change
- ☐ Prep. / Admin. Insulin
- ☐ Im Injection / SQ Injection
- ☐ Diabetic Observation / Care
- ☐ Observation / Inst Med. (N or C) effects / Side Effects _____
- ☐ Inst. Safety Precaution / Emergency Prep.
- ☐ Inst. Disease Process _____
- ☐ Diet. Teaching _____
- ☐ Safety Factors Management Conducted
- ☐ Peg / GT Tube Site Care
- ☐ Trache. Care / Suctioning

TECHNIQUES USED

- ☐ Universal Precautions Followed
- ☐ Aseptic Tech. Used.
- ☐ Quality Control of Glucometer Performed as per Agency P & P
- ☐ Glucometer Calib. on _____
- ☐ Soiled Dressings Double Bagged
- ☐ Sharps Discarded Inside Sharps Container

PAIN

Frequency of pain interfering with patients Activity or movement

- ☐ 0 - Patient has no pain or pain does not interfere with activity or movement
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time

PAIN PROFILE

Primary Site _____

Intensity 0 1 2 3 4 5 6 7 8 9 10

Low High

Current pain management & effectiveness _____

☐ Pain Management Teaching to patient / family (document below)

Patient's pain goal: _____

Progress toward pain goal: _____

☐ No deficit

SKILLED INTERVENTION - TEACHING - PT. RESPONSE

☐ PT / S.O. / CG verbalized understanding of inst. given ☐ No S/O or C/G able / willing for Inj. Adm. at this time ☐ Tx well tolerated by PT.

☐ PT / S.O. / CG able to return correct demonstration of Tech. / procedure Inst. on ☐ No S/O or C/G able / willing for wound care at this time.

☐ Patient unable to perform own W/C due to _____

CARE PLAN: ☐ Reviewed / Revised with patient / client involvement. ☐ Outcome achieved ☐ PRN Order Obtained: _____

MEDICATION STATUS ☐ No Change ☐ Order Obtained: _____

DISCHARGE PLANNING DISCUSSED? Yes ☐ No ☐ N/A ☐

SUPPLIES USED: _____

NURSE'S SIGNATURE

CARE COORDINATION: Physician ☐ PT ☐ OT ☐ ST ☐ SS ☐ SN ☐ CM ☐

☐ Other: _____

PRINT NAME RN / LPN DATE

Signature / Date - Complete TIME OUT (above) prior to signing below (circle title) ___/___/___

1-Class Home Health, Inc.

HOMEBOUND STATUS:
❑ Assist of 1-2 persons ❑ Painful Ambulation ❑ Bedbound/Chairbound
❑ Taxing effort to leave home ❑ Compromised Disease Status ❑ Mobility/Ambulatory device used
❑ SOB upon amb ___ FT ❑ Generalized Weakness ❑ Angina/Dyspnea on Min.Exertion
❑ Unsteady Gait ❑ Poor Endurance/Limited Ambulation Other: _____

SKILLED NURSING PROGRESS NOTE

DATE OF VISIT ____/____/____
TIME IN _____AM ❑ PM ❑ OUT _____ AM ❑ PM ❑

MARK ALL APPLICABLE WITH AN X CIRCLE APROPRIATE ITEM | MEDICARE ❑ MEDICAID ❑ MX OTHER ❑

TYPE OF VISIT ❑ SN ❑ SN SUP. ❑ SUP. ONLY Other. _____

T' _____ WT _____ BS _____
Resp. _____ Reg. ❑ Irreg. ❑
Pulse: A _____ R _____
❑Regular ❑ Irregular

B/P	LYING	Sitting	Standing
Right			
Left			

CARDIOVASCULAR
- Fluid retention
- Chest pain
- Neck vein distension
- Edema (specify) ❑RUE ❑LUE ❑RLE ❑LLE
- Ascites
- Peripheral Pulse
- Arrhythmia
- Other
- No Deficit

RESPIRATORY
- Rales/Rhonchi/Wheeze
- ❑ R. Lung: ❑ L. Lung:
- Cough/Sputum
- Dyspnea/SOB
- Orthopnea
- O2: LPM: VIA:
- No Deficit

DIGESTIVE
- Bowel sounds LBM:
- Nausea/Vomiting
- Anorexia./NPO
- Epigastric distress
- Difficulty swallowing
- Abdominal distention
- Colostomy/Ileostomy
- Bowel incontinence
- Constipation/Impaction/Diarrhea
- Diet:
- Appetite: ❑ good ❑ Fair
- Fluid Intake
- Enteral Feeding Route:
- Type:
- Amount:
- Via:
- Flushing:
- No Deficit:

GENITOURINARY
- Burning/Dysuria
- Distention/Retention
- Frequency/Urgency/Hesitancy
- Hematuria
- Bladder incontinence
- Catheter/Ileoconduit
- Suprapubic Catheter ❑ External ❑
- Foley Catheter
- Size Fr cc
- Last changed:
- Irrigation cc/nss
- Urine
- Output: cc/ hr
- Color:
- Consistency:
- Odor:
- Pain/Discharge
- Cath Leakage/dislodgement
- Diabetic urine testing=ketone ☐
- Other:

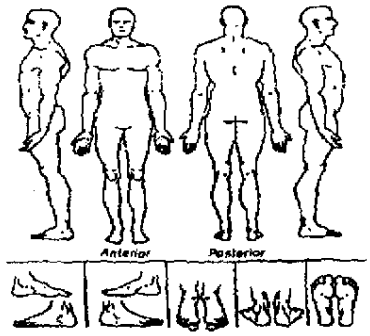
SKIN
- Warm/Dry
- Cold/Clammy
- Jaundice/Pallor/Cyanosis
- Integrity
- Chills
- Decubitus/Wound/Ulcer
- Rash/Itching/Discoloration
- Turgor/Hydration
- Tube Insertion Site
- Other
- Stage I☐ II❑ III❑
- No Deficit

MUSCULOSKELETAL
- Balance/Unsteady gait/Endurance
- Weakness/Ambulates With Assistance
- Limited Movement/Rom/Assist device
- Chair Bound ❑ Bed Bound
- Contracture ❑ Paralysis
- No Deficit

NEUROSENSORY
- Syncope/Vertigo
- Headache
- Grasp ☐ Equal ❑Unequal
- Right: _____
- Left: _____
- Movement ❑RUE ❑LUE ❑RLE ❑LLE
- Pupil reaction Brisk❑ Sluggish❑
- Right: _____ Left:
- Hand Tremors
- Poor Hand-Eye Coordination
- .Poor Manual Dexterity
- Speech impairment
- Hearing impairment
- Visual impairment/Blindness
- Tactile sensation/Ptosis❑
- No Deficit

EMOTIONAL STATUS
- Oriented ❑T ❑P ☐P
- Forgetful/Confused
- Disoriented ❑T ☐P ❑P
- Lethargic
- Comatose
- Restless/Agitated
- Anxious/Depressed
- Other:

Denote Location / Size of Wounds / Measure Ext. Edema Bil.



	#1	#2	#3	#4
length				
Width				
Depth				
Drainage				
Tunneling				
Odor				
Surr Tissue				
Edema				
Stoma				

❑ Diet Teaching: _____
❑ Safety Factors Management Conducted
❑ Teach Infant/Childcare

PAIN

Frequency of Pain interfering with patient's Activity or movement:
❑ 0- Patient has no Pain does not interfere with activity or movement
❑ I- Less often then daily
❑ 2- Daily, but not constantly
☐ 3- All of the time
PAIN PROFILE- Origin Dull ☐ burning ☐
Primary Site. _____
Intensity 0 1 2 3 4 5 6 7 8 9 10

PAIN (Cont.)
Current: Pain management & effectiveness
_____
☐Pain Management Teaching to patient/family *(document below)*
Patient pain goal:
_____
Progress toward pain goal:
_____
❑No Deficit

INTERVENTIONS / INSTRUCTIONS CONT.
❑Skilled Observation/Assesment
❑ Foley Change ☐ Foley irrigation
❑ Wound care/Dressing Change
❑ Venipuncture/Lab: _____
❑ Prep./Admin. Insulin
❑ IM injection/Sq Injection
❑ Diabetic. Observation/Care
❑ Observation/Inst. Med (N or C) effects/Side effects: _____
❑ Inst. Safety Precaution/Emergency Prep
☐ Inst. Disease Process

❑ Peg/GT Tube Site care
❑ Trachea care/Suctioning
TECHNIQUES USED:
☐ Universal Precautions Followed
☐ Aseptic Tech. Used
☐ Quality control of Glucometer performed as per agency p & p
❑ Glucometer calib. On: _____
❑ Soiled Dressings double bagged
❑ Sharps discarded inside Sharps container
INFUSION/IV SITE: _____
☐ IV Tubing Change
☐ Cap Change
❑Central Line Dressing Change
❑IV Site Dressing Change
❑IV Site Change
☐ Infusion by: _____
☐ Infusion Med: _____
☐ Infusion Rate: _____
Comments: _____
☐ Infusion well tolerated by PT

SKILLED INTERVENTION / TEACHING / PT RESPONSE

APROXIMATE NEXT VISIT DATE ____/____/____ PLAN FOR NEXT VISIT: ❑ SKILLED ASSESSMENT ❑ INSULIN ADMIN./PREP. ❑ W/C _____

❑PT / S.O. / CG verbalized understanding of inst. given ☐ No S/O or CG able / willing for Inj. Adm. At this time ❑Tx. well Tolerated by PT
❑PT / S. 0. / CG able to return correct demonstration of tech. /Procedure Inst. On ❑No s/o or CG able / willing for Wound Care at this time
☐Patient unable do own W/C/Inj. Adm. due to: _____

CARE PLAN: ☐reviewed / Revised with patient/ client Involvement ❑Outcome achieved ❑PRN Order Obtained: _____
MEDICATION STATUS: ❑No Change ☐ Order Obtained: _____
DISCHARGE PLANNING DISCUSSED? yes ❑ No ❑ N/A ☐
SUPPLIES USED: ❑GLOVES ❑ALCOHOL PAD ❑SYRINGE/LANCET ❑TEST TRIP ❑SALINE SOL. ❑KERLIX ❑DSD ❑THERMOMETER SLIP ❑TAPE
CARE COORDINATION: ☐Physician ❑PT ☐OT ☐ST ☐SS ❑SN ❑CM ❑Other
_____

COMPLETE FOR SUPERVISORY VISIT CIRCLE Y/N 1-POOR 2- FAIR 3- GOOD

Supervisory visit	Y N	Patient social needs met	Y N
RN/LPN/AIDE Following care plan	Y N	Universal & safety prec. Followed	Y N
Patient physical needs rnet	Y N	Employee present	Y N
Patient environmental needs met	Y N	Patient satisfied with service	Y N
Assignment update	Y N	Rapport with patient / s.o.	1 2 3
Service change requested	Y N	Clinical / Technical skill	1 2 3
Patient mental needs met	Y N	Patient response to Care	1 2 3

PATIENT (CLIENT NAME (First, Middle Initial (Print))

SIGNATURE/DATE - Complete TIME OUT (above) prior to signing below. (circle title) RN/LPN
_____
Nurse *(signature/title)* Print Name

Medical Record #:

BetLife HEALTHCARE CORP

HOME HEALTH CARE

SKILLED NURSING PROGRESS NOTE

DATE OF VISIT ____/____/____
AM ☐ PM ☐

HOMEBOUND STATUS:
☐ Unable to leave home safely without assistance ☐ Unsafe ambulation ☐ Can only ambulate_____ **feet without rest periods** ☐ **Acute episodes of hyper/hypoglycernia yield unsafe ambulation**
☐ **Requires assistive device to ambulate** ☐ Dyspnea on minimal exertion ☐ Bed to chair bound ☐ Severe pain on ambulation ☐ Angina upon minimal exertion ☐ Para/quadriplegic ☐ Bed bound
☐ Other:

MARK ALL APPLICABLE WITH AN X CIRCLE APPROPRIATE ITEM | MEDICARE ☐ MEDICAID ☐ MX OTHER ☐

TYPE OF VISIT ☐ SN ☐ SN SUP. ☐ SUP. ONLY Other.

