

SKILLED NURSING VISIT NOTE

SG	Patient's	Safety	Goal
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PT ID PERFORMED VIA NAME, DOE	3, AND ADDRESS BEFORE SERVICE PROVI	DED SG	SG Patient's Safety Goal		
PATIENT NAME - Last, First, Middle I	nitial	ID#	DATE OF VISIT		
			TYPE OF VISIT: SN Super.		
	ce for all activities 🛛 Requires assistance / device t		Super. Only Other		
-	Jnable to safely leave home unassisted Dyspnea		VITALS		
	brive device(s) 🗆 Acute episodes of hyper/hypoglycemia yi	eld unsafe ambulation 🗆 Unable to drive	TWtBS Resp □ Reg. □ Irregular		
Severe SOB, SOB upon exertion Other	(specify)		Pulse: A R		
MARK ALL APPLICABLE WITH AN X. CIRCLE A			🗆 Reg. 🔄 Irregular		
	GENITOURINARY	MUSCULOSKELETAL	B/P LYING SITTING STANDING RIGHT		
Fluid Retention Chest Pain	, <u>,</u>	Balance Unsteady gait Endurance Weakness Ambulates with Assistance			
Neck Vein Distension		Limited Movement 🛛 Rom	Denote Location / Size of Wounds /		
Edema (specify):		Chair Bound Bed Bound	Measure Ext. Edema Bil.		
Ascites		□ Contracture □ Paralysis No Deficit			
Peripheral Pulses	Suprapubic Catheter	NEUROSENSORY			
Arrhythmia		Syncope	$ \{3, 2, 5, 7\} $		
Other:		Headache	$(\Lambda I) = (\Lambda I) = (\Lambda I)$		
No deficit RESPIRATORY	Last Changed: Irrigation cc / nsa	Grasp Equal Unequal Right:			
Rales Ronchi Wheeze	Urine	Left:			
	Capat 007 111:	Movement			
	Color				
Dyspnea ISOB Orthopnea	Consistency Odor	RLE LLE Pupil Reaction	Anterior Posterior		
02. LPM: VIA:		☐ Right □ Left			
No deficit Fire Prevention followed SG	ů ů	Hand Tremors			
DIGESTIVE Bowel Sound:		Poor Hand-Eye coordination Poor Manual Dexterity	#1 #2 #3 #4		
Dowel Sourid.		Speech impairment	#1 #2 #5 #4		
Anorexia I NPO		Hearing Impairment	Width		
Epigastric Distress		Visual Impairment Blindness	Depth		
Difficulty Swallowing Abdominal Distention		Tactile Sensation No deficit	Drainage Tunneling		
	□ Rash □ Itching □ Discoloration	EMOTIONAL STATUS	Odor		
Bowel Incontinence	Decubitus Wound Ulcer	Oriented 🛛 T 🗬 P 🖓 P	Surr Tissue		
		Forgetful Confused	Edema		
Diet: Fluid Intake:		Disoriented ☐ T ☐ P ☐ P Lethargic ☐ Semi Lethargic	Stoma INTERVENTIONS / INSTRUCTIONS		
Enteral Feeding Route:		Comatose	Skilled Observation / Assessment		
Type: Amount.		Restless 🛛 Agitated	□ Foley Change □ Foley irrigation □ Wound Care □ Dressing Change		
Via:		Anxious Depressed	Prep. / Admin. Insulin:		
Flushing: Appetite: □Good □ Fair □ Poor	□ Sign/Symptoms of □ Polydipsia □ Polyphagia □ □ Sign/Symptoms of □ Hyperglycemia □ Hypoglycemia	Other	□ SQ Injection:Site:		
LBM: Deficit		No Deficit	Diabetic Observation / Care Observation / Inst Med. (N or C)		
		SG	effects / Side Effects		
Frequency of pain interfering with patients a	ctivity or movement: Current pain manager	ment & effectiveness: 🗆 No deficit / Pain	□ Inst. Fall Prevention □ Emergency Prepar. SG		
□ 1- Pain does not interfere with activity or movement	nress toward pain coal:	atient's pain goal:	Inst. Disease Process Diet. Teaching		
	imary Site(s):		Safety Precautions/Factors Management Conducted Teach Infant / Childcare		
4 - All of the time		all assessment conducted Yes 🗌 NA	Peg / GT Tube Site Care		
Pain Management Teaching to patient / family	Potential for falls: 012345678910	Potential for falls has:	Tracheostomy Care Suctioning TECHNIQUES USED		
(*) (*) (*) (*) (*)		Increased decreased	Universal Precautions/ Handwashing Tech. followed		
Intensity 0 1 2 3 4 5 6 7 8 9 10 Low High	Compliant with fall prevention plan: Yes	No 🔲 N/A	Aseptic Tech.used / Infection Control followed SC Quality Control of Glucometer Performed		
	ENTION - TEACHING -		as per Agency P & P on:		
			Glucometer Calib. on: Soiled Dressings Double Bagged		
			Sharps Discarded Inside Sharps Container		
			INFUSION / IV SITE:		
			Cap Change Venipuncture/Lab:		
			Central Line Dressing Change IV Site Dressing Change		
			□ IV Site Change □ Infusion by Pump		
		inar 🗆 Othari	□ Infusion Med:		
	BP cuff Glucometer Alcohol pads 4x4 Sharp contai		Comments:		
PLAN FOR NEXT VISIT:			Infusion Well Tol. by Pt.		
	S.O. / CG verbalized understanding of inst. given		□ Patient unable to perform own W/C due to:		
	ation of Tech. / procedure Inst. on DISCHARGE PLA				
□ No S.O. or C/G able / willing for Inj. Adm. a	t this time D Treatment well tolerated by Patient at this time. D Verification of Procedure Performed		TE OTE STE MSWE SNE CMEHHAE		
CARE PLAN: Reviewed / Revised with patient		□ Other:			
PRN Order Obtained:		NURSE SIGNATURE / PRINT NAME	RN/LPN DATE		
Verification of Medication Performed					
MEDICATION STATUS IN No Change IC	Jiver Obtained:	 Signature / Date -Complete TIME OUT (above) pr			



SKILLED NURSING VISIT NOTE

PATIENT NAME - Last, First, Middle Initial		MR#	DATE OF VISIT	-	
				AM PM OUT	
HOMEBOUND REASON: Contusion und	ce for all activities □ Requires assistan ble to go of home alone □ Unable to safely lo	nce to ambulate	TYPE OF VISIT:		N & Super.
□ Severe SOB, St □ Other (specify)	OB upon exertion Dependent upon	adaptive device(s) Medical restrictions		Super. Only 🗆 Of	
□ Other (specify)	· _ · · ·			VITALS	
			TW	tBS	
MARK ALL APPLICABLE WITH AN X. CIRCLE A			Resp. Pulse: A	Reg.	🗆 Irregular
CARDIOVASCULAR	GENITOURINARY	MUSCULOSKELETAL	Puise: A		gular
Fluid Retention Chest Pain	Burning / Dysuria Distension / Retention	Balance / Unsteady gait / Endurance Weakness / Ambulates with Assistance	-	·9·	guiui
Neck Vein Distension	Frequency / Urgency / Hesitancy	Limited Movement / Rom	B/P L)		STANDING
Edema (specify):	Hematuria	🗆 Chair Bound 🛛 🗆 Bed Bound	RIGHT		
	Bladder Incontinence	Contracture Daralysis			
Ascites Peripheral Pulses	Catheter / Ileoconduit Suprapubic Catheter	No Deficit	LEFT		
Arrhythmia	Foley Catheter	Syncope		TIONS / INSTRU	CTIONS
Other:	Size Fr. cc.	Headache		ation / Assessment □ Foley irrigation	
No deficit RESPIRATORY	Last Changed: Irrigation cc / nsa	Grasp 🗆 Equal 🗆 Unequal	□ Wound Care /		
Rales / Ronchi / Wheeze	Urine	Right: Left:	Prep. / Admin.	• •	
🗆 R. Lung 🗆 L. Lung	Output cc / hr.	Movement	Im Injection / S	Q Injection	
Cough / Sputum Dyspnea / SOB	Color Consistency		Diabetic Obser		
Orthopnea	Odor	Pupil Reaction	□ Observation / In	nst Med (N or C)	
02. LPM: VIA:	Pain / Discharge	Right Left	effects / Side E	ffects	
	Cath. Leakage / Dislodge	Hand Tremors Poor Hand-Eye coordination		ecaution / Emergency	
DIGESTIVE Bowel Sound	Other	Poor Manual Dexterity		Process	
Nausea / Vomiting		Speech impairment	🗆 🗆 Diet. Teaching		
Anorexia / NPO	No Deficit	Hearing Impairment	□ Safety Factors	Management Condu	icted
Epigastric Distress Difficulty Swallowing	SKIN Warm / Dry	Visual Impairment / Blindness Tactile Sensation	- 🗆 Peg / GT Tube	Site Care	
Abdominal Distention	Cold / Clammy	No deficit	🚽 🗆 Trache. Care /	Suctioning	
Colostomy / Ileostomy	Jaundice / Pallor / Cyanosis	EMOTIONAL STATUS	TECHNIQUES L	USED	
Bowel Incontinence Constipation / Impaction / Diarrhea	Integrity Chills	Oriented DT DP DP Forgetful / Confused	Universal Prec		
Appetite:	Decubitus / Wound / Ulcer	Disoriented T P P	🚽 🗆 Aseptic Tech. U		
Fluid Intake:	Rash / Itching / Discoloration	Lethargic / Semi Lethargic	Quality Control	of Glucometer Perfo	ormed
Enteral Feeding Route: Type:	Turgor / Hydration Tube Insertion Site	Comatose Restless /Agitated			
Amount:	Other	Anxious / Depressed	_ □ Glucometer Ca		
Via:		Other		gs Double Bagged	
Flushing: No Deficit	No Deficit	No Deficit	📙 🗆 Sharps Discard	ded Inside Sharps C	Container
	PAIN				
Frequency of pain interfering with patients	PAIN PROFILE	Current pain management & effectiveness	7		
Activity or movement □ 0 - Patient has no pain or pain does not	Primary Site	Pain Management Teaching to			
interfere with activity or movement	Intensity 012345678910	patient / famīly (document below) Patient s pain goal:			
 1 - Less often than daily 2 - Daily, but not constantly 	Low High	Progress toward pain goal:			
\square 3 - All of the time	0				
	ERVENTION - TEACHING - PT	No deficit			
SKIELED INTE	ERVENTION - TEACHING - FT	RESPONSE			
D 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.	Patient unable t	to perform own W/C o	lue
PT / S.O. / CG able to return correct demonstration	ation of Tech. / procedure Inst. on 🛛 🗆 No S/O or C	C/G able / willing for wound care at this time.	to	•	
CARE PLAN: CREViewed / Revised with patient .		CARE COORDINATION: Physician 🗆 🛛	PT D OT D ST	SS SN SN SN	CM□
MEDICATION STATUS No Change Or Or Observed Status No Change Or Observed Status Of the observed Status No Change Discussion No	rder Obtained:	□ Other:			
DISCHARGE PLANNING DISCUSSED? Yes □ SUPPLIES USED:	No 🗆 N/A 🗆	PRINT NAME	RN / LF	PN	DATE
NURSE'S SIGNATURE					
		Signature / Date - Complete TIME OUT (abov	(e) prior to signing below	v (circle title)	/ /



