NURSING VISIT NOTE

DATE _____ **TIME IN** _____ **TIME OUT**_____

TYPE OF VISIT: ❍ **Skilled:** ❍ Planned ❍ PRN ❍ **Skilled & Supervisory** ❍ **Supervisory Only** ❍ **Other**_____

❑ Q5001: Hospice or HH Care provided in patient's home/residence	❑ G0162: Management/Evaluation	❑ G0494: Observation/Assessment (LPN)
❑ Q5002: Hospice or HH Care provided in Assisted Living Facility	❑ G0299: Direct Skill (RN) ❑ G0300: Direct Skill (LPN)	❑ G0495: Education/Training (RN)
❑ Q5009: Hospice or HH Care provided in place not otherwise specified	❑ G0493: Observation/Assessment (RN)	❑ G0496: Education/Training (LPN)

Diagnosis(es) related to need:_____

Homebound reason:_____

VITAL SIGNS: Temperature:_____F ❍ Oral ❍ Axillary ❍ Tympanic ❍ Temporal/Forehead ❍ Rectal Pulse:_____ ❍ Radial ❍ Apical ❍ Brachial ❍ Carotid ❍ Regular ❍ Irregular

Respirations:_____ ❍ Regular ❍ Irregular Weight:_____ Blood Pressure: Right_____ Left_____

❑ Apnea Periods _____ sec. ❍ Observed ❍ Reported ❍ Actual ❍ Reported ❍ Lying ❍ Standing ❍ Sitting

PAIN: Is patient experiencing pain? ❍ Yes ❍ No ❍ Unable to communicate Origin_____ Location(s)_____

Duration_____ Intensity 0-10 _____ Relief measures_____

Non-verbals demonstrated: ❑ Diaphoresis ❑ Grimacing ❑ Guarding ❑ Moaning ❑ Crying ❑ Irritability ❑ Anger ❑ Tense ❑ Restlessness