Temp _____ A ☐ O ☐ R ☐ T ☐
BSL by Glucometer _____ FBS ☐ RBS
Resp. _____ Reg. _____ Irreg. _____ ☐
Pulse: A _____ R _____
☐ Regular ☐ Irregular

B/P	Lying	Sitting	Standing
Right			
Left			

CARDIOVASCULAR

☐ Fluid retention:
☐ Chest pain:
☐ Neck vein distension:
☐ Edema (specify) ☐ RUE ☐ LUE ☐ RLE ☐ LLE
☐ Ascites:
☐ Peripheral Pulse:
☐ Arrhythmia:
☐ Other:
☐ No Deficit

RESPIRATORY

☐ Rales ☐ **Rhonci** ☐ Wheeze:
☐ ☐ R.Lung: ☐ L.Lung:
☐ Cough ☐ Sputum:
☐ SOB:
☐ Orthopnea:
☐ O2: LMP: VIA:
☐ No Deficit

GASTROINTESTINAL

☐ **Bowel Sounds**
☐ **Abdominal Distention:**
☐ Colostomy ☐ **Ileostomy:**
☐ Bowel Incontinence ☐ LBM:
☐ Constipation ☐ Impaction ☐ Diarrhea
☐ Nausea ☐ Vomiting
☐ Heartburn (food Intolerance)
☐ NPO
☐ Difficulty Swallowing
☐ Diet:
☐ Appetite: ☐ Good ☐ Fair ☐ Poor
☐ Fluid Intake:
☐ Enteral Feeding Route:
☐ Type:
☐ Amount:
☐ Via:
☐ Flushing:
☐ No Deficit:

GENITOURINARY

☐ Burning ☐ Dysuria:
☐ Distention ☐ Retention:
☐ Frequency ☐ Urgency ☐ Hesitancy:
☐ Hematuria:
☐ Bladder incontinence:
☐ Catheter:
☐ Suprabubic Catheter ☐ External ☐
☐ Foley Catheter:
Size: **Fr** cc
Last changed:
Irrigation: cc/nss
Urine:
Output:
Color:
Consistency:
Odor:
☐ Dysuria ☐ Discharge:
☐ Cath Leakage ☐ Dislodgement:
Other:
☐ No Deficit

SKIN

☐ Warm ☐ Cold ☐ Dry:
☐ Bruises ☐ Clammy:
☐ Jaundice ☐ Pallor ☐ Cyanosis:
☐ Integrity:
☐ Chills:
☐ Rash ☐ Itching ☐ Discoloration:
☐ Turgor ☐ Hydration:
☐ Tube Insertion Site:
☐ Decubitus ☐ Wounds ☐ Ulcer:
☐ Stage: I ☐ II ☐ III ☐ IV ☐
☐ Other:
☐ No Deficit:

MUSCULOSKELETAL

☐ Balance ☐ Unsteady gait ☐ Endurance ☐
☐ Weakness ☐ Ambulates With Assistance ☐
☐ Limited Mvmt ☐ ROM ☐ Assist device ☐
☐ Chair Bound ☐ Bed Bound ☐
☐ Contracture ☐ Paralysis ☐
☐ No Deficit

NEUROSENSORY

☐ Syncope ☐ Vertigo:
☐ Headache:
☐ Grasp: ☐ Equal: ☐ Unequal
☐ Right: _____
☐ Left:
☐ Weakness:
☐ RUE ☐ LUE ☐ RLE ☐ LLE
☐ PERRLA: yes ☐ No ☐
☐ Right: Left:
☐ Hand Tremors: ☐ Apraxia
☐ Poor Hand-Eye Coordination:
☐ Poor Manual Dexterity:
☐ Speech impairment: Aphasia:
☐ Hearing Impairment:
☐ Visual impairment ☐ Blindness:
☐ Tactile sensation
☐ No Deficit

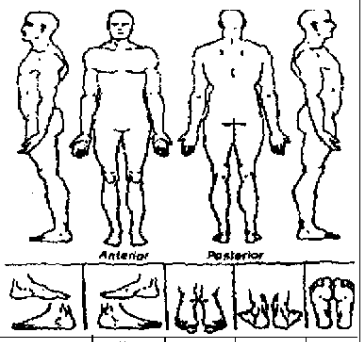
MENTAL STATUS

☐ Oriented: ☐ Time ☐ Place ☐ Person
☐ Disoriented: ☐ Time ☐ Place ☐ Person
☐ Forgetful ☐ Confused:
☐ Lethargic: Comatose:
☐ Anxious ☐ Agitated:
☐ Depressed: ☐ Recent ☐ Long Term

Treatment

☐ **Sleep/ Rest:** ☐ adequate ☐ inadequate
Treatment:
☐ No Deficit:

Denote Location / Size of Wounds /
Measure Ext. Edema Bil.



	#1	#2	#3	#4
Length				
Width				
Depth				
Drainage				
Tunneling				
Odor				
Surr Tissue				
Edema				
Stoma				

PAIN
Frequency of Pain interfering with patient's Activity of movements: _____
☐ 0- Patient has no Pain or Pain does not interfere with activity or movement
☐ I - Less often than daily
☐ 2- Daily, but not constantly
☐ 3- All of the time
PAIN PROFILE -Origin Dull ☐ Burning ☐
Primary Site: _____
Intensity 0 1 2 3 4 5 6 7 8 9 10
☐☐☐☐☐☐☐☐☐☐☐

PAIN (Cont.)
Current: Pain management & effectiveness _____
☐ Pain Management Teaching to Patient/family *(document below)*
Patient pain goal: _____
Progress toward pain goal: _____
☐ No Deficit

INTERVENTIONS/ INSTRUCTIONS
☐ Skilled Observation ☐ Assessment
☐ Prep. ☐ Admin. Insulin
☐ Wound Care ☐ Dressing Change
☐ Venipuncture ☐ Lab: _____
☐ Foley Change ☐ Foley Irrigation
☐ IM injection ☐ SubQ Injection
☐ Diabetic. ☐ Observation ☐ Care
☐ Medications Compliance Evaluated
☐ Observation ☐ Inst. Med (N or C)
☐ Effects ☐ Side effects: _____
☐ _____

☐ Diet Teaching: _____
☐ Safety Factors Management Conducted
☐ Emergency Plan
☐ Peg
☐ GT Tube Site Care
☐ Trachea Care ☐ Suctioning
TECHNIQUES USED: _____
☐ Universal Precautions Followed
☐ Aseptic Tech. Used
☐ Quality control of Glucometer performed as per agency p & p
☐ Glucometer calib. On: _____
☐ Soiled Dressing double bagged
☐ Sharps discarded inside Sharps container
☐ INFUSION ☐ IV SITE: _____
☐ IV Tubing Change
☐ Cap Change
☐ **Central Line Dressing Change**
☐ **IV Site Dressing Chan**
☐ **IV Site Change**
☐ **Infusion Med:** _____
☐ **Infusion Rate:** _____
Comments: _____
☐ **Infusion well tolerated by PT**

SKILLED INTERVENTION / TEACHING / PT RESPONSE

PLAN FOR NEXT VISIT:

☐ **PT / SO. / CG verbalized understanding of inst. Given** ☐ PT / S.O. / CG able to return correct demonstration of tech. / Procedures
☐ No s/s of CG able / willing to Wound Care/Inj. at this time ☐ Tx. Well Tolerated by PT ☐ PT / S.O. / CG Requires further instructions

☐ Patient unable perform inj/wound care due to:

CAREPLAN: ☐ Reviewed ☐ Revised with PT ☐ Client Involvement ☐ Outcome achieved ☐ PRN
Order Obtained:
MEDICATION STATUS: ☐ No Change ☐ Order Obtained:
DISCHARGED PLANNING DISCUSED? YES ☐ NO ☐ N/A ☐
SUPPLIES USED:
CARE COORDINATION: ☐ Physician ☐ PT ☐ OT ☐ ST ☐ SS ☐ SN ☐ CM
☐ Other

Client is at risk for falls ☐ yes ☐ no
Fall assessment conducted ☐ Yes ☐ N/A
Potential for falls: 0 1 2 3 4 5 6 7 8 9 10
☐☐☐☐☐☐☐☐☐☐☐
Potential for falls has: Increased ☐ decreased ☐
Intervention for this visit:
Client/C.G. response ☐ Compliant with fall prevention plan ☐
Verbalizes understanding of instructions ☐
Verbalizes understanding of instructions ☐

PART I - Clinical Record | **PART 2 - Employee**

PATIENT (CLIENT NAME First, Middle Initial (Print))

SIGNATURE/DATE - Complete DATE (above) prior to signing below. (circle title)
_____ RN/ LPN
Nurse (signature/title) Print Name

Medical Record #:

ABSOLUTE HOME HEALTH, INC.

SKILLED NURSING VISIT NOTE

PATIENT NAME - Last, First, Middle Initial | ID#

DATE OF VISIT _____

TIME IN _____ AM PM OUT _____ AM PM

TYPE OF VISIT: ☐ SN ☐ SN & Super. ☐ Super. Only ☐ Other

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Requires assistance to ambulate ☐ Residual weakness ☐ Contusion, unable to go of home alone ☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion ☐ Dependent upon adaptive device(s) ☐ Medical restrictions ☐ Other (specify) _____

MARK ALL APPLICABLE WITH AN X. CIRCLE APPROPRIATE ITEM MEDICARE ☐ MEDICAID ☐ MX ☐ OTHER ☐

VITALS

T _____ Wt _____ BS _____

Resp. _____ ☐ Reg. ☐ Irregular

Pulse: A _____ R _____

☐ Reg. ☐ Irregular

B/P	LYING	SITTING	STANDING
RIGHT			
LEFT			

CARDIOVASCULAR

- ☐ Fluid Retention
- ☐ Chest Pain
- ☐ Neck Vein Distension
- ☐ Edema (specify): ☐ RUE ☐ LUE ☐ RLE ☐ LLE
- ☐ Ascites
- ☐ Peripheral Pulses
- ☐ Arrhythmia
- ☐ Other:
- ☐ No deficit

RESPIRATORY

- ☐ Rales / Ronchi / Wheeze
- ☐ R. Lung ☐ L. Lung
- ☐ Cough / Sputum
- ☐ Dyspnea / SOB
- ☐ Orthopnea
- ☐ 02. LPM: VIA:
- ☐ No deficit

DIGESTIVE

- ☐ Bowel Sound / LBM
- ☐ Nausea / Vomiting
- ☐ Anorexia / NPO
- ☐ Epigastric Distress
- ☐ Difficulty Swallowing
- ☐ Abdominal Distention
- ☐ Colostomy / Ileostomy
- ☐ Bowel Incontinence
- ☐ Constipation / Impaction / Diarrhea
- ☐ Diet: Appetite:
- ☐ Fluid Intake:
- ☐ Enteral Feeding Route:
- ☐ Type:
- ☐ Amount:
- ☐ Via:
- ☐ Flushing:
- ☐ No Deficit

GENITOURINARY

- ☐ Burning / Dysuria
- ☐ Distension / Retention
- ☐ Frequency / Urgency / Hesitancy
- ☐ Hematuria
- ☐ Bladder Incontinence
- ☐ Catheter / Ileoconduit
- ☐ Suprapubic Catheter
- ☐ Foley Catheter
- ☐ Size Fr. cc.
- ☐ Last Changed:
- ☐ Irrigation cc / nsa
- ☐ Urine
- ☐ Output cc / hr.
- ☐ Color
- ☐ Consistency
- ☐ Odor
- ☐ Pain / Discharge
- ☐ Cath. Leakage / Dislodge
- ☐ Other

SKIN

- ☐ Warm / Dry
- ☐ Cold / Clammy
- ☐ Jaundice / Pallor / Cyanosis
- ☐ Integrity
- ☐ Chills
- ☐ Decubitus / Wound / Ulcer
- ☐ Rash / Itching / Discoloration
- ☐ Turgor / Hydration
- ☐ Tube Insertion Site
- ☐ Other
- ☐ No Deficit

MUSCULOSKELETAL

- ☐ Balance / Unsteady gait / Endurance
- ☐ Weakness / Ambulates with Assistance
- ☐ Limited Movement / Rom
- ☐ Chair Bound ☐ Bed Bound
- ☐ Contracture ☐ Paralysis
- ☐ No Deficit

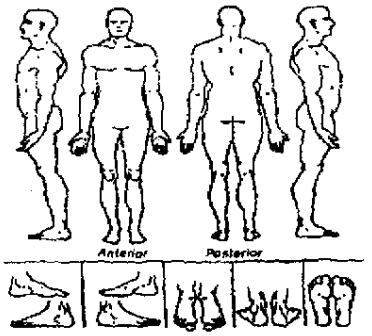
NEUROSENSORY

- ☐ Syncope
- ☐ Headache
- ☐ Grasp ☐ Equal ☐ Unequal Right: _____ Left: _____
- ☐ Movement ☐ RUE ☐ LUE ☐ RLE ☐ LLE
- ☐ Pupil Reaction Right Left
- ☐ Hand Tremors
- ☐ Poor Hand-Eye coordination
- ☐ Poor Manual Dexterity
- ☐ Speech Impairment
- ☐ Hearing Impairment
- ☐ Visual Impairment / Blindness
- ☐ Tactile Sensation
- ☐ No deficit

EMOTIONAL STATUS

- ☐ Oriented ☐ T ☐ P ☐ P
- ☐ Forgetful / Confused
- ☐ Disoriented ☐ T ☐ P ☐ P
- ☐ Lethargic / Semi Lethargic
- ☐ Comatose
- ☐ Restless /Agitated
- ☐ Anxious / Depressed
- ☐ Other
- ☐ No Deficit

Denote Location / Size of Wounds / Measure Ext. Edema Bil.