-Class Home Assist of 1-2 pu	ID STATUS: ersons Painful Ambulation	Bedbound/Chairbound	killed Nursing Progress	
 Health, Inc. Taxing effort to lead SOB upon amb Unsteady C 	we home Compromised Disease Status	Mobility/Ambulatory device used Angina/Dyspnea on Min.Exertion TIM	DAT 1E INAM 🗆 PM 🗆	e of visit/ outAM □ F
MARK ALL APPLICABLE WITH AN X		MEDICARE D MEDICAID D MX	OTHER D TYPE OF V	ISIT 🗖 SN 🗆 SN SUP.
CARDIOVASCULAR	GENITOURINARY	MUSCULOSKELI	ETAL SUP. ONLY	Other
Fluid retention	Burning/Dysuria	Balance/Unsteady gait/E	ndurance T' W	TBS
Chest pain	Distention/Retention	Weakness/Ambulates Wit	th Assistance Resp.	Reg. 🔲 Inreg. 🗋
Neck vein distension	Frequency/Urgency/Hesitancy	Limited Movement/Rom/2		RR
Edema (specify)	Hematuria Bladder incontinence	Chair Bound 🖵 Bed Bo	una	Ū
Ascites	Catheter/Ileoconduit	Contracture D Paralysi No Deficit	s B/P LYING Right	Sitting Standing
Peripheral Pulse	Suprapubic Catheter External		9	
Aπhythmia	Foley Catheter	Syncope/Vertigo		ation / Size of Wounds /
Other	Size Fr cc	Headache	Measu	ıre Ext. Edema Bil.
No Deficit	Last changed:	Grasp 🗆 Equal 🖵 Unequ		0 6
RESPIRATORY	Irrigation cc/nss	Right:		
Rales/Rhonchi/Wheeze	Urine Output: cc/	hr Movement		111111111
Cough/Sputum	Output: cc/	m wovement	$_{\rm E}$ DLLE $\left(\frac{1}{2}\right) \left(\frac{1}{2}\right)$	
Dyspnea/SOB	Consistency:	Pupil reaction Brisk		$M \rightarrow M (M)$
Orthopnea	Odor:	Right: Left:		1201 1 121 3
O2: LPM: VIA:	Pain/Discharge	Hand Tremors	\{`_\	4 NIN 11
No Deficit	Cath Leakage/dislodgement	Poor Hand-Eye Coordin	ation 1 1	()() () ()
DIGESTIVE	Diabetic urine testing=ketone	.Poor Manual Dexterity		
Bowel sounds LBM:	Other:	Speech impairment		tor Posterior
Nausea/Vomiting	NTo The Florit	Hearing impairment		
Anorexia./NPO Epigastric distress	No Deficit	Visual impairment/Blind Tactile sensation/Ptosis		~1)#(1)m(104)
Difficulty swallowing	Warm/Dry	No Deficit	لكالك السل	21440000000
Abdominal distention	Cold/Clammy	EMOTIONAL STAT	TUS #1	#2 #3 #4
Colostomy/Ileostomy	Jaundice/Pallor/Cyanosis	Oriented DT P P	length	
Bowel incontinence	Integrity	Forgetful/Confused	Width	
Constipation/Impaction/Diarrhea	Chills	Disoriented 🗖 T 🗖 P 🗖 P	Depth	
Diet:	Decubitus/Wound/Ulcer	Lethargic	Drainage	
Appetite: good Fair	Rash/Itching/Discoloration	Comatose Restless/Agitated	Tunneling Odor	
Fluid Intake Enteral Feeding Route:	Turgor/Hydration Tube Insertion Site	Anxious/Depressed	→ Surr Tissue	
Type:	Other	Other:	Edema	
Amount:		HQ Conner.	Stoma	
Via:			Diet Teaching:	
Flushing:			□ Safety Factors	s Management Conducted
No Deficit:	No Deficit	No Deficit	Teach Infant	t/Childcare
equency of Pain interfering with patient's ctivity 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 AIN PROFILE-Origin Dull burning	Current: Pain management & effecti Pain Management Teaching to patient/family (document below) Patient pain goal: Progress toward pain goal: DNo Deficit	veness Skilled Observation Foley Change Fol Wound care/Dressi Venipuncture/Lab: Prep./Admin.Insuli Diabetic. Observation Observation/Inst. Mu effects/Side effects: Inst. Safety Precaution	ley irrigation TECHNIQUES ing Change Universal Prec Aseptic Tech. Aseptic Tech. n Quality contro as per agency Glucometer ca od (N or C) Solled Dressi Sharps discard	S USED: autions Followed Used ol of Glucometer performed 'p & p lib. On: ligs double bagged led inside Sharps container
intensity 0 1 2 3 4 5 6 7 8 9 10	LINO Dericit	□ Inst. Disease Proce		
-	NTERVENTION / TEACHING / P		Cap Change	•
SKILLED I				Dressing Change
			UV Site Dress	sing Change
			IV Site Char	
			□ Infusion by:	
			Infusion Med:	
			Comments:	
			=	
				tolerated by PT
				· <i>y</i> = -
PROXIMATE NEXT VISIT DATE	// PLAN FOR NEX	T VISIT: 🗖 SKILLED ASSESSMENT	🗖 INSULIN ADMIN./PREP. 🗖 W/C	
PT / S.O. / CG verbalized understanding	of instativen 🗆 No S/O or CG able /	illing for Ini Adm Atthiatime	well Tolerated by DT	unable de sume mit/cut-s das de
PT / S. O. / CG verbalized understanding PT / S. O. / CG able to return correct dem				unable do own W/C/Inj. Adm. du
RE PLAN: reviewed / Revised with patient/		- D N		
der Obtained:		COMPLETE FOR SUPE	RVISORY VISIT CIRCLE Y/N	
DICATION STATUS: No Change Order	Obtained:	Supervisory visit	Y N Patient social nee	
SCHARGE PLANNING DISCUSSED? ye PPLIES USED: □GLOVES □ALCOHOL P.		RN/LPN/AIDE Following		
SALINE SOL. \Box KERLIX \Box DSD \Box T:		Patient physical needs rhet	Y N Employee presen	
RE COORDINATION: Physician PT		Patient environmental need		
Other		Assignment update	Y N Rapport with pati	
		Service change requested	Y N Clinical / Technic	
		Patient mental needs met	Y N Patient response t	to Care 123
ATIENT (CLIENT NAME (First, Mide	me initial (Print)) SIGNATURE/D	ATE - Complete TIME OUT (above) prior t	Modical P	ecord #:
			RN/LPN Medical K	coutum.
	Nu	rse (signature/title) Print Name		



HOME HEALTH CARE SKILLED NURSING PROGRESS NOTE

DATE OF VISIT	 /	1
AM	РМ 🗌	

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:

MA	RK ALL APPLICABLE WITH AN X CIRC	cle a			MED	ICA	RE MEDICAID MX OTHER		OF VISIT			JP.
	CARDIOVASCULAR		GE	NITOURINARY			MUSCULOSKELETAL		SUP. ONI			Π
	Fluid retention:			Dysuria:			Balance 🔲 Unsteady gait 🗌 Endurance 🗌	BSL by Gl	ucometer	F	BS F	RBS
	Chest pain:			n 🔲 Retention:			Weakness Ambulates With Assistance	Resp.	Reg	, ·	rreg.	
┝┝╡	Neck vein distension: Edema (specify)	⊢⊢	Frequenc	y 🗌 Urgency 🗌 Hes	sitancy:		Limited Mvmt ROM Assist device Chair Bound Bed Bound		gular [
	RUE LUE RLE LLE	H		ncontinence:		╡┼	Contracture Paralysis	B/P	Lying	Sittin		anding
	Ascites:		Catheter:		Ē		No Deficit	Right	-,8	Dittill	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Peripheral Pulse:			ic Catheter 🔲 Exter	mal 🗌		NEUROSENSORY	Left				
┝┝┩	Arrhythmia:		Foley Ca				Syncope Vertigo:	_	te Locatio			s /
┝┝╡	Other: No Deficit		Size: Last char	Fr ged:		╡┼	Headache: Grasp: Equal: Unequal		Measure E	xt. Edema	і ВП. ¬	<i>c</i> >
	RESPIRATORY		Irrigation	*			Right:	<i>€</i> ,?		J.	}	<u>{</u> }
	Rales Rhonci Wheeze:		Urine:				Left:		\sim	S.	: ``	1
	R.Lung:		Output:				Weakness:	1138			61	$\left\{ \right\}$
┝┝╣	Cough Sputum: SOB:		Color: Consister			┥┼	RUE LUE RLE LLE PERRLA: yes No	- እለ	7 A	12_		ለነረ
	Orthopnea:		Odor:	cy.			Right: Left:		ATR	\$4) I		13
	O2: LMP: VIA:		Dysuria	Discharge:			Hand Tremors: Apraxia	1 \{"	'MM'	- Υ.	1.	<i>}</i> ∮
	No Deficit		Cath Lea	kage Dislodgemen	t:		Poor Hand-Eye Coordination:		00	- ()	()	(}
	GASTROINTESTINAL Bowel Sounds		Other:				Poor Manual Dexterity: Speech impairment: Aphasia:	- <u>)</u>	- WH	}	Ц.	
┝╞╡	Abdominal Distention:		ouner.				Hearing Impairment:	-	Anterior	Pos	erior	
	Colostomy 🗌 Ileostomy:		No Defic			5†	Visual impairment Blindness:	N.S.	الريب	1. 11 /		(ATRA
	Bowel Incontinence LBM:			SKIN			Tactile sensation] ⁽)入	A.	1/81	-444 h	111
┝┝┩	Constipation Impaction Diarrhea Nausea Vomiting	⊢⊢		Cold Dry: Clammy:			No Deficit	لكسقطه		1 4252		100
⊢⊢	Heartburn (food Intolerance)	⊢⊢		PallorCyanosis	s:		Oriented: Time Place Person	Length	#1	#2	#3	#4
	NPO		Integrity:				Disoriented: Time Place Person	Width				
	Difficulty Swallowing		Chills:				Forgetful Confused:	Depth				
\square	Diet:	┝┝┥		tching Discolorati			Lethargic: Comatose:	Drainage				
⊢⊢	Appetite: Good Fair Poor Fluid Intake:	\square		Hydration: ertion Site:			Anxious Agitated. Depressed: Recent Long Term	Tunneling Odor				
⊢⊢	Enteral Feeding Route:			s 🗌 Wounds 🔲 Ulce		-	Treatment	Surr Tissue	-			
	Type:		Stage:					Edema				+
	Amount:		Other:				Sleep/Rest: adequate inadequate	Stoma				
	Via:						Treatment:	Diet Te				
	Flushing:					2		Safety F		iagement (onducted	1
	No Deficit:		No Defic				No Deficit: NTERVENTIONS/ INSTRUCTIONS	Emerge	ency Plan			
PAI Free	uency of Pain interfering with patient's		PAIN (Con Current: Pa	t.) in management & ef:	fectiveness		Skilled Observation Assessment	Peg GT Tut	e Site Car	e		
Act	vity of movements:					ΝĒ	Prep. Admin. Insulin	Trachea	i Care 🔄 S	uctioning		
	Patient has no Pain or Pain does not interfere with a stimity or parameter	:		anagement Teaching /family <i>(document be</i>			Wound Care Dressing Change Venipuncture Lab:	TECHNIQ				
	with activity or movement I - Less often than daily			a goal:	erow)	∣⊦⊧	Foley Change 🗌 Foley Irrigation	Aseptic			wea	
	2- Daily, but not constantly					Ī	IM injection SubQ Injection	Quality			er perfoi	med
	3- All of the time		Progress to	ward pain goal:	_	ļĻ	Diabetic. Observation Care		agency p &			
Drin	N PROFILE -Origin Dull 🗌 Burning 🗌 nary Site:		No De	iicit		ŀF	Medications Compliance Evaluated Observation Inst. Med (N or C)		neter calib. Dressing d			
Int	ensity 0 1 2 3 4 5 6 7 8 9 10					Ē	Effects Side effects:	🔲 Sharps	discarded			ainer
							<u></u>	INFUS	ION 🗌 IV	SITE:		_
	SKI	LLED	INTERVE	NTION / TEACHIN	G / PT RES	PO	NSE	IV Tub		е		
								Cap C				
								Centr	ai Line D	ressing (_nange	
<u> </u>								$ $ \square IV SI	te Change	is chall S		
								Infusi				
								Comment				_
								Infusi	on well to	lerated l	y PT	
PLA	N FOR NEXT VISIT:											
	PT / SO. / CG verbalized understanding of	inst. G	iven 🗖	PT / S.O. / CG able	to return corr	ect (demonstration of tech. / Procedures	D Patient	unable nerf	orm ini/wa	ound care	due to:
	No s/s of CG able / willing to Wound Care.	/Ini. at	this time [] Tx. Well Tolerate	ed by PT 🔲	PT	/ S.O. / CG Requires further instructions		anao 1 0 p e 11	o		
	EPLAN: Reviewed Revised with PT						Client is at risk for falls yes no	Fall asse	ssment co	nducted	Yes	N/A
Ord	er Obtained:	_					Potential for falls: 0 1 2 3 4 5 6 7 8	9 10 Pote	ntial for f	alls has:		
	DICATION STATUS: 🗌 No Change 🗌 O								ased 🗌 d	ecreased		
	CHARGED PLANNING DISCUSED? YE	s 🔲 ī	10 🗌 N/A				Intervention for this visit:					
	PLIES USED:		┯┌┓ _╝ ┯┍				4					
	RE COORDINATION: Physician P1 Other		т П рт Г				Client/C.G. response Compliant with	fall nrevent	ion ntan F	-		
\vdash	j tatvi						Verbalizes understanding of instructions	-	s understar		struction	
	PARTI-	Clinic	al Record					- Employee				
PA	IIENT (CLIENT NAME First, Middle Initi			SIGNATURE/DAT	TE - Complet	e D/	ATE (above) prior to signing below. (circle title)	Medical R	ecord #:			
				l								
					Nurse (cioro	ture	/title) Print Name					
L					remse (alaua	iure.	/ uu () 1 1111 1 10110					

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.
HOMEBOUND REASON: Deeds assist:		🛛 Requires assista		
🗆 Contusion, ur	nable to go of home alo	ne 🔲 Unable to safely l	eave home unassisted	VITALS
□ Severe SOB,	SOB upon exertion	🗆 Dependentupon	adaptive device(s) 🛛 🗆 Medical restri	
🗆 Other (specify	/)			Resp Reg. 🗆 Irregular
MARK ALL APPLICABLE WITH AN X. CIRCLE				Pulse: A R
CARDIOVASCULAR				
Fluid Retention	Burning / Dysuria		Balance / Unsteady gait / Endurance	
Chest Pain	Distension / Rete		Weakness / Ambulates with Assistant	
Neck Vein Distension	Frequency / Urge	ncy / Hesitancy	Limited Movement / Rom	Denote Location / Size of Wounds /
Edema (specify):	Hematuria		Chair Bound Bed Bound	Measure Ext. Edema Bil.
	Bladder Incontine		Contracture Paralysis	
Ascites	Catheter / Ileocor		No Deficit NEUROSENSORY	
Peripheral Pulses Arrhythmia	Suprapubic Cath Foley Catheter	leter	Syncope	(i)
Other:	·	Fr. cc.	Headache	
No deficit	Last Changed:		Grasp 🗆 Equal 🗌 Unequal	
RESPIRATORY	Irrigation	cc / nsa	Right:	
Rales / Ronchi / Wheeze	Urine		Left:	
R.Lung L.Lung	Output	cc / hr.	Movement	
Cough / Sputum	Color			
Dyspnea / SOB Orthopnea	Consistency Odor		Pupil Reaction	Anterior Posterior
02. LPM: VIA:	Pain / Discharge		Right Left	and an and an and an
No deficit	Cath. Leakage / [Dislodge	Hand Tremor	
DIGESTIVE	Other		Poor Hand-Eye coordination	
Bowel Sound / LBM			Poor Manual Dexterity	#1 #2 #3 #4
Nausea / Vomiting Anorexia / NPO	No Deficit		Speech impairment Hearing Impairment	length Width
Epigastric Distress		KIN	Visual Impairment / Blindness	Depth
Difficulty Swallowing	Warm / Dry		Tagtile Sensation	Drainage
Abdominal Distention	Cold / Clammy		No deficit	Tunneling
Colostomy / Ileostomy	Jaundice / Pallor	/ Cyanosis	EMOTIONAL STATUS	Odor
Bowel Incontinence Constipation / Impaction / Diarrhea	Integrity Chills	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	Oriented	Surr Tissue Edema
			r orgenui / contuseu	Edellia
	Decubitus / Wour	nd / Ulcer	Disoriented T P P	Stoma
Diet: Appetite: Fluid Intake:	Decubitus / Wour Rash / Itching / Di		Disoriented 🗆 T 🔅 P 🔅 P Lethargic / Semi Lethargic	Stoma INTERVENTIONS / INSTRUCTIONS
Diet: Appetite:	Rash / Itching / Di Turgor / Hydratio	iscoloration on	Lethargic / Semi Lethargic Comatose	INTERVENTIONS / INSTRUCTIONS
Diet: Appetite: Fluid Intake: Enteral Feeding Route: Type:	Rash / Itching / Di Turgor / Hydratio Tube Insertion S	iscoloration on	Lethargic / Semi Lethargic Comatose Restless /Agitated	INTERVENTIONS / INSTRUCTIONS Skilled Observation / Assessment Goley Change Goley irrigation
Diet: Appetite: Fluid Intake: Enteral Feeding Route: Type: Amount:	Rash / Itching / Di Turgor / Hydratio	iscoloration on	Lethargic / Semi Lethargic Comatose Restless /Agitated Anxious / Depressed	INTERVENTIONS / INSTRUCTIONS Skilled Observation / Assessment Foley Change Foley irrigation Wound Care / Dressing Change Venipuncture / Lab:
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Diet: Appetite: Fluid Intake: Enteral Feeding Route: Type: Amount:	Rash / Itching / Di Turgor / Hydratio Tube Insertion S	iscoloration on	Lethargic / Semi Lethargic Comatose Restless /Agitated Anxious / Depressed	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
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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:_____ DATE:_____ DATE:_____

