

Purpose of Visit \_\_\_\_\_ Pulse \_\_\_\_\_ R A R/I \_\_\_\_\_ Respirations \_\_\_\_\_ R/I \_\_\_\_\_

Temp \_\_\_\_\_ F O/ R/A BP: Sitting \_\_\_\_\_ / \_\_\_\_\_ L/R Standing \_\_\_\_\_ / \_\_\_\_\_ L/R Lying \_\_\_\_\_ / \_\_\_\_\_ L/R Weight \_\_\_\_\_ lb Stated / Actual

**Mental**  Alert  Oriented X  Restless  Forgetful  Confused  Anxious  Depressed

Agitated  Comatose  Semi-Comatose Comment: \_\_\_\_\_

**Neurological**  No problem assessed at this time  Aphasia  Slurred Speech  Seizure  Headache  Tremors  Vertigo

Change in LOC  Grips Unequal  Pupils Unequal  Numbness  Visual deficit  Hearing deficit  Speech deficit

Comment: \_\_\_\_\_

**Cardiovascular:**  No problem assessed at this time **Pedal Pulses:**  Present  Absent **Edema:**  None  Pitting  Non - Pitting

Location/ Amount: \_\_\_\_\_  Chest Pain  Palpitations  Dizziness  Orthopnea

Comment \_\_\_\_\_

**Respiratory:**  No problem assessed at this time **Lung Sounds** \_\_\_\_\_  Cough  Prod  Non-Prod  O2

\_\_\_\_\_ LPM/C/MASK SOB:  Rest  Min Exertion Sputum Color \_\_\_\_\_ Amt \_\_\_\_\_

Oxygen Saturation \_\_\_\_\_ % Comment \_\_\_\_\_

**Gastrointestinal**  No problem assessed at this time **Appetite**  Good  Fair  Poor **Bowel Sounds**  Present  Absent

Hypo  Hyper  Nausea  V omitting  Diarrhea  Constipation  Incontinent Last BM \_\_\_\_\_

Feeding Tube \_\_\_\_\_ Diet \_\_\_\_\_ Comment \_\_\_\_\_

**Genitourinary**  No problem assessed at this time  Incontinent  Frequency  Urgency  Pain or Urination  Nocturia  Burning

Retention  FC  Suprapubic Catheter/Size \_\_\_\_\_ F \_\_\_\_\_ cc balloon  Condom Catheter (S/M/L)

Urine: Color \_\_\_\_\_  Odor  Cloudy Amount \_\_\_\_\_ ml Comment \_\_\_\_\_

**Endocrine**  No problem assessed at this time Blood Glucose \_\_\_\_\_ MG/dl random/fasting  Per patient/PCG  Diaphoretic

Polyuria  Blurred Vision  Polydipsia  Polyphagia  S/S Hyperglycemia  Tachycardia

Comment \_\_\_\_\_

**Skin**  No problem assessed at this time **Turgor**  Good  Fair  Poor **Skin Temp**  Warm  Hot  Cold  Rash

Diaphoretic  Bruises  Dry  Excoriation  Pallor  Jaundice  Pruritis  Blister(s)  Surgical Wound

Skin Tear  Stasis ulcer  Pressure ulcer  Diabetic ulcer Site: \_\_\_\_\_  Drainage

Description/Amount \_\_\_\_\_  Odor  Skin on Feet Intact  Perineal Area Intact  Wound Sheet Q week completed

Comment \_\_\_\_\_

**Musculoskeletal**  No problem assessed at this time  Stiff joints  Painful joints  Weakness \_\_\_\_\_  Contractures

Unsteady Balance /Gait Comment \_\_\_\_\_

**Pain**  Yes  No Location \_\_\_\_\_ Origin \_\_\_\_\_ Frequency \_\_\_\_\_

Intensity  1  2  3  4  5  6  7  8  9  10  Sharp  Dull  Burning

Radiating  Controlled  Yes  No Pain med last given: \_\_\_\_\_ Current Pain Management: \_\_\_\_\_

Comment \_\_\_\_\_

**Medications:**  No meds currently  No problem assessed at this time  Pt/PCG complian with med regime  Medications are effective

Pt/PCG lacks knowledge regarding med regime  No drug interaction noted  Starded on new med \_\_\_\_\_

Med profile updated Comment \_\_\_\_\_

Abnormal Findings/Skilled Care Provided:  Standard Precautions observed  Infections Control Measures observed including handwashing

Two Identifiers used to verify Patient  Safety Precautions observed  Medical Equipment in good working order Requires SN since:

No willing and able CG to administer Insulin  No willing and able CG to provide wound care/administer IM/IV medication Pt/PCG response

Pt/PCG verbalizes understanding of teaching \_\_\_\_\_ %  Pt/PCG needs further instructions  Pt/PCG demonstrated procedure properly w/o cues

Pt/PCG demonstrated procedure properly w/cues \_\_\_\_\_

Communication with (name and title) \_\_\_\_\_ RE: \_\_\_\_\_

No new orders at this time  Medications change  Treatment change  Physician Appointment

Lab specimen obtained Plans for next Visit: \_\_\_\_\_

**Homebound Status:**  Needs assistance with all activities  Residual Weakness  Requires assistance to ambulate

Medical Restrictions  Confusion unable to go out of home alone  Unable to safely leave home unassisted  Dependent upon adaptive device(s)

Severe SOB, SOB on exertion  Other (specify) \_\_\_\_\_

**AIDE SUPERVISION** Name of Aide \_\_\_\_\_ Aide present  Yes  No

Follows task care / plan?  Yes  No Patient satisfied with services?  Yes  No

Clean up work areas  Yes  No Uses good safety practice  Yes  No

Aid Task sheet updated?  Yes  No Care Observed \_\_\_\_\_ Instructed in \_\_\_\_\_

Patient Name \_\_\_\_\_ Patient Number \_\_\_\_\_

Nurse's Name \_\_\_\_\_ Nurse's Signature \_\_\_\_\_ Date of Visit \_\_\_\_\_ Time In \_\_\_\_\_ Time Out \_\_\_\_\_