	#1	#2	#3	#4
length				
Width				
Depth				
Drainage				
Tunneling				
Odor				
Surr Tissue				
Edema				
Stoma				

PAIN

Frequency of pain interfering with patients activity or movement
☐ 0 - Patient has no pain or pain does not interfere with activity or movement
☐ 1 - Less often than daily
☐ 2 - Daily, but not constantly
☐ 3 - All of the time
☐ Pain Management Teaching to patient / family

Current pain management & effectiveness _____

Progress toward pain goal: _____

Patient's pain goal: _____

Primary Site: _____

Intensity 0 1 2 3 4 5 6 7 8 9 10 (Low – High) ☐ No deficit

SUPERVISION

COMPLETE FOR SUPERVISORY VISIT CIRCLE Y/N
1-POOR 2-FAIR 3-GOOD

Supervisory visit	Y N	Patient social needs met	Y N
RN/LPN/AIDE Following care plan	Y N	Universal & safety prec. followed	Y N
Patient physical needs met	Y N	Employee present	Y N
Patient environmental needs met	Y N	Patient satisfied with service	Y N
Assignment update	Y N	Rapport with patient / s.o.	1 - 2 - 3
Service change requested	Y N	Clinical / Technical skill	1 -2 - 3
Patient mental needs met	Y N	Patient response to Care	1 - 2 - 3

SKILLED INTERVENTION - TEACHING - PT. RESPONSE

INTERVENTIONS / INSTRUCTIONS

- ☐ Skilled Observation / Assessment
- ☐ Foley Change ☐ Foley irrigation
- ☐ Wound Care / Dressing Change
- ☐ Venipuncture / Lab: _____
- ☐ Prep. / Admin. Insulin
- ☐ Im Injection / SQ Injection
- ☐ Diabetic Observation / Care
- ☐ Observation / Inst Med. (N or C) effects / Side Effects _____
- ☐ Inst. Safety Precaution / Emergency Prep.
- ☐ Inst. Disease Process _____
- ☐ Diet. Teaching _____
- ☐ Safety Factors Management Conducted
- ☐ Teach Infant / Childcare
- ☐ Peg / GT Tube Site Care
- ☐ Trache. Care / Suctioning

TECHNIQUES USED

- ☐ Universal Precautions Followed
- ☐ Aseptic Tech. Used.
- ☐ Quality Control of Glucometer Performed as per Agency P & P
- ☐ Glucometer Calib. on _____
- ☐ Soiled Dressings Double Bagged
- ☐ Sharps Discarded Inside Sharps Container

INFUSION / IV SITE: _____

- ☐ IV Tubing Change
- ☐ Cap Change
- ☐ Central Line Dressing Change
- ☐ IV Site Dressing Change
- ☐ IV Site Change
- ☐ Infusion by _____ Pump
- ☐ Infusion Med: _____
- ☐ Infusion Rate: _____
- Comments: _____
- ☐ Infusion Well Tol. by Pt.

PLAN FOR NEXT VISIT

☐ PT / S.O. / CG verbalized understanding of inst. given ☐ No S/O pr C/G able / willing for Inj. Adm. at this time ☐ Tx well tolerated by PT.
☐ PT / S.O. / CG able to return correct demonstration of Tech. / procedure Inst. on ☐ No S/O or C/G able / willing for wound care at this time.

☐ Patient unable to perform own W/C due to _____

CARE PLAN: ☐ Reviewed / Revised with patient / client involvement. ☐ Outcome achieved ☐ PRN Order Obtained: _____
MEDICATION STATUS ☐ No Change ☐ Order Obtained: _____
DISCHARGE PLANNING DISCUSSED? Yes ☐ No ☐ N/A ☐
SUPPLIES USED: _____

CARE COORDINATION: Physician ☐ PT ☐ OT ☐ ST ☐ SS ☐ SN ☐ CM ☐
☐ Other: _____

APPROXIMATE NEXT VISIT DATE

NURSE SIGNATURE / PRINT NAME **RN / LN** **DATE**

Signature / Date -Complete TIME OUT (above) prior to signing below (circle title) ___/___/___

YOUR FAMILY HOME HEALTH CARE SERVICES, INC.

12963 W. Okeechobee Rd. Ste #5 Hialeah Gardens. FL 33018 Ph 305-558-4111 Fx. 305-558-8811

Nursing Clinical Note

TYPE OF VISIT: ☐ SN ☐ SUP

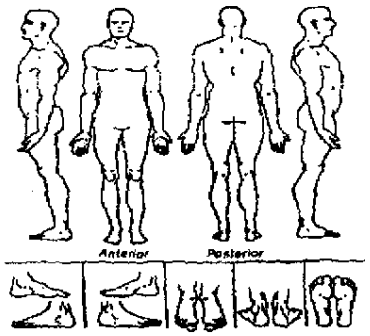
PATIENT:_____ DATE:_____ ☐AM ☐PM MR#_____

HOMEBOUND STATUS: ☐ Weakness ☐Bed Bound ☐ Unsteady Gait ☐Requires Assist ☐ SOB
OTHER: _____

CARDIOVASCULAR	PULMONARY	INTEGUMENTARY	MUSCULOSKELETAL	VITAL SIGNS & WOUND ASSESS.
☐ Chest Pain	☐ Lungs _____	☐ Warm☐Dry☐Cool☐Chills	☐ Poor balance	T _____ HT _____ WT _____
☐Edema _____	☐ SOB ☐ Dyspnea	☐ Intact	☐ Limited Movement	RESP ☐REG ☐IRR
☐Abnormal Rhythmn	☐ Cough _____	☐ Wound ☐ Ulcer ☐ Incision	☐ Chair ☐Bed Bound	PULSE A R☐REG ☐IRR
☐ Pulses _____	☐Sputum _____	☐ Rash ☐ Itching	☐ Walks with _____	B/P LYING SIT/STAND
☐ Anticoagulant Therapy	☐Oxygen _____	☐Turgor _____	☐ Contracture ☐Paralysis	RIGHT
☐ OTHER _____	☐OTHER	☐OTHER _____	☐ OTHER _____	LEFT
☐NO DEFICIT	☐NO DEFICIT	☐NO DEFICIT	☐ NO DEFICIT	☐FBS/RBS _____via glucomter

GASTROINTESTINAL	GENITOURINARY	NEUROLOGICAL	MENTAL
☐ Bowel Sounds x _____	☐ Burning ☐ Dysuria ☐ Odor	☐ Headache	☐ ORIENTED ☐ Person ☐ Place ☐ Time
☐ Abdomen ☐ Soft ☐ Tender	☐ Distention ☐ Retention	☐ Syncope ☐Vertigo	☐ Forgetful ☐ Confused
☐ Distended	☐ Frequency ☐ Urgency	☐ Grasp☐ Strong ☐ Weak	☐ Disoriented
☐ Nausea ☐ Vomiting☐ NPO	☐ Incontinence ☐ Hesitancy	☐ Movement _____	☐ Lethargic ☐Comatose
☐ Diarrhea ☐Constipation	☐ Hesitancy ☐ Itching	☐ Pupils ☐ R ____ ☐ L ____	☐ Restless ☐ Agitated
☐ Incontinence	☐ Color _____	☐ Hand tremors	☐ Anxious ☐ Depressed
☐ Ostomy _____	☐ Catheter _____	☐ Aphasia ☐ Dysphagia	☐ Altered LOC
☐ PEG _____	☐ FR ____ / ____ CC	☐ Speech Impairment	☐ Nervous
☐Feeding _____	☐ Last Changed _____	☐ Hearing Impairment	☐ Impaired Memory
☐Flushing _____	☐ Irrigation _____	☐ Visual Impairment	☐ Psych HX
☐OTHER _____	☐ OTHER _____	☐OTHER _____	☐OTHER _____
☐DIET: _____	☐ NO DEFICIT	☐ NO DEFICIT	☐NO DEFICIT

Denote Location / Size of Wounds / Pressure Sores / Measure Ext. Edema Bil.



	1	2	3	4
Length				
Width				
Depth				
Drainage				
Tunneling				
Odor				
Sur. Tissue				
Edema				
Stoma				

☐ **ORDER CHANGE:**

PAIN	INTERVENTIONS	TECHNIQUES USED	INFUSION/IV SITE
☐No pain	☐Skilled Assessment	☐ Universal Precaution	☐ IV tubing changed
☐Less often than daily	☐Foley Change ☐ Irrigation	☐ Aseptic Technique	☐ Cap change
☐Daily but not constant	☐Wound ☐Ulcer ☐Incision	☐ Proper Sharps Disp.	☐ Catheter Site Care
☐All of the time	☐Prep/Admin Insulin	☐ Proper Waste Disp.	☐ IV site change
☐Pain level (1-10)_____	☐ IM ☐ SQ Injection	☐ QC of glucometer	☐ Med _____
☐Site_____	☐ PEG/GT Site Care	☐ Glucomter Calib. On	☐ Rate
☐Relieved with Med ☐ Y ☐ N	☐OTHER _____	☐Other_____	☐VIA _____

SKILLED INTERVENTION & TEACHINGS

SUPERVISORY VISIT (CIRCLE Y/N)

- ☐ Supervisory Visit LPN/HHA ☐Y ☐ N
- ☐ Following Care Plan ☐Y ☐ N
- ☐ Patient Needs Met ☐Y ☐ N
- ☐ Assignment Updated ☐Y ☐ N
- ☐ Service Change Requested ☐Y ☐ N
- ☐ Univ. & Safety Prec. Followed ☐Y ☐ N
- ☐ Employee Present ☐Y ☐ N
- ☐ Patient Satisfied with Service ☐Y ☐ N

NEXT VISIT DATE: _____ MD NEXT VISIT:_____

☐ Comments:

- ☐PT/CG verbalized understanding of instructions given
- ☐ PT/CG able to demonstrate correct Technique/Procedure Instruction
- ☐ PT unable to perform/administer ☐ woundcare ☐injection due to:
- ☐CG unable to perform/administer ☐ woundcare ☐ injection due to:
- ☐ No able or Willing CG available at this time to assist with:
- ☐Treatment/injection tolerated well by patient

ABNORMAL FINDINGS/CHANGES

- ☐ MD notified-Name:
- ☐New Order:
- ☐New Order:
- ☐Discharge Planning Discussed
- ☐ Case Manager Informed

NURSE NAME: _____ SIGNATURE: _____ RN/LPN
EMPLOYEE# _____

Highlite Home Care
we are here for your every need

SKILLED NURSING NOTE

MR# _____ PATIENT NAME: _____ DATE: _____

Time in: _____ ☐ AM ☐ PM - out _____ ☐ AM ☐ PM Visit Type: ☐ Routine ☐ SV ☐ PRN ☐ Psych. ☐ High Tech

T _____ WT _____ BS _____ ☐ Reg ☐ Irreg

Resp: _____ Pulse: _____

Pain: ☐ yes ☐ no/ Scale _____ /10

Site: _____

B/P	Lying	Sitting	Standing
Right			
Left			

PSYCHOLOGICAL ☐ WNL

☐ Disoriented x _____ ☐ A&O x ___
☐ Forgetful ☐ Anxious
☐ Confused ☐ Fatigue
☐ Depressed ☐ Agitated
☐ Other _____

NEUROLOGICAL ☐ WNL

☐ Syncope / Vertigo
☐ Hearing Impairment / Speech impairment
☐ Visual impairment
☐ Hand tremors
☐ Poor hand-eye coordination
☐ Poor manual dexterity

HOME HEALTH AIDE SV VISIT:

☐ HHA Name: _____
☐ Patient's hygiene needs being met
☐ Respectful of rights, property & confidentiality
☐ Following Care Plan
☐ Environment clean and safe
☐ Patient satisfied with care giver
☐ Documents on the ICR on each visit
☐ Follow Universal Precautions (i.e. handwashing, etc.)