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

OTHE						
CARDIOVASCULAR	PULMONARY	INTEGUMENTARY	MUSCULOSKELETAL		-	ND ASSESS.
Chest Pain	Lungs	UWarm Dry Cool Chills	Poor balance	Т	нт	WT
□Edema	□SOB □Dyspnea	🗌 Intact	☐ Limited Movement	RESP		i □IRR
Abnormal Rhythmn	Cough	Wound Ulcer Incision	□Chair □Bed Bound	PULSE	A R	\Box REG \Box IRR
Pulses	□Sputum	🗆 Rash 🛛 Itching	☐ Walks with	B/P	LYING	SIT/STAND
Anticoagulant Therapy	Oxygen	Turgor	□Contracture □Paralysis	RIGHT		
	Dother			LEFT		
NO DEFICIT					-	via glucomter
GASTROINTESTINAL	GENITOURINARY	NEUROLOGICAL	MENTAL	l	on / Size of Wounds	
Bowel Sounds x	🗌 Burning 🔲 Dysuria 🗌 Odor	Headache	ORIENTED Person Place	Me	asure Ext. Edema	ВП.
🗆 Abdomen 🗖 Soft 🔲 Tender	Distention 🗌 Retention	☐ Syncope □ Vertigo	☐ Forgetful ☐ Confused	ର	\odot	
Distended	🗌 Frequency 🔲 Urgency	Grasp Strong Weak	Disoriented	1 236		763
Nausea Vomiting NPO	Incontinence Hesitancy	Movement	☐ Lethargic ☐Comatose	{		41){]
Diarrhea Constipation	Hesitancy Itching	Pupils 🗌 R 🔄 L	Restless Agitated		x 11/1 -	F 18584 - 1
		Hand tremors	Anxious Depressed	~{{~~		
	Catheter	Aphasia Dysphagia	Altered LOC	\ } -	(10)	() ([
		Speech Impairment	Nervous	<u>ال</u> ے	<u> </u>	16 65
			Impaired Memory		Anterior Pos	arior
Feeding	Last Changed	Hearing Impairment	Psych HX	221	RC12H1	1311/11
IFlushing	Irrigation	Visual Impairment				
				1	1 2	3 4
	NO DEFICIT		INFUSION/IV SITE	Length Width		
	Skilled Assessment	Universal Precaution	IV tubing changed	Depth		
□No pain □Less often than daily		Aseptic Technique	Cap change	Drainage		
Daily but not constant		Proper Sharps Disp.	Catheter Site Care	Tunneling Odor		
\square All of the time	Prep/Admin Insulin	Proper Waste Disp.	IV site change	Sur. Tissue		
Pain level (1-10)	IM SQ Injection	QC of glucometer	Med	Edema Stoma		
	PEG/GT Site Care	Glucomter Calib. On			CHANGE:	
Relieved with Med Y N		Other				
	SKILLED INTERVENT			SUPERVIS	ORY VISIT (CIRCLE Y/N)
				Supervisor	y Visit LPN/H	HA 🗌 Y 🗌 N
				Patient Ne		
				<u> </u>	•	
					-	wed Y N
				Employee		
				Patient Sati	sfied with Serv	ice 🛛 Y 🗌 N
NEXT VISIT DATE:		MD NEXT VISIT:		Comments	5:	
PT/CG verbalized underst	anding of instructions given			ABNORMA	AL FINDING	SICHANGES
	te correct Technique/Proced			☐ MD notified	I-Name:	
	minister 🗌 woundcare 🔲 inj			New Order	:	
CG unable to perform/adr	minister 🗆 woundcare 🗌 inj	ection due to:		New Order:		
No able or Willing CG ava	ilable at this time to assist wi	th:			Planning Discu	
Treatment/injection tolerat	ted well by patient			Case Man	ager Informed	
NURSE NAME: EMPLOYEE#		SIGNATU	RE:		RN	/LPN



SKILLED NURSING NOTE

MR# PATIE			DATE:
Time in: AM DPM -	out 🗖 A M 🗖 PM 🛛 Visit Ty	pe: 🛛 Routine 🗖 SV 🗖 P	RN 🗖 Psych. 🗖 High Tech
TWTBS	PSYCHOLOGICAL 🗆 WNL	NEUROLOGICAL 🔲 WNL	HOME HEALTH AIDE SV VISIT:
T WT BS Resp: Pulse: □Reg □Irreg	Disoriented x D A&O x	Syncope / Vertigo	HHA Name:
Pain: □ yes □ no/ Scale /10		Hearing Impairment / Speech impairr	nent Patient's hygiene needs being met Respectful of rights, property & confidentiality
Site:	□ Confused □ Fatigue	□ Visual impairment	Following Care Plan
B/P Lying Sitting Standing	Depressed D Agitated	Hand tremors	Environment clean and safe
Right	-	Poor hand-eye coordination	 Patient satisfied with care giver Documents on the ICR on each visit
Left	· · · · · · · · · · · · · · · · · · ·	Poor manual dexterity	 Follow Universal Precautions (i.e. hand washing, etc.)
CARDIOVASCULAR UNL	RESPIRATORY D WNL	E	Denote Location / Size of Wounds /
Ascites	Dyspnea: At rest / On exertion		Measure Ext. Edema Bil.
□ Chest pain/pressure	Cough / Sputum	L <u>Ę</u> ,	$\int R \prod L L \int R \int R$
□ Fluid retention	□ O2@	6	3F2 (:)(A
🗖 Edema site	□ O2 @ □ Breath sounds R I	İ i i	
🗖 Arrhythmia	□ Other	Ŭ	
□ Other	GASTROINTESTINAL	VL Y	
MUSCULOSKELETAL D WNL	Appetite: 🛛 Good 🗖 Fair 🛛 Po	or 🗖 NPO	
🗖 Weakness / Paralysis	Diet:		
Limited ROM / Atrophy	Fluid intake		Antenor Posterior
□ Assistance device	Bowel sounds		
□ Altered gait / Balance	🗖 Stoma		
Prosthesis	□ Last BM:		#1 #2 #3 #4 #5
Chair bound	□ Nausea/vomiting □ Diarrhea/	constipation	
☐ Bone/joint pain ☐ NWB	Colostomy / Ileostomy	Depth	
GENITOURINARY UWNL		WNL Drainage Type: Drainage Amount:	
Frequencies / Urgency / Pain /	U Warm / Dry / Intact	Tunneling	
Burning / Hernaturia		Undermining Ødor	
	Cool / Clammy / Chills	Surr Tissue	
Anuria / Oliguria / Polyuria	Poor turgor	Edema	
Catheter (type & size)	 Pale / Flushed / Clammy Staples / Stitches 	Stoma	
last changed	 Decubitus Wound / ulcer / st 		Phone conf. to Dr.
Dialysis Freq			urn call. Message given to Dr. office
Tesio /Quinton			poke with rs New order:
		IN TIONS: (see comments)	**
□ Universal precaution observed	Med. Changes (updated)	med sheet) *	Glucometer calibrated
	Tube feedings		
	Diabetic care		•
□ Skilled observation & assessment □		Peg/GT tube site of	
INSTRUCTED IN: (see comments		HOMEBOUND DUE TO:	
□ Meds / Action S/E		Taxing effort to leave home	e
Diet / hydration	❑ Wound care □ Safety	Require use of assistive dev	
	⊐ Pain management Factor	Dyspneic / Reqs. use of 0	2
	□ O2 therapy	Needs assistance for all ac	tivities
Disease process I	□ Other:	Gait instability	
	Return Demo:	Unable to leave home alo	
Demo	Verbalizes understanding	□ Other:	
Requires further instruction	written material supplied		
WOUND CARE: 1) Cleanse wound #			
2) Applied: □ Vaseline gauze □ Xeroform 3) Covered with: □ Telfa □	🗖 Betadine 🗖 Wet dry 🗖 A	lquacel Ag 🗖 Silvasorb gel 🗖 Duode	erm 🗖 Panafil 🗖 Other:
3) Covered with:	Dry gauze DAdaptic	Other:	— 0. to a -
	Stretch bandage D Unna Boot	□ Other:	& tape
Comments required			
-			
Approximate next visit date/	_/ Plan for next visit:		lojt:-1-
Nurse (LPN / RN)			Initials