CARDIOVASCULAR ☐ WNL

☐ Ascites
☐ Chest pain/pressure
☐ Fluid retention
☐ Edema site _____
☐ Arrhythmia
☐ Other _____

RESPIRATORY ☐ WNL

☐ Dyspnea: At rest / On exertion
☐ Cough / Sputum
☐ O2 @ _____
☐ Breath sounds R _____ L _____
☐ Other _____

MUSCULOSKELETAL ☐ WNL

☐ Weakness / Paralysis
☐ Limited ROM / Atrophy
☐ Assistance device _____
☐ Altered gait / Balance
☐ Prosthesis _____
☐ Chair bound ☐ Bed bound
☐ Bone/ joint pain ☐ NWB _____

GASTROINTESTINAL ☐ WNL

Appetite: ☐ Good ☐ Fair ☐ Poor ☐ NPO
Diet: _____
☐ Fluid intake _____
☐ Bowel sounds _____
☐ Stoma _____
☐ Last BM: _____
☐ Nausea/vomiting ☐ Diarrhea/constipation
☐ Colostomy / Ileostomy

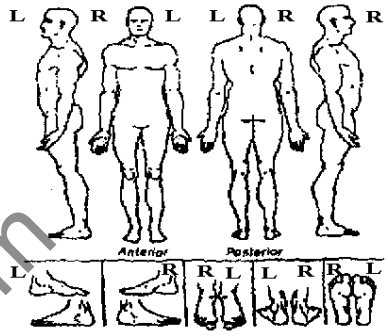
GENITOURINARY ☐ WNL

☐ Frequencies / Urgency / Pain /
☐ Burning / Hernaturia
☐ Incontinence
☐ Anuria / Oliguria / Polyuria
☐ Catheter (type & size) _____
last changed _____
☐ Dialysis Freq. _____
☐ AV Shunt: Bruit ____ Thrill ____
☐ Tesio /Quinton _____

INTEGUMENTARY ☐ WNL

☐ Warm / Dry / Intact
☐ Jaundice / Cyanotic
☐ Cool / Clammy / Chills
☐ Poor turgor
☐ Pale / Flushed / Clammy
☐ Staples / Stitches
☐ Decubitus Wound / ulcer / surgical
☐ Stage ☐ I ☐ II ☐ III
☐ Other _____

Denote Location / Size of Wounds / Measure Ext. Edema Bil.



	#1	#2	#3	#4	#5
Length					
Width					
Depth					
Drainage Type:					
Drainage Amount:					
Tunneling					
Undermining					
Odor					
Surr Tissue					
Edema					
Stoma					

Communication: Phone conf. to Dr. _____
☐ Dr. will return call. Message given to Dr. office
_____ spoke with _____
☐ No new orders ☐ New order: _____

PROFESSIONAL SERVICES/INTERVENTIONS: (see comments) **

☐ Universal precaution observed ☐ Med. Changes (updated med sheet) * ☐ Glucometer calibrated
☐ Catheter insert / change ☐ Tube feedings ☐ Wound care ☐ Infection control ☐ Sharp discarded in biohazard box
☐ Med. Administration ☐ Diabetic care ☐ Ostomy care ☐ Picc line care ☐ Biomedical Waste
☐ Skilled observation & assessment ☐ IV therapy ☐ O2 therapy ☐ Peg/GT tube site care ☐ Other _____

INSTRUCTED IN: (see comments)**

☐ Meds / Action S/E _____
☐ Diet / hydration ☐ Wound care ☐ Safety Factor
☐ Universal precautions ☐ Pain management
☐ Infection control ☐ O2 therapy
☐ Disease process _____ ☐ Other: _____

☐ Patient: ☐ Caregiver: ☐ Return Demo: _____
☐ Demo _____ ☐ Verbalizes understanding
☐ Requires further instruction ☐ written material supplied

HOMEBOUND DUE TO:

☐ Taxing effort to leave home
☐ Require use of assistive device
☐ Dyspneic / Reqs. use of 02
☐ Needs assistance for all activities
☐ Gait instability
☐ Unable to leave home alone
☐ Other: _____
_____

WOUND CARE: 1) Cleanse wound # _____ with: ☐ Normal Saline ☐ Acetic acid ☐ Other: _____ & pat dry

2) Applied: ☐ Vaseline gauze ☐ Xeroform ☐ Betadine ☐ Wet dry _____ ☐ Aquacel Ag ☐ Silvasorb gel ☐ Duoderm ☐ Panafil ☐ Other: _____
3) Covered with: ☐ Telfa ☐ Dry gauze ☐ Adaptic ☐ Other: _____
4) Secured with: ☐ Kling ☐ Stretch bandage ☐ Unna Boot ☐ Other: _____ ☐ & tape

****Comments required****

Approximate next visit date ____/____/____ Plan for next visit: _____

Nurse (LPN / RN) _____ Initials _____

SUNSHINE GOOD CARE, LLC

VISIT DATE: _____

SKILLED NURSING VISIT NOTE

TIME IN: TIME OUT:

PATIENTS NAME:	MED. REC. NUMBER:	HOMEBOUND STATUS: ☐ Needs assistance with all activities ☐ Residual weakness ☐ Requires assistance to ambulate ☐ Confusion, unable to go out of home alone ☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion ☐ Depends upon adaptive device(s) ☐ Medical restrictions ☐ Other (specify) _____
NURSES NAME:	EMP. NO:	

TYPE OF VISIT: ☐ SN ☐ SN & SUPERVISORY ☐ SUPERVISORY ONLY ☐ OTHER _____

DAIGNOSIS:

APPETITE: ☐ POOR ☐ FAIR ☐ GOOD
HYDRATION: ☐ POOR ☐ FAIR ☐ GOOD

NUTRITION/HYDRATION: ☐ WNL DIET: ☐ NAS ☐ NCS ☐ REGULAR ☐ 1800 CALORIE ADA ☐ OTHER _____

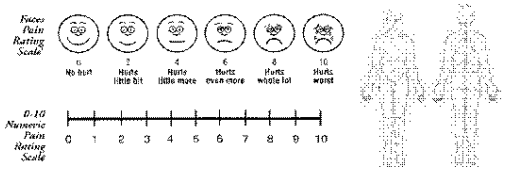
B/P	LYING	SITTING	STANDING
RIGHT			
LEFT			

TEMP:_____
WEIGHT:_____LBS

PULSE:
APICAL:_____
RADIAL:_____

RESP.:_____
☐ REGULAR
☐ IREGULAR

CIRCULATORY: ☐ WNL ☐ EDEMA: ☐ Pitting ☐ Non Pitting Location_____
GRADE: ☐ Trace ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+



PAIN: ☐ YES ☐ NO LOCATION(S):_____
TYPE: ☐ ACHING ☐ RADIATING ☐ THROBBING ☐ OTHER _____
☐ DOES NOT INTERFERE WITH ACTIVITY / MOVEMENT ☐ LESS OFTEN THAN DAILY
☐ DAILY BUT NOT CONSTANTLY ☐ ALL OF THE TIME
PAIN RELIEVING MEASURES USED:_____ FREQ:_____
RELIEF: ☐ COMPLETE ☐ MODERATE ☐ NONE

HEART SOUNDS: ☐ WNL
IRREG:_____
FAINT:_____ BOUNDING:_____
CHEST PAIN :_____
FREQ:_____
RELIEF:_____
PACEMAKER:_____ RATE:_____
OTHER:_____

RESPIRATORY:
RALES/RHONCHI/WHEEZE
☐ R. LUNG ☐ L. LUNG
☐ COUGH/SPUTUM
☐ DYSPNEA/SOB
☐ ORTHOPNIA
☐ O2: LPM:_____ VIA:_____
☐ NO DEFICIT

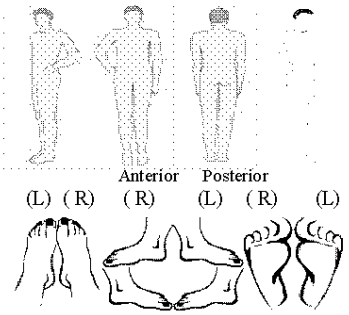
NEUROSENSORY:
☐ SYNCOPE/VERTIGO/DIZZINESS
☐ HEADACHE ☐ HAND TREMORS
☐ POOR HAND–EYE COORDINATION
☐ POOR MANUAL DEXTERITY
☐ SPEECH IMPAIRMENT
☐ VISUAL IMPAIRMENT/BLINDNESS
☐ TACTILE SENSATION
☐ NO DEFICIT
OTHER:_____

ENDOCRINE STATUS: ☐ WNL
ABNORMAL FINDINGS:_____
_____
BS PER GLUCOMETER:_____
☐ FASTING ☐ NON FASTING
BY: ☐ SN ☐ PT ☐ PCG
INSULIN
_____ U. HUMULIN R
_____ U. HUMULIN N
_____ U. LANTUS
_____ U. HUMALOG
_____ U. OTHER _____
SITE _____ # _____
ADMINISTERED BY:
☐ SN ☐ PT ☐ PCG

GENITOURINARY STATUS: ☐ WNL
URINE (DESCRIBE):_____
INDWELLING CATH (SIZE):_____
LAST CATH CHANGE :_____
URINARY INCONTINENCE: ☐ YES ☐ NO
OTHER:_____

GASTROINTESTINAL STSTUS: ☐ WNL
LAST BM (DATE):_____
☐ CONSTIPATION ☐ DIARRHEA
☐ NAUSEA ☐ VOMITING
BOWEL INCONTINENCE: ☐ YES ☐ NO
OTHER:_____

Denote Location / Size of Wounds / Measure Ext. Edema Bil.



☐ NO S/O OR CG. ABLE/WILLING FOR: ☐ W/C ☐ INSULIN ADMINISTRATION AT THIS TIME
☐ PATIENT UNABLE TO PERFORM OWN: ☐ W/C ☐ INSULIN DUE TO: ☐ SEE NEUROSENSORY
☐ OTHER:_____

SKIN INTEGRITY: ☐ INTACT ☐ COMPROMISED TURGOR: ☐ BRISK ☐ SLUGGISH
ABNORMAL FUNDINGS:_____
WOUND DESCRIPTION:
LOCATION:_____
SIZE (IN CM):_____ COLOR:_____
DRAINAGE:_____
SURROUNDING AREA:_____
WOUND CARE PROVIDED:_____

EXTREMITIES: COLOR:_____ TEMP:_____ PERIPHERAL PULSES:_____

MENTAL STATUS: ☐ ALERT ☐ ORIENTED TO T P PL ☐ DISORIENTED ☐ FORGETFUL ☐ CONFUSED ☐ AGITATED ☐ ANXIOUS ☐ DEPRESSED ☐ LETHARGIC
☐ ABLE TO FOLLOW COMMANDS ☐ RESPONDS TO PAIN/VERBAL STIMULI ☐ OTHER _____

SKILLED CARE PROVIDED/TEACHING/PERTINENT OBSERVATION/TREATMENT: _____

PHYSICIAN CONTACT: ☐ YES ☐ NO RE: _____
DISCHARGE PLANING/PROGRESS TOWARD GOALS: _____
PATIEND AND/OR SIGNIFICANT OTHER FEEDBACK (*VERBAL OR NONVERBAL*): _____

TEACHING: PROVIDED TO: ☐ PT ☐ S.O. ☐ CG RESPONSE TO TEACHING: ☐ GOOD ☐ FAIR ☐ POOR ☐ ANXIOUS ☐ CANNOT COPE
UNDERSTANDING ☐ YES, VERBALIZED _____% UNDERSTANDING ☐ NO RETURNS CORRECT DEMONSTRATION ☐ YES ☐ NO
☐ NEEDS FURTHER SUPERVISION IN: _____ ☐ NEEDS FURTHER INSTRUCTION IN: _____
☐ PROBLEM-TEACHING RESOLVED FOR: _____

SUPERVISORY VISIT: LPN PRESENT ☐ YES ☐ NO HHA PRESENT ☐ YES ☐ NO
☐ FOLLOW PLAN OF CARE ☐ DEMONSTRATES COMPETENT SKILLS ☐ COMMUNICATES EFFECTIVLY ☐ NOTIFIES SUPERVISOR OF PATIENTS NEEDS/PROBLEMS
COMMENTS: _____
HHA CARE PLAN: ☐ REVIEWED ☐ REVISED ☐ PT INSTRUCTED IN CHANGES COMMENTS: _____

☐ UNIVERSAL PRECAUTIONS ☐ ASCEPTIC TECNIQUES ☐ SOILED DRESSING BAGGED ☐ SHARPS DISCARDED INSIDE SHARP CONTAINER

NURSE'S SIGNATURE: _____ RN / LPN

PATIENT'S SIGNATURE: _____

WHITE: MEDICAL RECORD YELLOW: NURSE'S COPY

AMERICAN HOME HEALTH PROVIDERS, CORP.

SKILLED NURSING NOTES

PATIENT/CLIENT NAME _____ MR # _____ DATE _____

TIME IN _____ AM PM

TYPE OF VISIT: ☐ SN ☐ SUPV ☐ Medicare ☐ Medicaid ☐ Other _____ TIME OUT _____ AM PM

HOME BOUND REASON: _____ Needs Assistance for all activities _____ Requires Assistance ambulate _____ Dependent upon adaptive device(s)
_____ Confusion, unable to go out of home alone _____ Unable to safely leave home unassisted _____ Severe SOB, SOB upon exertion
_____ Residual Weakness _____ Medical Restrictions _____ Other (specify)

CARDIOVASCULAR

- ☐ Chest
- ☐ Edema _____
- ☐ Abnormal Rhythm
- ☐ Pulses _____
- ☐ Anticoagulant Therapy
- ☐ OTHER _____
- ☐ WNL

PULMONARY

- ☐ Lungs
- ☐ SOB/Dizzy
- ☐ Cough
- ☐ Sputum
- ☐ Oxygen _____
- ☐ OTHER _____
- ☐ WNL

INTEGUMENTARY

- ☐ Warm/Dry/Cool/Chilis
- ☐ Intact
- ☐ Wound[Ulcer/incision
- ☐ Rash/Itching
- ☐ Turgor
- ☐ OTHER _____
- ☐ WNL

MUSCOSKELETAL

- ☐ Poor balance
- ☐ Limited Movement
- ☐ Chair/Bed Bound
- ☐ Walks with _____
- ☐ Contracture/Paralysis
- ☐ OTHER _____
- ☐ WNL

VITAL SIGNS & WOUND ASSESS

T | HT | WT

RESP _____ (REG / IRR)

PULSE A _____ R _____ (REG / IRR)

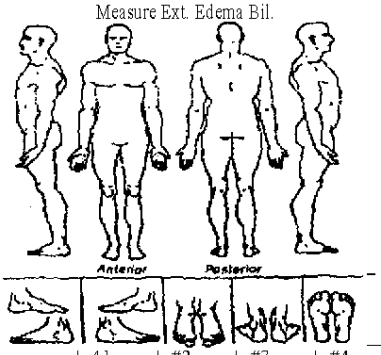
B/P LYING _____ SIT / STAND _____

RIGHT _____ / _____

LEFT _____ / _____

☐ FBS/RBS _____ via glucometer

Denote Location / Size of Wounds / Measure Ext. Edema Bil.



	#1	#2	#3	#4
Length				
Width				
Depth				
Drainage				
Tunneling				
Odor				
Sur. Tis.				
Edema				
Stoma				

GASTROINTESTINAL

- ☐ Bowel Sounds X ___
- ☐ Abdomen Soft/Tender
- ☐ Distended
- ☐ Nausea/Vomiting/NPO
- ☐ Diarrhea/Constipation
- ☐ Incontinence
- ☐ Ostomy _____
- ☐ PEG _____
- ☐ Feeding _____
- ☐ Flushing _____
- ☐ Last BM _____
- ☐ WNL
- ☐ Diet

GENITOURINARY

- ☐ Burning/Dysuria/Odor
- ☐ Distention/Retention
- ☐ Frequency/Urgency
- ☐ Incontinence/Hesitancy
- ☐ Itching
- ☐ Color _____
- ☐ Catheter _____
- ☐ FR _____/_____cc
- ☐ Last Changed _____
- ☐ Irrigation _____
- ☐ OTHER
- ☐ WNL

NEUROLOGICAL

- ☐ Headache
- ☐ Syncope/Vertigo
- ☐ Grasp_equal_unequal
- ☐ Movement _____
- ☐ Pupils equal_unequal
- ☐ Hand tremors
- ☐ Aphasia/Dysphagia
- ☐ Speech Impairment
- ☐ Hearing Impairment
- ☐ Visual Impairment
- ☐ OTHER
- ☐ WNL

MENTAL

- ☐ Oriented X _____
- ☐ Forgetful/Confused
- ☐ Disoriented
- ☐ Lethargic/Comatose
- ☐ Restless/Agitated
- ☐ Anxious/Depressed
- ☐ Altered LOC
- ☐ Impaired Memory
- ☐ Psych HX
- ☐ OTHER
- ☐ WNL

PAIN

- ☐ No pain
- ☐ Less often than daily
- ☐ Daily but not constant
- ☐ Constant
- ☐ Pain level (1-10) ____
- ☐ Site _____

Relieved with Med

☐ Y ☐ N

INTERVENTIONS

- ☐ Skilled Assessment
- ☐ Foley Change/Irrigation
- ☐ Wound/Ulcer/Incision
- ☐ Prep/Admin Insulin
- ☐ IM/SQ Injection
- ☐ PEG/GT Site Care
- ☐ Diet / Meds Instruction
- ☐ S/S Disease Process
- ☐ OTHER _____

TECHNIQUE(S) USED

- ☐ Universal Precautions
- ☐ Aseptic Technique
- ☐ Proper Sharps Disp.
- ☐ Proper Waste Disp.
- ☐ QC of Glucometer
- ☐ Glucometer Calib. On _____
- ☐ OTHER _____

INFUSION/IV SITE

- ☐ IV tubing change
- ☐ Cap change
- ☐ Catheter Site Care
- ☐ IV Site Change

From: _____

To: _____

☐ Med _____

☐ Rate _____

☐ VIA _____

SKILLED INTERVENTION & TEACHING

SN ADMINISTERED IM/SQ

CONTINUE TO VISIT FOR: OBSERVATION/ASSESS, INSTRUCTIONS, FOLEY/WOUND CARE,

LABS/PREP/ADMIN INJECTION, MAX TEACHING ATTAINED, REINSTRUCT UNATTAINED

WEEKLY QUALITY CONTROL / GLUCOSE CONTROL SOLUTION

☐ N/A	RANGE	EXPIRATION DATE	DATE OPENED	CONTROL INDICATOR
High				
Low				

☐ PT/GC verbalized understanding of instructions given ☐ Compliant with Present/Prior Instruction
☐ PT/CG able to demonstrate correct Technique/Procedure Instruction
☐ PT unable to perform/administer wound care/injection due to: _____
☐ CG unable to perform/administer wound care/injection due to: _____
☐ No able CG available at this time to assist with: _____
☐ Treatment/injection tolerated well by patient ☐ Compliant with Diet ☐ Compliant with Medication Regimen
PT ability with Oral Meds ☐ Unable ☐ Able ☐ Demonstrates Understanding
Supplies Used: ☐ Syringes ☐ Lancets ☐ N/S Gloves ☐ Alcohol Pads ☐ Glucometer Strips ☐ 4x4 ☐ Other
☐ Discharge Planning Discussed

NURSE PRINTED NAME _____

NURSE SIGNATURE _____ ☐ RN ☐ LPN

CHANGES IN PATIENT CONDITION

☐ N/A
☐ MD Notified: _____
☐ New Order(s): _____

☐ Supervisor Notified ___Y ___N ___N/A

COMMENTS: _____

SUPERVISORY VISIT (CIRCLE ONE)

☐ N/A
☐ Supervisory Visit LPN/HHA Y N
☐ Following Care Plan Y N
☐ Patient Needs Met Y N
☐ Assignment Updated Y N N/A
☐ Service Change Requested Y N
☐ Univ. & Safety Prec. Followed Y N
☐ Employee Present Y N
☐ Patient Satisfied with Service Y N
☐ Comments: _____

Renaissance Home Health Care, Inc.

SKILLED NURSING PROGRESS NOTE

DATE OF VISIT ____/____/____

PATIENT/CLIENT NAME: _____ ID# _____ TIME IN _____ ☐ AM

PATIENT/CLIENT SIGNATURE: _____ TIME OUT _____ ☐ PM

HOMEBOUND STATUS: ☐ Unable to leave home safely without assistance ☐ Unsafe ambulation ☐ Can only ambulate _____ feet without rest periods
☐ Accute episodes of hyper/hypoglycemia yield unsafe ambulation ☐ Requires assistive device to ambulate ☐ Dyspnea on minimal exertion ☐ Bed to Chair bound
☐ Severe pain on ambulation ☐ Angina upon minimal exertion ☐ Para/quadriplegic ☐ Bed bound ☐ Other: _____

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Edema _____
- ☐ Abnormal Rhythm
- ☐ Pulses _____
- ☐ Anticoagulant Therapy
- ☐ OTHER _____
- ☐ NO DFFICIT

GASTROINTESTINAL
- ☐ Bowel Sounds X _____
- ☐ Abdomen SoftrTener
- ☐ Distended
- ☐ Nausea/Vomiting/NPO
- ☐ Diet _____
- ☐ Diarrhea/Constipation
- ☐ Incontinence
- ☐ Ostomy _____
- ☐ PEG _____
- ☐ Feeding _____
- ☐ Flushing _____
- ☐ Last BM _____
- ☐ OTHER _____
- ☐ NO DEFICIT

TECHNIQUES USED
- ☐ Universal Precautions
- ☐ Aseptic Technique Used
- ☐ Sharps to Sharps cont.
- ☐ Soiled dressing double bagged
- ☐ Quality control of Glucometer performed as per agency p&p
- ☐ Glucometer calib On _____

RESPIRATORY
- ☐ R Lung _____
- ☐ L Lung _____
- ☐ Rales / Rhonchi / Wheeze
- ☐ SOB/Dysnea
- ☐ Cough
- ☐ Sputum _____
- ☐ 02 LIMP _____ VIA _____
- ☐ OTHER _____
- ☐ NO DEFICIT

GENITOURINARY
- ☐ Burning/Dysuria/Odor
- ☐ Distention/Retention
- ☐ Frequency/Urgency
- ☐ Incontinence/Hesitancy
- ☐ Hesitancy/Itching
- ☐ Color _____
- ☐ Catheter _____
- ☐ FIR _____/_____cc
- ☐ Last Changed _____
- ☐ Irrigation _____cc/nss
- ☐ OTHER _____
- ☐ NO DEFICIT

TECHNIQUES USED cont
- ☐ Control Solution # _____
- ☐ Control Solution Results: _____
- ☐ Other _____

SKIN
- ☐ Warm/Dry Cool Chills
- ☐ Intact
- ☐ Turgor
- ☐ Rash/Itching
- ☐ Decubitus / Wounds / Ulcers
  - Stage 1 ☐ 2 ☐ 3 ☐ 4 ☐
- ☐ OTHER _____
- ☐ NO DEFICIT

NEUROLOGICAL
- ☐ Headache
- ☐ Syncope/Vertigo
- ☐ Grasp ___Equal ___Unequal
- ☐ Weakness
- ☐ Movement _____
- ☐ Pupils _____
- ☐ Hand tremors
- ☐ Aphasia/Dysphagia
- ☐ Speech Impairment
- ☐ Hearing Impairment
- ☐ Visual Impairment
- ☐ OTHER
- ☐ NO DEFICIT

INTERVENTIONS
- ☐ Skilled Assessment
- ☐ Foley Change / Irrigation
- ☐ Wound / Ulcer / Incision
- ☐ Prep / Admin Insulin
- ☐ IM / SQ Injection
- ☐ PEG/GT Site Care
- ☐ OTHER _____

MUSCULOSKELETAL
- ☐ Poor Balance
- ☐ Endurance
- ☐ Unsteady Gait
- ☐ Weakness
- ☐ Limited Movement
- ☐ Chair/Bed Bound
- ☐ ROM _____
- ☐ Contracture
- ☐ Paralysis
- ☐ Walks with _____
- ☐ OTHER _____
- ☐ NO DEFICIT

MENTAL STATUS
- ☐ Oriented X _____
- ☐ Disoriented X _____
- ☐ Forgetful/Confused
- ☐ Lethargic/Comatose
- ☐ Restless/Agitated
- ☐ Anxious/Depressed
- ☐ Altered LOC
- ☐ Impaired Memory
- ☐ Psych HX
- ☐ OTHER _____
- ☐ NO DEFICIT

DISCHARGES
- ☐ Continue care for _____ visits/wks
- ☐ Discharge planned for _____

VITAL SIGNS
T | HT | WT

RESP _____ (REG/IRR)

PULSE _____ A _____ R (REG/IRR)

B/P	LYING	SIT/STAND
RIGHT	/	
LEFT	/	

☐ FBS/RBS _____ via glucometer

CHANGES IN PATIENT CONDITION
- ☐ MD notified. _____
- ☐ New Order: _____
- ☐ Supervisor notified

PAIN
Frequency of pain _____

- ☐ 0 No Pain
- ☐ 1 Less often than daily
- ☐ 2 Daily but not constant
- ☐ 3 All the time
- ☐ Origin Dull ☐ Burning

Primary Site _____

Intensity:

0 1 2 3 4 5 6 7 8 9 10
☐☐☐☐☐☐☐☐☐☐☐

Relieved with Med: ☐ Y ☐ N

Progress toward pain goal:

- ☐ Pain Management Teaching to Patient / Family *(document below)*
- ☐ NO DEFICIT

FALLS
Fall Assessment Made ☐ Y ☐ N/A

Client at risk for falls ☐ Y ☐ N

Potential for falls:

0 1 2 3 4 5 6 7 8 9 10
☐☐☐☐☐☐☐☐☐☐☐

Potential for falls has:

☐ Increased ☐ Decreased

SUPERVISION ☐ Y ☐ N
Supervisory Visit ☐ LPN ☐ HHA

Employee present ☐ Y ☐ N

Care plan followed ☐ Y ☐ N

Univ/Safety Prec Observed ☐ Y ☐ N

Patient Satisfied with Service ☐ Y ☐ IN

Service Change Requested ☐ Y ☐ N

Comments: _____

SKILLED INTERVENTION AND TEACHINGS

Intervention for this visit:

NEXT VISIT DATE ____/____/____

Supplies Used: _____

- ☐ PT/CG verbalized understanding of instructions given
- ☐ PT/CG able to demonstrate correct Teaching Procedures
- ☐ PT/CG requires further instruction
- ☐ TX well tolerated by patient
- ☐ PT/CG unable to perform/administer wound care/injection due to: _____
- ☐ No able or willing CG available at this time to assist with:

NURSE NAME: _____ EMPLOYEE# _____

NURSE SIGNATURE: _____ RN/LPN

I certify that the date and time in/out represent actual time of visit

ARC Home Health, Inc.