SUNSHINE GOOD CARE, LLC

SKILI	ED NUI	RSING V	VISIT NO	те					TIME I	N: TIME OUT:
PATIENTS					. NUMBER:	ном	EBOUND STAT	rus: 🗆 Needs assista		l activities Residual weakness
							equires assistan	ce to ambulate 🗆 Co	onfusion, u	nable to go out of home alone \Box Unable to
<u>NURSES NAME:</u>				<u>EMP. NO:</u>	EMP. NO:safely leave home unass device(s) \Box Medical re					pon exertion \Box Depends upon adaptive
TYPE OF	<u>visit:</u> 🗆 sn	SN & SUP	ERVISORY 🗆 S	UPER VISOI	RYONLY 🗆	OTHER				
DAIGNO	SIS:				$\underline{\mathbf{E}}:\square$ poor \square			NUTRITION/HYDR	ATION: 🗆	WNL <u>DIET:</u> \Box NAS \Box NCS
					<u>ion:</u> 🛛 poor	_				RIE ADA 🗆 OTHER
B/P RIGHT	LYING	SITTING	STANDING	TEMP:		PULS		RESP.:		LATORY: WNL EDEMA: Pitting
LEFT				WEIGHT	:LBS	APIC. RADI		□ REGULAR □ IREGULAR		Pitting Location ∴ □ Trace □ 1+ □ 2+ □ 3+ □ 4+
DLI I							D LOCATION		GRADE	
Faces Pain Retien	903	Ì) 🅱 🦂	2405				IG 🗆 THROBBING		3
Rating Scale		4 6 8 unio Hunts Hunts imore even more whole for								LESS OFTEN THAN DAILY
	Hitle bit Hitle	more even more whole lo	eronst go					$LY \square$ ALL OF THE		
D-10 Numeric Pain		5678			PAIN RELIE	EVING N	ÆASURES US	SED:		FREQ:
Rating Scale		5073			RELIEF: 🗆	COMP	LETE 🗆 MO	DERATE 🗆 NONE	;	
HEART S	SOUNDS: 🗆 V	WNL		RESPIRA			NEUROSEN	ISORY:		ENDOCRINE STATUS: WNL
IRREG:				RALES/R	HONCHI∕WHEI IG □L.L			/VERTIGO/DIZZINES		ABNORMAL FINDINGS:
	BC			\Box K. LOP		UNU		HE □ HAND TREMOR ND–EYE COORDINA		
				□ COUG	H/SPUTUM			ND-E YE COORDINA NUAL DEXTERITY		BS PER GLUCOMETER:
FREQ:_ RELIEF:				□ DYSP1				MPAIRMENT		BY: \Box SN \Box PT \Box PCG
		RATE:			DPNIA M: VIA:_			MPAIRMENT/BLIND	NESS	INSULIN
OTHER:				\square NO DE			☐ TACTILE :			U. HUMULIN R
							□ NO DEFIC OTHER:	TI 🔶		U. HUMULIN N U. LANTUS
GENITOI	TRINARY STA	TUS: WNL		GASTRO	NTESTINAL S	TSTUS				U. HUMALOG
	DESCRIBE):					10100.				U. OTHER
INDWELLING CATH (SIZE):			□ CONS.	CONSTIPATION DIARRHEA SITE						
LAST CATH CHANGE :			□ NAUSI	Image: NAUSEA ID VOMITING ADMINISTERED BY: BOWEL INCONTINENCE: ID YES Image: NO Image: NO Image: NO					ADMINISTERED BY: \Box SN \Box PT \Box PCG	
URINARY INCONTINENCE: 🗆 YES 🗆 NO BOWEL INCONTINE OTHER: OTHER:				CE: LI Y	ES ∐NO					
	te Location / S	ize of Wounds		-				SULIN ADMINISTRA	FION ATT	
	Measure Ext.	Edema Bil.	🗆 РА					INSULIN DUE TO: \Box		
(L)	(R) (L)	(L) (R) (R) □ 01							
			- <u>SKIN</u>	INTEGRITY	INTACT] COMP	ROMISED		TURGOR: [🗆 BRISK 🗆 SLUGGISH
			ABNO	RMAL FUN	DINGS:					
				ND DESCRIP TION:	<u>TION:</u>	\bigcirc	•			
				IN CM):				COLOR:		
Ċ,	Anterior	Posterior		NAGE:						
(L) ((L) (R)		OUNDING						
a Pf	M JA	n (my	Can wou	ND CARE P	ROVIDED:					
	لتسبع	-317	\square							
1 00	1 12 - Se	$\langle \rangle$	()	EMITIES:	COLOR:			TEMP:	PERI	PHERAL PULSES:
MENTAL	STATUS:	_ Alert 🗌 or				□ FORG	BETFUL 🗆 CO	NFUSED AGITAT	ED 🗌 AN	XIOUS DEPRESSED LETHARGIC
□ ABLE	TO FOLLOW	COMMANDS	□ RESPONDS	TO PAIN/VI	RBAL STIMUI	и 🗆 от	'HER			
SKILLED	CARE PROV	IDED/TEACHI	NG/PERTINEN	OBSERVA	TION/TREATM	ENT:				
		T: 🗆 YES 🗆								
			S TOWARD GO OTHER FEEDE		AL OR NON	FRRAT	•			
TEACHIN				,	ML OK NOW.	,		CHING GOOD	FATR []	POOR 🗌 ANXIOUS 🗌 CANNOT COPE
			LIZED%		NDING 🗆 NO		ONSE TO TEA			RECT DEMONSTRATION \Box Yes \Box NO
		UPERVISION					_ 🗆 NEEDS FU	JRTHER INSTRUCTIO	ON IN:	
D PROB	LEM-TEACHI	NG RESOLVE	D FOR:							
	<u>SORY VISIT:</u>		N PRESENT 🗆					Г 🗆 YES 🗆 NO		
		CARE 🗆 DEN	MONSTRATES (COMPETEN	SKILLS 🗆 CO	OMMUN	ICATES EFFEC	TIVLY D NOTIFIES	SUPERVIS	SOR OF PATIENTS NEEDS/PROBLEMS
COMMEN			REVISED 🗆	DT INCTO IT		JARS C.	OMMENTE			
								SHARPS DISCAP	חצעו חבט	DE SHARP CONTAINER
NURSE'S			THE PROPERTY OF THE PROPERTY O	STAQUES			PATIENT'S	- SILINI S DISCAR	тер пири	
SIGNATU					RN / .	LPN	SIGNATURE:			

SKILLED NURSING NOTES

					DATE	
PATIENT/CLI	IENT NAME			MR # TIME	IN	AM PM
TYPE OF VISIT	Г: 🗆 SN 🗆 S	UPV □Medicare □Medic	aid □Other	TIME	IN OUT Dependent upon adaptive	AM PM
HOME BO	UND REASO	N:Needs Assistance f	or all activitiesRequi	ires Assistance ambulate	Dependent upon adaptive	edevice(s)
Coni	tusion, unable t	to go out of home alone s Medical Restrictions	_ Unable to safely leave nom	e unassisted Severe S	SOB, SOB upon exertion	
				MUSCOSKELETAL	VITAL SIGNS & WOU	ND ASSESS
Chest		🗆 Lungs	□ Warm/Dry/Cool/Chilis	Poor balance	Т НТ	WT
□ Edema		□ SOB/Dizzy	□ Intact	🗆 Limited Movement	RESP PULSE A R	(REG / IRR)
□ Abnormal	Rhythm	🗆 Cough	□ Wound[Ulcer/incision	□ Chair/Bed Bound	PULSE A R	(REG / IRR)
□ Pulses □ Anticoagula	ant Thereer	□ Sputum	□ Rash/Itching	□ Walks with	B/P LYING SIT	/ STAND
□ Anticoaguis	ant i nerapy	□ Oxygen □ OTHER	□ Turgor □ OTHER	□ Contracture/Paralysis □ OTHER	RIGHT / LEFT /	
\square WNL		U WNL	\square WNL		□ FBS/RBSvi	a glucometer
					Denote Location / Size o	of Wounds /
CASTROIN	TEOTINAL	GENITOURINARY		MENTAL	Measure Ext. Edem	a Bil.
GASTROIN Bowel Sou		□ Burning/Dysuria/Odor	NEUROLOGICAL	□ Oriented X		2 513
□ Bower Sou □ Abdom en		Distention/Retention	□ Headache □ Syncope/Vertigo	□ Forgetful/Confused	123656	765
□ Distended		□ Frequency/Urgency	\Box Grasp equal unequal	Disoriented	$ \{3, (1, -1), \}$	61 5.)
□ Nausea/V or		□ Incontinence/Hesitancy	□ Movement	\Box Lethargic/Comatose		_ N X)?
Diarrhea/C	Constipation	□ Itching	Pupils equal_unequal	Restless/Agitated	▶ 赵(胡天松扒丁	1018
□ Incontinen	ice	□ Color	□ Hand tremors	□ Anxious/Depressed	·	15-34
\Box Ostomy _		$\Box Catheter ___ CC$	□ Aphasia/Dysphagia	□ Altered LOC		() (]
□ PEG □ Feeding		Last Changed	Speech Impairment Hearing Impairment	□ Impaired Memory □ Psych HX	$1 \rightarrow 1 \rightarrow 1 \rightarrow 1$	N K
□ Flushing			□ Visual Impairment		Anterior Poste	erior
□ Flushing _ □ Last BM _		□ Irrigation	□ OTHER		N. C.A. H.	area.
□ WNL		□ OTHER	□ WNL			LUNG ITT
🗆 Diet		\square WNL		INFUSION/IV SITE		
PAI	N	INTERVENTIONS	TECHNIQUE(S) USÊD	□ IV tubing change	Length	
🗆 No pain		□ Skilled Assessment	Universal Precautions	□ Cap change	Width	
□ Less often 1	-	Foley Change/Irrigation	🗆 Aseptic Technique 💦	🗆 Catheter Site Care	Depth	
Daily but n	iot constant	□ Wound/Ulcer/Incision	Proper Sharps Disp.	□ IV Site Change	Drainage	
□ Constant □ Pain level ((1.10)	□ Prep/Admin Insulin □ IM/SQ Injection	 Proper Waste Disp. QC of Glucometer 	From: To:	Tunneling	
	(1-10)	\Box PEG/GT Site Care	□ Glucometer Calib.	□ Med	Odor	
Relieved wit		Diet / Meds Instruction	On		Sur. Tis.	
		□ S/S Disease Process	DOTHER	🗆 Rate	Edema	
		□ OTHER		□ VIA	Stoma	
		SKILLED INTERVE	NTION & TEACHING		- stoma	
					CHANGES IN PATIEN	T CONDITION
					□ N/A	
					D MD Notified:	
					□ New Order(s):	
SN ADMINIS	TERED		IM/SQ			
CONTINU	JE TO VISIT I	FOR: OBSERVATION/ASSI	ESS, INSTRUCTIONS, FOL	EY/WOUND CARE,	Supervisor Notified V	
LABS/PR	.EP/ADMIN IN	NJECTION, MAX TEACHIN	G ATTAINED, REINSTRU	CT UNATTAINED	□ Supervisor NotifiedY	NN/A
					COMMENTS:	
	WED.	KLY QUALITY CONTROL	GUICOSE CONTROL SO	UUTION		
□ N/A	RANGE	EXPIRATION DATE	DATE OPENED	CONTROL INDICATOR		
High Low					SUPERVISORY VISIT	(CIRCLE ONE)
					□ N/A	
		anding of instructions given		rior Instruction	□ N/A □ Supervisory Visit LPN/H	HHA YN
		te correct Technique/Procedur ninister wound care/injection o			□ Following Care Plan	YN
		ninister wound care/injection			□ Patient Needs Met	Y N
	-	is time to assist with:	uue to		□ Assignment Updated	Y N N/A
🗆 Treatment/i	injection tolera	tted well by patient 🛛 🗆 Comp	liant with Diet 🛛 Compliant	t with Medication Regimen	□ Service Change Request	
PT ability wit	th Oral Meds 🛛	⊐Unable □Able □Demon	strates Understanding		Univ. & Safety Prec. Fo	
		\Box Lancets \Box N/S Gloves \Box A	Alcohol Pads 🗆 Glucometer S	Strips □4x4 □Other	□ Employee Present	YN
□ Discharge I	Planning Discu	ssed			□ Patient Satisfied with \$	
					Comments:	
NURSE PRIN	NTED NAME					
NURSE SIGN	NATURE			□ RN □ LPN		
- TORDE DIGI						



SKILLED NURSING PROGRESS NOTE

DATE OF VISIT _____

PATIEN	T/CLIEN	T NAME:	

PATIENT/CLIENT SIGNATURE:

TATIEN ROLIENT GIONATORE.				
HOMEBOUND STATUS: 🗆 Uni	able to leave home safely withou	t assistance 🔲 Unsafe ambulatio	on Can only ambulate	feet without rest periods
				mal exertion 🔲 Bed to Chair bound
Severe pain on ambulation		·		
CARDIOVASCULAR	RESPIRATORY	SKIN	MUSCULOSKELETAL	VITAL SIGNS
Chest Pain	R Lung	☐ Warm/Dry Cool Chills	☐ Poor Balance	
Edema		□ Intact	Endurance	RESP(REG/IRR)
Abnormal Rhythm	Rales / Rhonchi / Wheeze		Unsteady Gait	PULSE A R (REG/IRR)
Pulses	SOB/Dysnea	Rash/Itching	Weakness	B/P LYING SIT/STAND
Anticoagulant Therapy		Decubitus / Wounds / Ulcers		RIGHT /
□ OTHER	Sputum	□ Stage 1 □ 2 □ 3 □ 4 □	□Chair/Bed Bound	LEFT /
NO DFFICIT	02 LIMPVIA	OTHER		FBS/RBSvia glucometer
GASTROINTESTINAL	OTHER	NO DEFICIT	□Contracture	CHANGES IN PATIENT CONDITION
Bowel Sounds X	NO DEFICIT	NEUROLOGICAL	□ Paralysis	MD notified.
Abdomen SoftrTener	GENITOURINARY	Headache	□ Walks with	New Order:
Distended	Burning/Dysuria/Odor	☐ Syncope/Vertigo		
☐ Nausea/Vomiting/NPO	Distention/Retention	GraspEqual Unequal		Supervisor notified
Diet	Frequency/Urgency	Weakness		PAIN
Diarrhea/Constipation	☐ Incontinence/Hesitancy	Movement	MENTAL STATUS	Frequency of pain
☐ Incontinence	Hesitancy/Itching		Oriented X	
Ostomy	Color	Hand tremors	Disoriented X	 □ 0 No Pain
	☐'Catheter	Aphasia/Dysphagia	Forgetful/Confused	1 Less often than daily
□ Feeding		Speech Impairment	Lethargic/Comatose	2 Daily but not constant
Flushing	Last Changed		Restless/Agitated	\square 3 All the time
Last BM	☐ Irrigation cc/nss	☐ Visual Impairment	Anxious/Depressed	☐ Origin Dull ☐ Burning
				Primary Site
	_			
			Impaired Memory	Intensity:
	TECHNIQUES USED cont	INTERVENTIONS	Psych HX	
Universal Precautions	Control Solution #	Skilled Assessment		
Aseptic Technique Used		Foley Change / Irrigation		Relieved with Med: Y N
☐ Sharps to Sharps cont.		Wound / Ulcer / Incision	DISCHARGES	Progress toward pain goal:
Soiled dressing double bagged		Prep / Admin Insulin	□Continue care for	
└ Quality control of Glucometer	Other	IM / SQ Injection	visits/wks	🗌 Pain Management
performed as per agency p&p		PEG/GT Site Care	□Discharge planned	Teaching to Patient / Family
Glucometer calib On			for	(document below)
	SKILLED INTERVENTIO	N AND TEACHINGS		
				FALLS
				FALLS
				Fall Assessment Made 🛛 Y 🔲 N/A
				Clientatrisk for falls □ Y □ N
				·
				Potential for falls:
				012345678910
				Potential for falls has:
				Increased Decreased
				. 1
had a second and for all the training				
Intervention for this visit:			NEXT VISIT DATE	Supervisory Visit LPN HHA
			/ /	- Employee present □ Y □ N
Supplies Used:				Care plan followed 🛛 🖓 🗋 N
				Univ/Safety Prec Observed 🛛 Y 🗋 N
PT/CG verbalized understandin	ng of instructions given	/CG able to demonstrate correct	Teaching Procedures	Patient Satisfied with Service 🛛 Y 🗌 🛛
□ PT/CG requires further instructi			-	Service Change Requested Y
— .	• •			s i
PT/CG unable to perform/admir		·		Comments:
No able or willing CG available	at uns ume to assist with:			•
NURSE NAME:		EMPLOYE	E#	
NURSE SIGNATURE:			RN/LPN	
	t the date and time in/out represe	ent actual time of visit		

ARC Home Health, Inc.

SKILLED NURSING PROGRESS NOTE

T ID PERFORMED VIA NAME, DOB, AND ADDRESS

TIME IN _____ AM D PM D · OUT _____ AM D PM D

DATE OF VISIT ____ / ___

HOMEBOUND STATUS	NEDIC	ADE D MEDICAID D MY OTHED D	TYDE	C OF VISIT 🗆 SN 🗆 SN SUP.				
MARK ALL APPLICABLE WITH AN X CI		ARE 🗌 MEDICAID 🗋 MX OTHER 🗖	I SUP. ON					
CARDIOVASCULAR	GENITOURINARY	MUSCULOSKELETAL						
Fluid retention	Burning/Dysuria	Balance/Unsteady gait/Endurance	1	WTBS				
Chest pain Neck vein distension	Distention/Retention Frequency/Urgency/Hesitancy	Weakness/Arnbulates With Assistance Limited Movement/Rom/Assist device	Eulse: A	Reg. 🖸 Inreg. 🖸				
Edema (specify)	Hematuria	Chair Bound D Bed Bound		ular 🗌 Irregular				
RUE LUE RLE LLE	Bladder incontinence	Contracture Dearlysis	-	NG Sitting Standing				
Ascites	Catheter/Ileoconduit	No Deficit	Right					
Peripheral Pulse	Suprapubic Catheter 🗖 External 🗖	NEUROSENSORY	Left					
Arrhythmia	Foley Catheter	Syncope/Vertigo	Deno	ote Location / Size of Wounds /				
Other	Size Fr cc	Headache		Measure Ext. Edema Bil.				
No Deficit	Last changed:	Grasp 🗆 Equal 🖵 Unequal	E.					
RESPIRATORY	Irrigation cc/nss	Right:	54					
Rales/Rhonchi/Wheeze	Urine	Left:	63	in it of the				
🛛 R. Lung: 🖓 L. Lung:	Output: cc/ hr	Movement	1.173					
Cough/Sputum	Color:	Image: Constraint of the second sec	- እየለ	$I = M = M \cap I = M$				
Dyspnea/SOB	Consistency: Odor:	Right: Left:	1 KE					
Orthopnea O2: LPM: VIA:	Pain/Discharge	Hand Tremors	- ~ · ·	\0/**\4/*\7				
No Deficit	Cath Leakage/dislodgement	Poor Hand-Eye Coordination		RR RR ((
DIGESTIVE	Diabetic urine testing=ketone	.Poor Manual Dexterity						
Bowel sounds LBM:	Other:	Speech impairment	- <u>-</u> -3					
Nausea/V omiting		Hearing impairment		Anterior Posterior				
Anorexia./NPO	No Deficit	Visual impairment/Blindness	1 pm	And the second				
Epigastric distress	SKIN	Tactile sensation/Ptosis 🗖	<u>الأر</u>	TT 1/ AILWALLIA!				
Difficulty swallowing	Warm/Dry	No Deficit	انسک					
Abdominal distention	Cold/Clammy	EMOTIONAL STATUS		#1 #2 #3 #4				
Colostomy/Ileostomy	Jaundice/Pallor/Cyanosis	Oriented 🖬 T 🖬 P 🗆 P	length					
Bowel incontinence	Integrity	Forgetful/Confused	Width					
Constipation/Impaction/Diarrhea	Chills	Disoriented T T P P	Depth					
Diet:	Decubitus/Wound/Ulcer	Lethargic	Drainage					
Appetite: 🗋 good 🖨 Fair	Rash/Itching/Discoloration	Comatose	Tunneling					
Fluid Intake	Turgor/Hydration	Restless/Agitated	Odor					
Enteral Feeding Route:	Tube Insertion Site	Anxious/Depressed	Surr Tissue					
Type:	Other Stage I 11 III	Other:	Edema Stoma					
Amount: Via:	Stage I 11 III		Diet Tea	ohing:				
Flushing:				Factors Management Conducted				
No Deficit:	No Deficit	No Deficit		nfant/Childcare				
No Denen.	No Belleit	INTERVENTIONS / INSTRUCTIONS CON						
PAIN	PAIN (Cont.)	Skilled Observation/Assesment		care/Suctioning				
Frequency of Pain interfering with patient's	Current: Pain management & effectiveness	GFoley Change Goley irrigation		UES USED:				
Activity or movement:		Wound care/Dressing Change		al Precautions Followed				
🗖 0- Patient has no Pain does	□Pain Management Teaching to	🗖 Venipuncture/Lab:	Aseptic Tech. Used					
not interfere with activity or movement	patient/family (document below)	🗖 Prep./Admin. Insulin	🗌 Quality -	control of Glucometer performed				
1 - Less often then daily	Patient pain goal:	IM injection/Sq Injection		gency p & p				
2 - Daily, but not constantly	Progress toward pain goal:	Diabetic. Observation/Care		eter calib. On:				
□ 3- All of the time PAIN PROFILE- Origin Dull □ burning □	Progress low and pain goal:	Observation/Inst. Med (N or C) effects/Side effects:		Dressings double bagged discarded inside Sharps container				
Primary Site.	No Deficit	□ Inst. Safety Precaution/Emergency Pre	n INFUSION	N/IV SITE:				
Intensity 0 1 2 3 4 5 6 7 8 9 10		□ Inst. Disease Process		ng Change				
	TERVENTION / TEACHING / PT RES		Cap Ch:					
		0102	□ Central	Line Dressing Change				
			🗆 IV Site	Dressing Change				
			□ IV Site	Change				
<u> </u>			Infusion by:					
			Infusion Med:					
			Infusion	Rate:				
			Commer	nts:				
			☐ Infusion	n well tolerated by PT				
Verification of Procedure Performed								
Uerification of Medication Performe	ed Prior to Admin.							
		_						
APROXIMATE NEXT VISIT DATE	_// PLAN FOR NEXT VISI	ſ:						
□ PT / S.O. / CG verbalized understanding of	Singt given I No S/O on CC -11- (million S-	e Toi Adm At this time Dure	her DT	Define un al 1. de come TTVC de la				
PT / S. 0. / CG wereanized understanding of PT / S. 0. / CG able to return correct demon				□ Patient unable do own W/C due to:				
CARE PLAN: reviewed / Revised with patient/ cli		0						
Order Obtained:	ent myorvement 🔤 Outcome achieved 🛄 PKN	COMPLETE FOR SUPERVISORY VI	SIT CIRCLE	Y/N 1-POOR 2-FAIR 3-GOOD				
MEDICATION STATUS: 🗋 No Change 🗋 Order Obtained: Supervisory visit Y N Patient social needs met Y N								
DISCHARGE PLANNING DISCUSSED? yes	NON N/A	RN/LPN/AIDE Following care plan Y N	Universal a	& safety prec.Followed 🛛 Y N				
SUPPLIES USED: CARE COORDINATION: Physician PT O	T ST SS DEN DCM	Patient physical needs rnet Y N	 Employee 					
		Patient environmental needs met Y N	Patient sat	isfied with service YN				
		Assignment update Y I	N Rapport w	ith patient / s.o. 123				
		Service change requested Y N						
		Service change requested Y N Patient mental needs met Y N		ponse to Care 123				
PAR	T 1- Clinical Record	· · ·	N Patient res					
PAR PATIENT (CLIENT NAME (First, Middl		Patient mental needs met Y 1 PART 2- Em	N Patient resp ployee					
		Patient mental needs met Y I PART 2- Em mplete TIME OUT (above) prior to signing below. (c	N Patient resp ployee bircle title)					
	e Initial (Print)) SIGNATURE/DATE - Co	Patient mental needs met Y I PART 2- Em mplete TIME OUT (above) prior to signing below. (c	N Patient resp ployee circle title)	ponse to Care 123				