SKILLED NURSING PROGRESS NOTE

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

DATE OF VISIT ____/____/____

TIME IN _____ AM ☐ PM ☐ - OUT _____ AM ❑ PM ❑

HOMEBOUND STATUS _____

MARK ALL APPLICABLE WITH AN X CIRCLE APPROPRIATE ITEM | MEDICARE ☐ MEDICAID ❑ MX OTHER ❑

TYPE OF VISIT ❑ SN ☐ SN SUP. ☐ SUP. ONLY Other. _____

T' _____ WT _____ BS _____
Resp. _____ Reg. ❑ Irreg. ❑
Pulse: A _____ R _____
❑Regular ☐ Irregular

B/P	LYING	Sitting	Standing
Right			
Left			

CARDIOVASCULAR
- Fluid retention
- Chest pain
- Neck vein distension
- Edema (specify) ❑RUE ❑LUE ❑RLE ❑LLE
- Ascites
- Peripheral Pulse
- Arrhythmia
- Other
- No Deficit

RESPIRATORY
- Rales/Rhonchi/Wheeze
- ❑ R. Lung: ❑ L. Lung:
- Cough/Sputum
- Dyspnea/SOB
- Orthopnea
- O2: LPM: VIA:
- No Deficit

DIGESTIVE
- Bowel sounds LBM:
- Nausea/Vomiting
- Anorexia./NPO
- Epigastric distress
- Difficulty swallowing
- Abdominal distention
- Colostomy/Ileostomy
- Bowel incontinence
- Constipation/Impaction/Diarrhea
- Diet:
- Appetite: ❑ good ❑ Fair

Fluid Intake
- Enteral Feeding Route:
- Type:
- Amount:
- Via:
- Flushing:
- No Deficit:

GENITOURINARY
- Burning/Dysuria
- Distention/Retention
- Frequency/Urgency/Hesitancy
- **Hematuria**
- Bladder incontinence
- Catheter/Ileoconduit
- Suprapubic Catheter ❑ External ❑
- Foley Catheter
- Size Fr cc
- Last changed:
- Irrigation cc/nss
- Urine
- Output: cc/ hr
- Color:
- Consistency:
- Odor:
- Pain/Discharge
- Cath Leakage/dislodgement
- Diabetic urine testing=ketone ☐
- Other:
- No Deficit

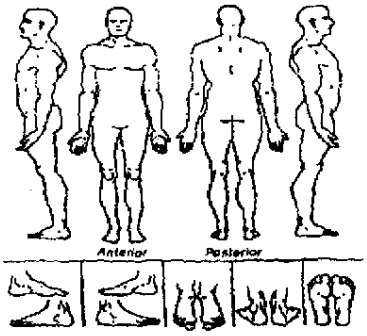
SKIN
- Warm/Dry
- Cold/Clammy
- Jaundice/Pallor/Cyanosis
- Integrity
- Chills
- Decubitus/Wound/Ulcer
- Rash/Itching/Discoloration
- Turgor/Hydration
- Tube Insertion Site
- Other
- Stage I☐ II❑ III❑

MUSCULOSKELETAL
- Balance/Unsteady gait/Endurance
- Weakness/Arnbulates With Assistance
- Limited Movement/Rom/Assist device
- Chair Bound ❑ Bed Bound
- Contracture ❑ Paralysis
- No Deficit

NEUROSENSORY
- Syncope/Vertigo
- Headache
- Grasp ☐ Equal ❑Unequal
- Right: _____
- Left: _____
- Movement ❑RUE ☐LUE ❑RLE ❑LLE
- **Pupil reaction Brisk**❑ Sluggish❑
- Right: _____ Left:
- Hand Tremors
- Poor Hand-Eye Coordination
- .Poor Manual Dexterity
- Speech impairment
- Hearing impairment
- Visual impairment/Blindness
- Tactile sensation/Ptosis ❑
- No Deficit

EMOTIONAL STATUS
- Oriented ❑T ❑P ☐P
- Forgetful/Confused
- Disoriented ❑T ❑P ❑P
- Lethargic
- Comatose
- Restless/Agitated
- Anxious/Depressed
- Other:

Denote Location / Size of Wounds / Measure Ext. Edema Bil.



	#1	#2	#3	#4
length				
Width				
Depth				
Drainage				
Tunneling				
Odor				
Surr Tissue				
Edema				
Stoma				

☐ Diet Teaching: _____
❑ **Safety Factors Management Conducted**
❑ **Teach Infant/Childcare**
❑ **Peg/GT Tube Site care**
❑ **Trachea care/Suctioning**

TECHNIQUES USED:
☐ **Universal Precautions Followed**
☐ **Aseptic Tech. Used**
☐ **Quality control of Glucometer performed** as per agency p & p
❑ Glucometer calib. On: _____
❑ **Soiled Dressings double bagged**
❑ **Sharps discarded inside Sharps container**
INFUSION/IV SITE: _____
☐ **IV Tubing Change**
☐ Cap Change
❑ Central Line Dressing Change
❑ IV Site Dressing Change
❑ IV Site Change
☐ Infusion by: _____
☐ Infusion Med: _____
☐ Infusion Rate: _____
Comments: _____
☐ **Infusion well tolerated by PT**

PAIN

Frequency of Pain interfering with patient's Activity or movement:
❑ 0- Patient has no Pain does not interfere with activity or movement
❑ 1- Less often then daily
❑ 2- Daily, but not constantly
☐ 3- All of the time
PAIN PROFILE- Origin Dull ☐ burning ☐
Primary Site. _____
Intensity 0 1 2 3 4 5 6 7 8 9 10

PAIN (Cont.)

Current: Pain management & effectiveness _____
☐Pain Management Teaching to patient/family *(document below)*
Patient pain goal: _____
Progress toward pain goal: _____
❑No Deficit

INTERVENTIONS / INSTRUCTIONS CONT.
❑Skilled Observation/Assesment
❑Foley Change ☐ Foley irrigation
❑ Wound care/Dressing Change
❑ Venipuncture/Lab: _____
❑ Prep./Admin. Insulin
❑ IM injection/Sq Injection
❑ Diabetic. Observation/Care
❑ Observation/Inst. Med (N or C) effects/Side effects: _____
❑ Inst. Safety Precaution/Emergency Prep
☐ Inst. Disease Process

SKILLED INTERVENTION / TEACHING / PT RESPONSE

❑ **Verification of Procedure Performed**
❑ **Verification of Medication Performed Prior to Admin.**

APROXIMATE NEXT VISIT DATE ____/____/____ PLAN FOR NEXT VISIT: _____

❑PT / S.O. / CG verbalized understanding of inst. given ☐ No S/O or CG able / willing for Inj. Adm. At this time ❑Tx. well Tolerated by PT
❑ PT / S. 0. / CG able to return correct demonstration of tech. /Procedure Inst. On ❑**No s/o or CG able / willing for Wound Care at this time**

☐ Patient unable do own W/C due to: _____

CARE PLAN: ☐reviewed / Revised with patient/ client Involvement ❑Outcome achieved ❑ PRN Order Obtained: _____
MEDICATION STATUS: ❑No Change ☐ Order Obtained: _____
DISCHARGE PLANNING DISCUSSED? yes ❑ No ❑ N/A ☐
SUPPLIES USED: _____
CARE COORDINATION: ☐Physician ❑PT ☐OT ☐ST ☐SS ❑SN ❑CM
❑Other

COMPLETE FOR SUPERVISORY VISIT CIRCLE Y/N 1-POOR 2- FAIR 3- GOOD

Supervisory visit	Y N	Patient social needs met	Y N
RN/LPN/AIDE Following care plan	Y N	Universal & safety prec. Followed	Y N
Patient physical needs rnet	Y N	Employee present	Y N
Patient environmental needs met	Y N	Patient satisfied with service	Y N
Assignment update	Y N	Rapport with patient / s.o.	1 2 3
Service change requested	Y N	Clinical / Technical skill	1 2 3
Patient mental needs met	Y N	Patient response to Care	1 2 3

PART 1- Clinical Record **PART 2- Employee**

PATIENT (CLIENT NAME (First, Middle Initial (Print))	SIGNATURE/DATE - Complete TIME OUT (above) prior to signing below. (circle title) RN/LPN Nurse *(signature/title)* Print Name	Medical Record #:

GENTLE HANDS HEALTH CARE SERVICES

CHECK TYPE OF VISIT: ☐ SCHEDULED ☐ UNSCHEDULED ☐ SUPERVISORY

NURSING PROGRESS NOTE

Joint Commission

PATIENT _____ MR# _____

BP L Sit_____ Stand _____ Lie _____ R Sit_____ Stand _____ Lie _____	TEMP OAR	Pulse Radial _____ Apical _____	Resp	Weight: Height:	Last MD visit:

MENTAL STATUS: ☐ Alert ☐ Oriented to: T P PL ☐ Forgetful ☐ Confused ☐ Able to follow commands ☐ Agitated ☐ Anxious
☐ Depressed ☐ Lethargic ☐ Responds to: Pain / Verbal Stimuli Comments: _____

CARDIO-CIRCULATORY: ☐ Reg / Irreg HR ☐ Palpitations ☐ Neck Vein Distenstion ☐ Pacemaker ☐ Chest Pain (See Comments Sec.)
RLE: ☐ Warm ☐ Cold ☐ Mottled ☐ Edema: Trace 1+ 2+ 3+ 4+ Pitting / Nonpitting Pulse: ☐ Strong ☐ Weak ☐ Absent
LLE: ☐ Warm ☐ Cold ☐ Mottled ☐ Edema: Trace 1+ 2+ 3+ 4+ Pitting/ Nonpitting Pulse: ☐ Strong ☐ Weak ☐ Absent
Capillary refill: _____ Sec ☐ Cyanosis _____ ☐ Claudication Comments: _____

RESPIRATORY: SOB: ☐ At rest ☐ Min. exertion (eating, talking) ☐ Mod. exertion (dressing, walkin ↓ 20 ft) ☐ When walk. ↑20 ft/stairs
Cough: ☐ Dry ☐ Productive Sputum Color: _____ Amount: _____ ☐ Hemoptysis ☐ Suctioning Required
Lung Sounds: Left: ☐ Clear ☐ Decreased ☐ Rales ☐ Rhonchi ☐ Wheezes ☐ Orthopnea _____ pillows ☐ Tracheostomy
Right: ☐ Clear ☐ Decreased ☐ Rales ☐ Rhonchi ☐ Wheezes
☐ O_2_____ l/m via _____ Frequency of use: ☐ Cont ☐ PRN (Describe when): _____
☐ SAN (med/freq.): _____ Effectiveness of 02/SAN Tx: _____

GI : Appetite: _____ Inadequate: ☐ Nutrition ☐ Hydration ☐ Cachexia ☐ Bleeding Gums ☐ Nausea ☐ Vomiting (Freq.)
Dentures: ☐ Partial ☐ Upper ☐ Lower ☐ Edentulous ☐ Dysphagia ☐ ABD Distention ☐ Girth: _____ cm
☐ Constipation ☐ Diarrhea ☐ Incontinence ☐ Rectal Bleeding ☐ GT Feedings _____ ☐ Pump ☐ Gravity
☐ Colostomy ☐ Ileostomy ☐ Bowel Sounds: _____ ☐ Diet: _____

GENITOURINARY: ☐ Frequency ☐ Urgency ☐ Burning ☐ Nocturia ☐ Dysuria ☐ Oliguria ☐ Incontinence ☐ Retention ☐ Anuria
☐ Vaginal Bleeding/Discharge ☐ Penile Discharge ☐ Indwelling Catheter (size) _____ ☐ Suprapubic Catheter (size) _____
Date last changed: _____ ☐ External Catheter ☐ Irrigation ☐ Sediment ☐ Hematuria ☐ Foul Odor ☐ Diapers used
Character of Urine: ☐ Clear ☐ Cloudy ☐ Color: _____ Comments: _____

ENDOCRINE: ☐ WNL ☐ Sweating ☐ Polyuria ☐ Polydipsia ☐ Heat/Cold Intolerance ☐ Sharps box at home ☐ Meter cleaned/calibrated
☐ Blood Glucose Meter BS Results: _____ Fasting/Ramdom/Venous/Fingerstick ☐ Done by: _____

SKIN: ☐ Intact ☐ Pale ☐ Jaundice ☐ Warm ☐ Hot ☐ Cool ☐ Dry ☐ Moist ☐ Pruritus ☐ Rash ☐ Blisters ☐ Bruises ☐ Erythema
☐ Lesions ☐ Incision ☐ Staples/Sutures Turgor: ☐ Good ☐ Fair ☐ Poor ☐ Wound ☐ Decubitus Ulcers ☐ (See Weekly Addendum)
☐ Other (describe):

NEURO: ☐ Headaches ☐ Tinnitus ☐ Seizures ☐ Tremor ☐ Numbness ☐ Tingling Area: _____ ☐ Paralysis: _____
☐ Sensory Loss: _____ ☐ Aphasia ☐ Impaired Vision ☐ Glasses ☐ Blind ☐ Lt. Eye ☐ Rt. Eye ☐ Impaired Hearing ☐ Rt. Ear ☐ Lt. Ear
☐ Aid ☐ Slurred/Garbled Speech Pupils: _____ Hand grips: _____ Other: _____

MUSCULOSKELETAL: ☐ Arthritis ☐ Pain ☐ Swelling ☐ Rigidity ☐ Contractures ☐ Amputation ☐ Fracture Location: _____
Motor Deficit: Decreased: ☐ ROM ☐ Strength: _____ ☐ Poor Balance/Coordination ☐ Gait:_____ ☐ Prosthesis ☐ Cast:_____
☐ Bedfast ☐ Able / ☐ Unable to turn ☐ Unable to transfer self: ☐ Can / ☐ Cannot bear weight/pivot during transfer process
Transfers with: ☐ Human assistance ☐ Assistive device ☐ Hoyer lift ☐ Chairfast/unable to ambulate ☐ Able / ☐ Unable to wheel self
Ambulates with: ☐ Supv/asst of another person at all times ☐ Device: Cane/Walker ☐ Requires human supv/asst to go ⇕ stairs/steps

PAIN: Intensity: (1-10 scale): _____ Location(s): _____ Radiating to: _____ Type: _____
☐ Does not interfere with activity/movement ☐ Less often than daily ☐ Daily but not constantly ☐ All of the time

HOMEBOUND STATUS _____

SKILLED CARE: ☐ Assemt/Obs ☐ Wound Care ☐ IV Therapy ☐ Catheter change ☐ Injection Administration ☐ Teaching/Instructions
Narrate procedures performed/instructions given/patient tolerance: _____

Instructions given to: ☐ Patient ☐ Caregiver Response to instructions: ☐ Verbalizes ☐ Demonstrates ☐ Needs further instructions
COMMUNICATION WITH: ☐ MD ☐ Case Manager ☐ Status report given New orders: ☐ Yes (see Mod. Orders) ☐ No
PLANS FOR DISCHARGE: Discussed with ☐ Patient ☐ MD ☐ SO ☐ Case Manager ☐ Other: _____

Nurse Name/Title (Print) _____ Nurse Signature _____ Date _____ Visit Time In _____ Time Out _____

GENTLE CARE Inc.

NURSE PROGRESS NOTE

Patient's Name (Last)	(First)	(M.I.)	(MR#)	Month	Day-	Year	Employee Number	Initials

B/P LYING	SITTING	STANDING				
(R)			T_____ O,Ax,R	Finger glucose time: _____	VISIT TIME: _____	____ RV-Regular Visit
(L)			AP _____ Reg/Irreg	Fasting: _____	AM: _____ PM: _____	____ EV- Emergency Visit
			R_____ Wgt_____	Random: _____		Due To: _____

MENTAL STATUS: ALERT, ORIENTED TO TIME/PERSON/PLACE, FORGETFUL, CONFUSED, SAD, ANXIOUS, AGITATED. HOSTILE, _____

EENT: BLURRED VISION, INFLAMMATION _____ DISCHARGE _____ PAIN _____ OTHER:_____

NEURO: H/A, DIZZINESS. TREMORS _____ WEAKNESS _____ NUMBNESS _____ TINGLING _____ OTHER:_____

RESPIRATORY: BS (CLEAR, DECREASED _____ WHEEZES _____ RALES _____ RHONCHI _____) COUGH (DRY, PROD), SPUTUM (SM, MOD, LG, WHITE, YELLOW. GREEN, BLOODY), 02, SAN, SOB, ORTHOPNEA x _____ PILLOWS, _____

CARDIAC: CHEST PAIN/PRESSURE (LAST EPISODE) _____ x _____ MIN., RADIATED TO _____ RELIEVED BY _____ PALPITATIONS, NO COMPLAINTS, _____

PERIPHERAL: CIRCULATION: EXTREMITIES (WARM, COOL. PINK, PALE, MOTTLED, CYANOTIC), CAPILLARY REFILL (GOOD, FAIR, POOR), NAILBEDS (PINK. PALE, CYANOTIC), EDEMA (NONE, TR, 1+, 2+. 3+. 4+): LOCATION _____ PULSES (UPPER, LOWER, R+L) _____

GI/ABD: APPETITE (GOOD, FAIR, POOR), NAUSEA, VOMITING, NG/GT, BOWEL SOUNDS (PRESENT, HYPOACTIVE, HYPERACTIVE. ABSENT). TENDERNESS, PAIN, OSTOMY _____ LBM _____ (INCONTINENT. SOFT, HARD, LOOSE, BROWN, BLACK. TARRY, BLOODY), CONSTIPATION. DIARRHEA,

GU: INCONTINENT, DIAPERS, FOLEY, URINE (CLEAR, DARK, SEDIMENT, CLOUDY, MUCOUS, ODOR, BLOODY), PAIN, RETENTION, ILEAL CONDUIT _____

I&O: INTAKE: _____ CUPSIDAY, OUTPUT _____ cc or _____VOIDS/24 HOURS, FOLLOWS DIET (YES, NO) _____

MUSCULOSKEL: COORDINATION _____ ROM _____ PAIN _____ LIMITED MOBILITY DUE TO _____

ACTIVITY: BEDBOUND, CHAIR, ASSIST TO TRANSFER. GAIT (SLOW, UNSTEADY, NEEDS ASSIST OF- WALKER, CANE. 1. 2 PERSON, WALLS & FURNITURE), WHEELCHAIR, HOYER LIFT, _____

SKIN: TURGOR (GOOD, FAIR, POOR), WARM, COOL, DRY, DIAPHORETIC, PINK, PALE, FLUSHED, ICTERIC, GRAY, CYANOTIC, ITCHING _____ RASH _____ BRUISES _____ PETECHIAE _____ WOUNDS (INCISION, ABRASION, ULCER) L_____ W_____ D_____ (cm). STERISTRIPS, SUTURES, STAPLES, DRAINAGE (SM. MOD, LG, SEROUS, SANGUINEOUS, PURULENT), LOCATION _____ SURROUNDING SKIN _____

PAIN: LOCATION _____ INTENSITY (SCALE OF 0-10) _____ RESPONSE TO INTERVENTION _____

ADDITIONAL INFORMATION: (SPECIFIC INFO, NEW PROBLEMS, ENVIRONMENTAL/SOCIAL/SAFETY FACTORS IDENTIFIED) _____

SKILLED NURSING: ASSESSMENT/OBSERVATION, REVIEWED CARE PLAN WITH PATIENT/CAREGIVER, DISCUSSED DISCHARGE PLAN

PROCEDURE*: LAB: _____ INJECTION _____ NG/GT #_____ Fr. INSERTED, FEEDING GIVEN. FOLEY: REMOVED, INSERTED #_____ Fr_____cc. (BALLOON INFLATED E_____ccNS, _____cc URINE RETURNED), IRRIGATED *with*_____ccNS DIGITAL RECTAL EXAM, MANUAL DISIMPACT FIU ENEMA, WOUND CARE, OSTOMY/ILEAL CONDUIT CARE. 02/SAN TREATMENT GIVEN,
• SPECIFY _____

INSTRUCTIONS: ☐ TOLERATED WELL, ☐ DIFFICULTY ENCOUNTERED _____
MEDICATION _____ DISEASE PROCESS /COMPLICATIONS _____ S/S OF _____ ILEAL CONDUIT/ OSTOMY / SKIN FOLEY/WOUND CARE. DIET, FLUIDS, NG/GT FEEDING, EQUIP USE/CARE (PUMP. 02. SAN), INJECTION /FINGERSTICK TECHNIQUE, SAFETY, ACTIVITY LIMITATIONS. EMERGENCY MANAGEMENT 911. UNIVERSAL PRECAUTIONS, BIOMEDICAL WASTE MANAGEMENT. PRINTED INFO GIVEN,
• SPECIFY _____

PATIENT/CAREGIVER: ☐ DEMONSTRATES UNDERSTANDING OF TEACHING. ☐ NEEDS FURTHER TEACHING, ☐ GOOD RETURN DEMO

TEAM CONFERENCE: _____

PHYSICIAN CONTACT: STATUS REPORT, UNSTABLE CONDITION, MOD ORDER- _____

DISCHARGE PLANNING: CONTINUE T0 VISIT FOR: OBSERVATION/ ASSESS, FOLEY/WOUND CARE, LABS, PREP/ADM INJECTION. INSTRUCTIONS_____
D/C EXPECTED IN _____ WEEKS, OR _____ VISITS LAST PHYSICIAN VISIT _____

NURSE NAME (Print):_____ SIGNATURE _____

Advanced Therapeutics Home Health, LLC.

Nursing Progress Report

Patient's name	Medical Record

BP L Sit_____Stand_____Lie_____ R Sit Stand Lie_____	Temp. OAR	Pulse Radial _____ Apical _____	Resp	Height: Weight:	Last MD Visit

MENTAL STATUS ☐ Alert ☐ Oriented to: T P PL ☐ Forgetful ☐ Confused ☐ Able to follow commands ☐ Agitated ☐ Anxious ☐ Depressed ☐ Lethargic
☐ Respond to: Pain/Verbal ☐ Stimuli Comments: _____

CARDIO CIRCULATORY ☐ Reg / Irreg HR ☐ Palpitations ☐ Neck Vein ☐ Distention ☐ Pacemaker ☐ Chest pain
RLE: ☐ Warm ☐ Cold ☐ Mottled ☐ Edema: Trace 1+ 2+ 3+ 4+ Pitting/Nonpitting Pulse: ☐ Strong ☐ Weak ☐ Absent
LLE: ☐ Warm ☐ Cold ☐ Mottled ☐ Edema: Trace 1+ 2+ 3+ 4+ Pitting/Nonpitting Pulse: ☐ Strong ☐ Weak ☐ Absent
☐ Capillary refill ____ Sec ☐ Cyanosis _____ ☐ Claudication Comments: _____

RESPIRATORY SOB ☐ At rest ☐ Min. exertion (eating, talking) ☐ Mod. exertion (dressing, walking 20 ft) ☐ When walk. 20 ft.stair
Cough ☐ Dry ☐ Productive sputum Color: _____ Amount: _____ ☐ Hemoptysis ☐ Suctioning required
Lung Sounds: Left: ☐ Clear ☐ Decreased ☐ Rales ☐ Rhonchi ☐ Wheezes ☐ Orthopnea ☐ Pillows _____ ☐ Tracheostomy
Right: ☐ Clear ☐ Decreased ☐ Rales ☐ Rhonchi ☐ Wheezes

GI Appetite _____ Inadequate: ☐ Nutrition ☐ Hydration ☐ Cachexia ☐ Bleeding gums ☐ Nausea ☐ Vomiting (freq)
Dentures: ☐ Partial ☐ Upper ☐ Lower ☐ Edentulos ☐ Dysphagia ☐ ABD Distention ☐ Girth: _____ cm ☐ Constipation ☐ Diarrhea
☐ Incontinence ☐ Rectal Bleeding ☐ GT feedings _____ ☐ Pump ☐ Gravity ☐ Colostomy ☐ Ileostomy
☐ Bowel sounds: _____ ☐ Diet: _____

GENITOURINARY ☐ Frequency ☐ Urgency ☐ Burning ☐ Nocturia ☐ Dysuria ☐ Oliguria ☐ Incontinence ☐ Retention ☐ Anuria
☐ Vaginal Bleeding / Discharge ☐ Penile Discharge ☐ Indwelling catheter (size) _____ ☐ Suprapubic catheter (size)
Date last changed _____ ☐ External catheter ☐ Irrigation ☐ Sediment ☐ Hematuria ☐ Foul odor ☐ Diapers used
Character of urine: ☐ Clear ☐ Cloudy ☐ Color: _____ ☐ Comments: _____

ENDOCRINE ☐ WNL ☐ Sweating ☐ Polyuria ☐ Polydipsia ☐ Heat/Cold intolerance ☐ Sharps box at home ☐ Meter cleaned/calibrated
BS Results: _____ ☐ Fasting / Ramdom / Venous / Fingerstick ☐ Done by: _____

NEURO ☐ Headaches ☐ Tinnutis ☐ Seizures ☐ Tremor ☐ Numbness ☐ Tingling Area: _____ ☐ Paralysis: _____
☐ Sensory loss: _____ ☐ Aphasia ☐ Impaired vision ☐ Glasses ☐ Blind ☐ Lt. eye ☐ Rt. eye ☐ Impaired hearing ☐ Rt. Ear ☐ Lt. Ear
☐ Aid ☐ Slurred / Garbled Speech Pulpis: _____ Hand grips: _____ Other: _____

MUSCOSKELETAL ☐ Arthritis ☐ Swelling ☐ Rigidity ☐ Contractures ☐ Amputation ☐ Fracture location: _____
Motor Deficit: Decreased: ☐ ROM ☐ Strength: _____ ☐ Poor Balance/Coordination ☐ Gait: _____ ☐ Prosthesis ☐ Cast: _____
☐ Bedfast ☐ Able / Unable to transfer self: ☐ Can / ☐ Cannot bear weight/pivot during transfer process
Transfer with: ☐ Human assistance ☐ Assistive device ☐ Hoyer lift ☐ Chairfast/unable to ambulate ☐ Able / ☐ Unable to wheel self
Ambulates with: ☐ Supv/asst of another person at all times ☐ Device: Cane / Walker ☐ Requires human assistance to go stairs/steps.