CHECK TYPE OF VISIT: SCHEDULED

□ UNSCHEDULED SUPERVISORY

PATIENT		MR#	date of Proceedings of Statis	oast Indestation	
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 Depressed Lethargic Responds	to: Pain / Verbal Stimuli	Comments:			
CARDIO-CIRCULATORY: Reg / Irreg H RLE: Warm Cold Mottled Ede LLE: Warm Cold Mottled Ede Capillary refill: Sec Cyanosis	ema: Trace 1+ 2+ 3+ 4+ ema: Trace 1+ 2+ 3+ 4+	Pitting / Nonpitting Puls Pitting/ Nonpitting Puls	se: 🛛 Strong	🛛 Weak 🛛 A	bsent
RESPIRATORY: SOB: At rest Min. e Cough: Dry Productive Sputum Colo Lung Sounds: Left: Clear Decrease Right: Clear Decrease 02 I/m via Frequency of SAN (med/freq.):	r: Amount: _ ed	☐ Wheezes ☐ Orthop ☐ Wheezes = Wheezes =scribe when):		g Required	
GI : Appetite: Inadequate: Dentures:] Partial] Upper] Lower Constipation] Diarrhea Incontinen Colostomy] Ileostomy] Bowel Sour	☐ Nutrition	☐ Cachexia ☐ Bleeding agia ☐ ABD Distention ☐ I GT Feedings	Girth:	cm	,
GENITOURINARY: □ Frequency □ Urget □ Vaginal Bleeding/Discharge □ Penile Dis □ Date last changed: □ □ □ Character of Urine: □ □ □ □	charge 🔲 Indwelling Cathe xternal Catheter 🔲 Irrigatio	eter (size) 🗍 on 🔲 Sediment 🞵 Hematur	Suprapubic Catl	neter (size)	
ENDOCRINE: WNL Sweating Poly	Fasting/Ramdo	om/Venous/Fingerstick	Done by:		
SKIN: Intact I Pale I Jaundice W Lesions I Incision Staples/Sutures Other (describe):					
NEURO: □ Headaches □ Tinnitus □ Seiz □ Sensory Loss: □ Aphasia □ Im □ Aid □ Slurred/Garbled Speech Pupils:	paired Vision 🗖 Glasses [🕽 Blind 🗖 Lt. Eye 🗖 Rt. Eye	e 🔲 Impaired ⊢	learing 🗖 Rt.	Ear 🗖 Lt. Ear
MUSCULOSKELETAL: Arthritis Pain Motor Deficit: Decreased: ROM Streng Bedfast Able / Unable to turn Transfers with: Human assistance As Ambulates with: Supv/asst of another pe	nable to transfer self: ☐ C sistive device ☐ Hoyer lift	nce/Coordination Cant: Can / Cannot bear weight	/pivot during tra bulate 🗖 Able /	osthesis 🗖 Ca ansfer process ′ 🔲 Unable to	s o wheel self
PAIN: Intensity: (1-10 scale): Does not interfere with activity/movement		Radiating to: Daily but not constantly			
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 DMD S0 Case Manager Other:



NURSE PROGRESS NOTE

Patient	's Name (Las	st)		—(First)——	(M.I.)-	(MR#) ————] ^{Month} [Day-	Year 7	- Employ	ee Number-	Initials
		1									<u> </u>		
B/P LYING	SITTING	STANDING		O,Ax,R Reg/Irreg		e time:						RV-Re EV- Em	gular Visit ergency Visit
(L)				_ Wgt			AM:		РМ	:)ue To:		
MENTAL STATUS:	ALERT			-			SAD, ANXIOU	S AGITA	TED H	IOSTILI	I		
EENT:							P4					IER:	
NEURO:							STI					-ER:	
RESPIRATORY:							R						(DRY, PROD).
							N, SOB, ORTH						
CARDIAC:		AIN/PRESSUR TIONS, NO CO					ATED TO		_ REL	IEVED I	BY		
PERIPHERAL: CIRCULATION:	EXTREMITIES (WARM, COOL. PINK, PALE, MOTTLED, CYANOTIC), <u>CAPILLARY REFILL</u> (GOOD, FAIR, POOR), NAILBEDS (PINK. PALE, CYANOTIC), EDEMA (NONE, TR, 1+, 2+. 3+. 4+): LOCATION												
		(UPPER, LOV	. ,										
GI/ABD:							INDS (PRESEN OOSE, BROWN		•				
GU:		INENT, DIAF					ENT, CLOUD	Y, MUCC	DUS, C	DOR,	BLOOD	Y), PAIN, F	ETENTION,
1&0:	INTAKE:	CUPS	SIDAY, <u>OU</u>		cc or	VOIDS/2	4 HOURS, FOL	LOWS DI	ET (YE	S, NO)			
MUSCULOSKEL:	COORDI			1 F	24IN		BILITY DUE TO	o	<u>`</u>				
ACTIVITY:							EDS ASSIST O						FURNITURE),
		HAIR, HOYER					<u> </u>						
SKIN:	TURGOR	(GOOD, FAIR,	POOR), W	IARM, COOL, E	DRY, DIAPHOR	ETIC, PINK, F	ALE, FLUSHED						
							ANGUINEOUS,						· /
		INDING SKIN				3, SEROUS, 3	ANGOINEOUS,	FOROLEI	NT), EC	CATIO	·		
	0011100												
PAIN:		N	INTENSI	TY (SCALE OF	- 0-10)	RESPO	NSE TO INTER						
.,			_										
ADDITIONAL	(SPECI	FIC INFO, N	EWPRC	DBLEMS, EN	VIRONME	TAL/SOCI	AL/SAFETY	FACTO	RS ID	ENTIF	IED) _		
INFORMATION:													
SKILLED NURSING							NT/CAREGIVE						
PROCEDURE*:	LAB:			INJE				NG/G	T #		_ Fr. INS	SERTED, FEE	DING GIVEN.
	DIGITAL I	RECTAL EXAM	I, MANUAL	L DISIMPACT I	FIU ENEMA, V	OUND CARE	EccNS, OSTOMY/ILEA	AL CONDU	JIT CA				
INSTRUCTIONS:		RATED WELL,		ULTY ENCOUN SEASE PROCE	NTERED	ATIONS	S/	SOF _			ILEAL CO	ONDUIT/ OS	TOMY / SKIN
	FOLEY/W	OUND CARE.	DIET, FLU	JIDS, NG/GT F	EEDING, EQ	JIP USE/CAR	E (PUMP. 02. S	SAN), INJE	ECTIO	V /FING	ERSTIC	K TECHNIQU	JE, SAFETY,
	ACTIVITY • SPECIFY						CAUTIONS, BIC		. WAST	E MAN	AGEMEN'	T. PRINTED	INFO GIVEN,
		CAREGIVER:		NSTRATES UN	DERSTANDIN	G OF TEACHI	NG. 🗌 NEEDS	FURTHE	R TEA	CHING,	🗌 GOO	D RETURN I	DEMO
TEAM CONFERENCE PHYSICIAN CONTACT:		REPORT, UNST	TABLE CON	NDITION, MOE	ORDER								
DISCHARGE Planning:							E, LABS, PREP LAST PHYSI						
		IAME (Print):					SIGNATURE		_				
	NORGEN	~wr (r mu):_					- SIGNATORE						

Advanced Therapeutics Home Health, LLC.