PAIN ☐ Absence of pain ☐ Complaint of pain Location: _____ Severity: 1 2 3 4 5 6 7 8 9 10
What makes pain worse? ☐ Movement ☐ Ambulation ☐ Increased pain with activity ☐ Others: _____
What makes pain better? ☐ Medication ☐ Heat/Ice ☐ Massage ☐ Rest/Relaxation ☐ Others: _____

HOMEBOUND STATUS
☐ Need assist. for all activity
☐ Residual weakness
☐ Non ambulatory
☐ Confusion
☐ Severe dyspnea
☐ Leaving home requires a considerable taxing effort
☐ Severe pain
☐ Other _____

SKIN
☐ Intact ☐ Dry ☐ Cold
☐ Warm ☐ Diaphoretic
☐ Color _____
☐ Tugor _____
☐ Wound ☐ Lesions
☐ Rash ☐ Incision
☐ Location _____

MEASURE (Every two weeks)

	#1	#2	#3	#4
Length				
Width				
Depth				
Drainage				
Tunneling				
Undermining				
Odor/Color/Consist				
Sur.Tissue				

HHA / LPN / SV
☐ Present
☐ Not present
☐ Following plan
☐ PT's needs met
☐ Universal prec. & safety followed
☐ PT / SO satisfied
Assigment updated SN
done by: _____

SKILL CARE ☐ Assessment and observation of all systems ☐ Monitor vital signs ☐ Wound care ☐ Ostomy care ☐ Tracheostomy care
☐ Administration: O2 ____ lpm ☐ Cont. ☐ PRN ☐ SAN Med _____
☐ Injection administration ☐ I M ☐ SC ☐ IV Medication: _____ Dosage: _____ Site: _____
☐ Lab specimen obtained ☐ Catheter type _____ Size _____ ☐ Insertion ☐ Irrigation ☐ Change _____
☐ Procedure: _____
☐ Procedure well tolerated ☐ Difficulty encountered ☐ Universal precautions ☐ Aseptic technique followed

TEACHING/INSTRUCTIONS Given to ☐ P T ☐ SO ☐ Medication side effects, safe ans effective use: _____
☐ Universal precautions ☐ Safety Measures ☐ Emergency prep. ☐ Waste disposal ☐ Disease ☐ Process ☐ Crisis intervention ☐ Pain management
☐ Wound care ☐ Skin care ☐ Insulin administration ☐ Use of glucometer ☐ Record own BP ☐ Diet ☐ Diabetic care ☐ S/S of infection ☐ Catheter management ☐ Safe and effective use of equipment
Other: _____

RESPONSE ☐ No SO ☐ Available ☐ Refuse ☐ Willing for ☐ Wound care ☐ Injection adm. ☐ Verbalize ☐ Demonstrates procedure ☐ P T ☐ SO unable to perform procedure due to ☐ Complexity of procedure ☐ Poor hand dexterity ☐ Contamination of supplies ☐ Location of wound ☐ Needs further teaching
LEARNING BARRIES ☐ None ☐ Emotional/Psychological ☐ Cognative deficit ☐ Seems disinterested ☐ Impaired thought process ☐ Impaired hearing
☐ Impaired vision ☐ Language barries **COMMUNICATION WITH** ☐ MD ☐ Case Manager ☐ Status given ☐ New orders **CASE PLAN CHANGES**
☐ Discussed with PT/SO ☐ Visit frequency changed **PLANS FOR D/C DISCUSSED** ☐ P T ☐ SO ☐ MD ☐ Case Manager

Nurse name	Signature	Title RN / LPN	Date

L • T • C
PROFESSIONAL CONSULTANTS, INC.

NURSE PROGRESS NOTE

Patient's Name (Last)	(First)	(M.I.)	Month	Day	Year	Employee Number	Initials

B/P LYING	SITTING	STANDING				
(R)			T_____ O,Ax,R	BS Level: _____ AM / PM	AIDE SUPERVISORY VISIT	____ RV-Regular Visit
(L)			AP _____ Reg/Irreg	Glucometer Cal:	_____ Plan discussed with patient	____ EV- Emergency Visit
			R_____ Wgt_____	Aseptic Tech:	Pt satisfied with care ___ Yes, ___ No	Due To: _____
				Sharp Cont.		

MENTAL STATUS: ALERT, ORIENTED TO TIME/PERSON/PLACE, FORGETFUL, CONFUSED, SAD, ANXIOUS, AGITATED. HOSTILE, _____

EENT: BLURRED VISION, INFLAMMATION _____ DISCHARGE _____ PAIN _____

NEURO: H/A, DIZZINESS. TREMORS _____ WEAKNESS _____ NUMBNESS _____ TINGLING _____

RESPIRATORY: BS (CLEAR, DECREASED _____ WHEEZES _____ RALES _____ RHONCHI _____) COUGH (DRY, PROD), SPUTUM (SM, MOD, LG, WHITE, YELLOW. GREEN, BLOODY), 02, SAN, SOB, ORTHOPNEA x _____ PILLOWS, _____

CARDIAC: CHEST PAIN/PRESSURE (LAST EPISODE _____ x _____ MIN., RADIATED TO _____ RELIEVED BY _____). PALPITATIONS, NO COMPLAINTS, _____

PERIPHERAL CIRCULATION: EXTREMITIES (WARM, COOL. PINK, PALE, MOTTLED, CYANOTIC), CAPILLARY REFILL (GOOD, FAIR, POOR), NAILBEDS (PINK. PALE, CYANOTIC), EDEMA (NONE, TR, 1+, 2+. 3+. 4+): LOCATION _____ PULSES (UPPER, LOWER, R+L) _____

GI/ABD: APPETITE (GOOD, FAIR, POOR), NAUSEA, VOMITING, NG/GT, BOWEL SOUNDS (PRESENT, HYPOACTIVE, HYPERACTIVE. ABSENT). TENDERNESS, PAIN, OSTOMY _____ LBM _____ (INCONTINENT. SOFT, HARD, LOOSE, BROWN, BLACK. TARRY, BLOODY), CONSTIPATION. DIARRHEA,

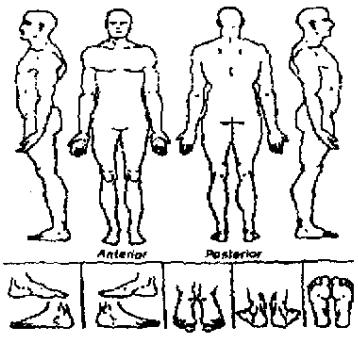
GU: INCONTINENT, DIAPERS, FOLEY, URINE (CLEAR, DARK, SEDIMENT, CLOUDY, MUCOUS, ODOR, BLOODY), PAIN, RETENTION, ILEAL CONDUIT _____

I&O: INTAKE: _____ CUPSIDAY, OUTPUT _____ cc or _____VOIDS/24 HOURS, FOLLOWS DIET (YES, NO) _____

MUSCULOSKELTAL: COORDINATION_____ ROM_____ PAIN_____ LIMITED MOBILITY DUE TO _____

ACTIVITY: BEDBOUND, CHAIR, ASSIST TO TRANSFER. GAIT (SLOW, UNSTEADY, NEEDS ASSIST OF- WALKER, CANE., 1-2 PERSON, WALLS, FURNITURE, WHEELCHAIR, HOYER LIFT _____

SKIN:
TURGOR (GOOD, FAIR, POOR), WARM, COOL, DRY, DIAPHORETIC, PINK, PALE, FLUSHED, ICTERIC, GRAY, CYANOTIC, ITCHING
RASH_____ BRUISES_____ PETECHIAE_____ WOUNDS (INCISION, ABRASION, ULCER) L_____W_____ D_____ (cm)
STERISTRIPS, SUTURES, STAPLES, DRAINAGE (SM. MOD, LG, SEROUS, SANGUINEOUS, PURULENT), LOCATION _____
SURROUNDING SKIN: _____ WOUND BED APPEARANCE: _____
WOUNDS (INCISION, ABRASION, ULCER) L _____W_____ D_____ (cm)
STERISTRIPS, SUTURES, STAPLES, DRAINAGE (SM. MOD, LG, SEROUS, SANGUINEOUS, PURULENT), LOCATION _____
SURROUNDING SKIN: _____ WOUND BED APPEARANCE: _____



PAIN: LOCATION _____ INTENSITY (SCALE OF 0-10)_____ RESPONSE TO INTERVENTION _____

ADDITIONAL INFORMATION: (SPECIFIC INFO, NEW PROBLEMS, ENVIRONMENTAL/SOCIAL/SAFETY FACTORS IDENTIFIED. TEAM CONFERENCES) _____

SKILLED NURSING: ASSESSMENT/OBSERVATION, REVIEWED CARE PLAN WITH PATIENT/CAREGIVER, DISCUSSED DISCHARGE PLAN

PROCEDURE: LABS _____ NG/GT #_____ Fr. INSERTED, FEEDING GIVEN.
FOLEY: REMOVED, INSERTED #_____ Fr_____cc. (BALLOON INFLATED E_____ccNS, _____cc URINE RETURNED), IRRIGATED with _____ccNS
DIGITAL RECTAL EXAM, MANUAL DISIMPACT FIU ENEMA, WOUND CARE, OSTOMY/ILEAL CONDUIT CARE. 02/SAN TREATMENT GIVEN,
INJECTION ROUTE:_____ SITE: _____ MED. GIVEN: _____ DOSE: _____ REACTION: _____
TEACHING :_____
SPECIFY: _____

☐ TOLERATED WELL, ☐ DIFFICULTY ENCOUNTERED _____

INSTRUCTIONS: MEDICATION _____ DISEASE PROCESS /COMPLICATIONS _____ S/S OF _____ ILEAL CONDUIT/ OSTOMY / SKIN FOLEY/WOUND CARE. DIET, FLUIDS, NG/GT FEEDING, EQUIP USE/CARE (PUMP. 02. SAN), INJECTION /FINGERSTICK TECHNIQUE, SAFETY, ACTIVITY LIMITATIONS. EMERGENCY MANAGEMENT 911. UNIVERSAL PRECAUTIONS, BIOMEDICAL WASTE MANAGEMENT. PRINTED INFO GIVEN,
• SPECIFY _____

PATIENT/CAREGIVER: ☐ DEMONSTRATES UNDERSTANDING OF TEACHING. ☐ NEEDS FURTHER TEACHING, ☐ GOOD RETURN DEMO

PHYSICIAN CONTACT: STATUS REPORT, UNSTABLE CONDITION, MOD ORDER- _____

DISCHARGE PLANNING: CONTINUE T0 VISIT FOR: OBSERVATION/ ASSESS, FOLEY/WOUND CARE, LABS, PREP/ADM INJECTION. INSTRUCTIONS_____
D/C EXPECTED IN _____ WEEKS, OR _____ VISITS LAST PHYSICIAN VISIT _____

SIGNATURE _____

PATIENT SIGNATURE: _____ PRINT NAME: _____