Nursing Progress Report

Patient's name					Medical	Record		
BP L SitStand	Lie	Temp.	Pulse Radial		Resp	Height:	La	ast MD Visit
R Sit Stand		OAR	Apical			Weight:		
MENTAL STATUS □ Alert □ □ Respond to: Pain/Verbal □ Sti		-orgetful 🗋 Confused 🗋 A	ble to follow commands		a 🗆 Anxiou	s 🗆 Depressed	□ Letharg	lic
	/ 🗌 Reg / Irreg HR 🗌	Palpitations 🗌 Neck Vein	Distention	Pacemak	er 🗌 Che	st pain		
RLE: □Warm □Cold □M LLE: □Warm □Cold □M	ottled 🗌 Edema: Trace	e 1+ 2+ 3+ 4+ Pittina/No	onpitting Pulse: 🗆	Strong [JWeak ∐]Weak []	Absent Absent		
Capillary refill <u>Sec</u>	Cyanosis	Claudication C	omments:	uoll/ing 00 fl	E) [] \0/L			
Cough Dry Productive :	sputum Color:	Amount:	a. exertion (dressing, \ 🗌 Hemoptysis	waiking 20 li Su	u vvn ctioning rec	en waik. Zu ft.st juired	air	
Cough Dry Productives Lung Sounds: Left: Clear Right: Clear	Decreased Rales Decreased Rales	Rhonchi Wheezes	🗌 Orthopnea 📋 Pillo	ows	_ 🗆 Trache	ostomy		
GI Appetite Ina	adequate: 🗌 Nutrition	🗌 Hydration 🛛 Cach	exia 🗌 Bleeding	gums	Nausea	🗌 🗌 Vomiting (1	req)	
Dentures: Partial Uppe Incontinence Rectal Blee	er 🗌 Lower 🔲 Edentu eding 👘 GT feedings	los 🗌 Dysphagia 🗌 AB	D Distention 🗌 Girth	1:Colo	cm □(Constipation] Diarrhea	
Bowel sounds: GENITOURINARY	Die	t:				lieostomy		
GENITOURINARY	Frequency 🗌 Urgenc	;y 🗌 Burning 🔲 Noc ndwelling catheter (size)	turia 🗌 Dysuria	t ⊡Oli ⊡Suna	guria 🗌	Incontinence	□ Retentior	n 🗌 Anuria
□ Vaginal Bleeding / Discharge □ Date last changed	External catheter	□ Irrigation □ Sedim	nent 🗌 Hematur	ia 🔲 F	oul odor	Diapers us	sed	
Character of urine: Clear	Cloudy Co	olor: Comm	ents:	Charne	how at hom	n 🗆 Motor de	onod/onlibr	
BS Results:	🗆 Fastin	g / Ramdom / Venous / Fir	ngerstick 🛛 🗌 Done	by:				
NEURO 🗌 Headaches	🗌 Tinnutis 👘 🗌 Seiz	ures 🗌 Tremor 🔲 N	lumbness 👝 🗆 T	ingling Are	ea:] Paralysis	;:
□ Sensory loss: □ □ Aid □ Slurred / Garbled S	Apnasia 🛛 impair Speech Pulpis:	ed vision	Blind Lt. eye Other:	∐ Rt. ey	ye 🗌 Impa	aired hearing	∐ Rt. Ear	🗆 Lt. Ear
MUSCOSKELETAL Ard Motor Deficit: Decreased: RC		-		. 🗆 Fra	acture locat	ion:		
	adie to transfer seit:	- I Lan / I Lannor bea	r.weight/bivot.diiring/	transter pro	ocess			
Transfer with: Human assi Ambulates with: Supv/as	stance 📋 Assistive dev	/ice 🗌 Hoyerlift 🚺 🕻	hairfast/unable to am	bulate 🗌	Able /	Unable to wheel	self	
PAIN □ Absence of pain What makes pain worse? □ N	Complaint of pain	Location:			Severit	y: 1 2 3 4 4	56789	10
What makes pain worse? 🛛 N What makes pain better? 📋 N	/lovement □ Ambula ledication □ Heat/Ic	tion □Increased pain æ □Massage □Re	with activity C					
HOMEBOUND STATUS	SKIN		MEASURE (Eve		eeks)		HA / LPN /	I SV
□ Need assist. for all activity	□ Intact □ Dry □ (#1		#3	#4 🛛	Present	+
 Residual weakness Non ambulatory 	□ Warm □ Diapho □ Color	Longar					Not presen Following	plan
	🗌 Tugor 💦 📃	vvidtn			-		PT's needs	
Severe dyspnea Leaving home requires a	☐ Wound ☐ Lesion ☐ Rash ☐ Incisio	n Drainage					followed	orec. & safety
considerable taxing effort	Location	Tunneling					PT / SO sat	
□ Severe pain □ Other		Undermining					done by:	updated SN
		Odor/Color/C	onsist			 		
SKILL CARE 🛛 Assessme	nt and observation of all :	systems 🗌 Monitor vital si	gns 🗌 Wound car	l re ⊡ Ostr	omv care	I I Tracheost	omv care	
□ Administration: O2 Ipm □	Cont PRN	SAN Med		age:	-			
□ Injection administration □ □ Lab specimen obtained □	Catheter type		Dos Size [n 🛛 Irrig	gation 🛛 🗆 C	hange	
Procedure well tolerated	Difficulty encountered	Universal precaution	s 🗌 Aseptic techni	ique followe	d			
TEACHING/INSTRUCTIO	DNS Given to □ P	T 🗆 SO 🗆 Medication s	ide effects, safe ans	effective u	se:			
□ Universal precautions □ S □ Wound care □ Skin care	afety Measures 🛛 🛛 🗠	Emergency prep. 🗌 Waste	e disposal 🛛 Dis	ease 🗌 P	rocess 🗌 (🗆 Diabetic c	Crisis interventio are □ S/S of in	n □Painr fection □	nanagement Catheter
management 🗌 Safe and effec	tive use of equipment							outhotor
Other:								_
RESPONSE IN No SO AN perform procedure due to Co	/ailable 🗌 Refuse 🔲 W mplexity of procedure	illing for 🛛 Wound care	Injection adm.	Verbalize	e 🗆 Demons	trates procedure	PT S	O unable to
LEARNING BARRIES 🗆 No	one 🗌 Emotional/Psy	chological 🛛 Cognative o	deficit 🗌 Seems di	sinterested	🗌 Impaire	d thought proces	s 🗌 Impaire	d hearing
□ Impaired vision □ Lang □ Discussed with PT/SO □ Visit	uage barries COMM		ID 🗆 Case Manage	r 🗌 Statu MD 🗆 C	s given 🗆 N	lew orders CA	SE PLAN	CHANGES
						// 		
Nurse name		Signature			Title	RN / LPN	Date	

										NU	JRSI	EPR	ROGRES	SS NOTE
Patient'	s Name (Las	st)		– (First) ——	Т	(M.I.)—				Day-	[^{Year_}	Empl	oyee Number-	Initials
B/P LYING	SITTING	STANDING	т	O,Ax, R	BS Leve		AM / PM	AIDE SUPE	RVISOF		Г		RV-Re	gular Visit
(R)				Reg/Irreg	Glucomet Aseptic				Plan d	liscusse	d with p	atient		nergency Visit
(L)				Wat	Sharp			Pt satisfied	– with car	e`	Yes,	_ No	Due To:	
IENTAL STATUS:	ALERT, OF	RIENTED TO T	IME/PERSO	ON/PLACE, I	FORGET	FUL, C	ONFUSED, S	AD, ANXIOUS	, AGITA	TED. H	OSTILE	,		
ENT:	BLURRED	VISION, INFL/	AMMATION		C	ISCHA	RGE	PA	IN _					
IEURO:	H/A, DIZZI	INESS. TREM	ors	WEAKN	IESS		NUMBNESS	TIN	GLING					
RESPIRATORY:	BS (CLEAF	R, DECREASEI	י	WHEEZES _				RA	LES	F	RHONC	-11) COUGH	(DRY, PROD)
	SPUTUM ((SM, MOD, LO	9, WHITE, Y	YELLOW. G	REEN, E	BLOOD	Y), 02, SAN,	SOB, ORTHO	PNEA	х	_ PILLO	WS,		
CARDIAC:											EVED B	Y		
		ONS, NO COM												
PERIPHERAL: CIRCULATION:							· · ·		,				`	LE, CYANOTIC),
	```	IONE, TR, 1+,		<i>,</i>										
GI/ABD:		JPPER, LOWE								OACTN		ERACT		. TENDERNESS
JIADD.		. , ,		,									,	DN. DIARRHEA,
GU:														RETENTION,
													,, ,	
&0:	INTAKE:	CUPSI	DAY, <u>OUTPL</u>	JT	cc or _		VOIDS/24 H	IOURS, FOLLO	ows di	ET (YES	S, NO)			
MUSCULOSKELTAL:												<u> </u>	~	0 0
									ALKER,	CANE	<u> </u>	<u>.</u>	J.	从短
-2 PERSON, WAL	LS, FURNI	TURE, WHE	ELCHAIR,	HOYER LI	FT						Ì f	581		6166
<b>SKIN:</b> TURGOR (GOOD, FA											Ţ į	法者		° ₩ λ{7
													THA	+1818
STERISTRIPS, SUTU	RES STADI	ES DRAINAGE			IUN, ABR S SANG		ULCER) L		D	(	(cm)	۲Į۳	/////	\{{ <b>`</b> \$}}
SURROUNDING SKI								), EOOAHON -				$\left\{ \right\}$	00	
WOUNDS (INCISION						5		/ •				<u>_</u> !!	<u>}}</u> [[	
STERISTRIPS, SUTU	RES, STAPLE	ES, DRAINAGE	 (SM. MOD,	LG, SEROU	S, SANGI	JINEOU	S, PURULENT	), LOCATION			<del></del>	<del> 1</del>	Anterior J	Pasterior
SURROUNDING SKI	N:			Wol	JND BED /						Ł		£ 1)#	1 UNGLICH
PAIN: LOCATION		INTENSITY (S	CALE OF 0-1	10)	RE	SPONS		ENTION			-	الكسك	() کے اور ا	
ADDITIONAL INFORMATION:		INFO, NEW P					<b>\</b>				NFEREN	ICES)		
			1											
SKILLED NUR				,										HARGE PLAN EDING GIVEN.
PROCEDURE:														thccNS
														MENT GIVEN.
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		):												
	SPECIFY:													
		ATED WELL, [												
INSTRUCTIONS:	_	·												
No moe nono.														NIQUE, SAFETY
				·				•						
	SPECIFY													
	PATIENT/C	AREGIVER:	DEMONS	TRATES UNI	DERSTAI	NDING	OF TEACHING	. D NEEDS	FURTHE		CHING.		DD RETURN D	EMO
PHYSICIAN		EPORT, UNST									or inite,			
CONTACT:				*										
DISCHARGE	CONTINUE	TO VISIT FOR	R: OBSERVA	ATION/ ASS	ESS, FO	LEY/W	OUND CARE.	LABS, PREP/	ADM IN	JECTIO	N. INST	RUCTIO	ONS	
PLANNING:		TED IN			,		,	,						
								SIGNATURE						
PATIENT SIGNAT	TURE:						PRIN							