❑ Change in Vital Signs ❑ Other:_____ Implications Care Plan: ❍ Yes ❍ No

CARDIOPULMONARY

Lung Sounds ❍ Clear ❍ Crackles ❍ Rales Location_____

❑ Rhonchi/Wheeze Location _____

❑ Diminished ❑ Absent ❑ Other_____

Cough ❑ None ❍ Dry ❍ Acute ❍ Chronic

❍ Non-productive ❍ Productive Amt: ❍ Small ❍ Medium ❍ Large

❑ Hemoptysis frequency_____ Amount_____

❍ Able ❍ Unable to cough up secretions Suction: ❍ Yes ❍ No

Respiratory Status ❍ Accessory muscles used ❍ Orthopnea

❑ Dyspnea: ❍ At rest ❍ With exertion/activity

❑ Stridor/retractions ❑ O_2_____ LPM ❍ PRN ❍ Continuous

❑ O_2 saturation _____%

Chest Pain ❍ Denies ❍ Anginal ❍ Postural ❍ Localized

❑ Substernal ❑ Radiating ❑ Dull ❑ Aching ❑ Sharp/stabbing

❑ Viselike ❑ Other:_____

Associated with: ❑ Shortness of breath ❑ Activity ❑ Rest

❑ Frequency/duration _____

Heart Sounds ❍ Normal ❍ Regular ❍ Irregular ❍ Murmur

❍ Abnormal (explain)_____

Other

❑ Fatigued ❑ Edema ❑ Pedal: Right_____ Left_____

❑ Pitting: ❍ +1 ❍ +2 ❍ +3 ❍ +4

❑ Non-pitting site:_____ ❑ Cramps/claudication

❑ Capillary refill: ❍ Greater than 3 seconds ❍ Less than 3 seconds

NEUROMUSCULAR

❑ Alert/oriented to person/place/time

❑ Disoriented ❑ Syncope ❑ Headache

Grasp Right: ❍ Equal ❍ Unequal ❍ Other_____

Left: ❍ Equal ❍ Unequal ❍ Other_____

Pupils ❑ PERRLA: ❍ Equal ❍ Unequal ❍ Other_____

Impairment ❑ Speech ❑ Hearing ❑ Visual

❑ Decreased sensitivity ❑ Tremors ❑ Numbness ❑ Tingling

❑ Vertigo ❑ Ataxia

❑ Falls (explain):_____

❑ Balance WNL ❑ Unsteady gait

❑ Weakness (describe)_____

❑ Change in ADL (explain)_____

GASTROINTESTINAL

Appetite ❍ Good ❍ Fair ❍ Poor ❍ NPO

❑ Anorexia ❑ Nausea ❑ Vomiting

❑ Difficulty swallowing Oral intake_____

❑ Tube feeding (specify)_____ ❍ Cont. ❍ Intermittent

Bowel Sounds ❍ Active ❍ Absent ❍ Hypoactive ❍ Hyperactive

x____quadrants ❑ Abdominal: ❍ pain ❍ distention ❍ flatulence

❑ Last BM_____

❑ Incontinence ❑ Diarrhea ❑ Constipation ❑ Impaction

❑ Enema administered (results)_____

❑ Patient tolerated procedure well ❍ Yes ❍ No

❑ Other:_____

GENITOURINARY

Urine color:_____ ❑ Odor:_____ ❑ Burning ❑ Hesitancy

❑ Nocturia ❑ Oliguria/anuria ❑ Retention ❑ Incontinence occurs_____

Urinary Catheter Type (specify)_____ French_____

Bulb inflated_____mL sterile water Date changed _____

Irrigated with (specify) _____amt _____mL

❑ Other: _____

ENDOCRINE

Blood sugar range_____

Reported by: ❑ Patient ❑ Family/Caregiver ❑ Nurse ❑ Other_____

Blood sugar this visit:_____ Check by:_____

❑ Hyperglycemia: ❑ Glycosuria ❑ Polyuria ❑ Polydipsia

❑ Hypoglycemia: ❑ Sweats ❑ Polyphagia ❑ Weak ❑ Faint ❑ Stupor

Monitored by: ❑ Patient ❑ Family/Caregiver ❑ Nurse ❑ Other_____

MEDICATIONS

New or changed since last visit ❍ None ❍ Update Medication Profile

Drug(s) _____

Dosage/frequency _____

Effective ❍ Yes ❍ No ❍ Other:_____

❑ Orders obtained

Instructed on:

❑ S/S allergic reaction
❑ Drug/drug interactions
❑ Rx refill by:_____
❑ S/E contraindications
❑ Ample supply
❑ Other:_____
❑ Missed doses/what to do:_____
❑ Medication(s) names
❑ Drug/food interactions
❑ Expiration dates
❑ Pill count (if applicable)_____
❑ Proper disposal of sharps
❑ Duration of therapy

❑ Administered by: ❑ Patient ❑ Family/Caregiver ❑ Nurse

❑ Other:_____

❑ Medication administered this visit:

Type of line: ❍ Peripheral ❍ PICC ❍ Central (type) _____

❑ Implanted port Location (specify) _____

Catheter length _____cm ❑ No evidence of infection

Number of Lumens _____

❑ Dressing change_____

Performed by: ❑ Patient ❑ Family/Caregiver ❑ Nurse

❑ Other:_____

❑ Cap change performed by: ❑ Patient ❑ Family/Caregiver ❑ Nurse

❑ Other:_____

❑ Extension/tubing changed by: ❑ Patient ❑ Family/Caregiver ❑ Nurse

❑ Other:_____

❑ Flush ❑ Saline _____mL ❑ Heparin _____unit/mL _____mL

❑ Instructed ❑ Patient ❑ Family/Caregiver on infusion therapy

❑ Patient ❑ Family/Caregiver ❑ Demonstrates ❑ Verbalizes proper management of infusion(s)

Comments:

PATIENT NAME – Last, First, Middle Initial	ID#

EMOTIONAL STATUS

❑ Angry ❑ Agitated ❑ Fearful ❑ Sad
❑ Discouraged ❑ Lonely
❑ Depressed ❑ Helpless ❑ Forgetful
❑ Confused ❑ Content ❑ Happy
❑ Hopeful ❑ Motivated
❑ Other:_____

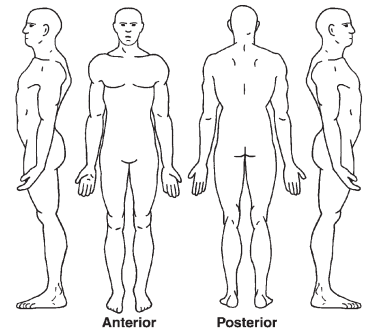
SKIN

Turgor: ❍ Good ❍ Poor
Color:_____ Temp:_____
❑ Itch ❑ Rash ❑ Dry ❑ Scaling
❑ Redness ❑ Ecchymosis ❑ Pallor
❑ Jaundice ❑ Other (specify):
_____

WOUND CARE PROVIDED

❑ Soiled dressing: ❑ removed ❑ disposed of properly
❑ Wound cleaned (specify)_____
❑ Wound irrigated (specify)_____
❑ Type of dressing(s) used_____
❑ Drainage collection container emptied. Volume_____
Vacuum assisted closure reset to _____mm/Hg
Patient tolerated procedure well ❍ Yes ❍ No
❑ Medicated prior to wound care
❑ Wound care/dressing change performed by: ❑ Patient
❑ Nurse ❑ Family/Caregiver ❑ Other:_____
❑ Patient ❑ Family/Caregiver instructed on: ❑ Wound care
❑ Disposal of soiled dressing ❑ Signs & Symptoms to report
❑ Patient ❑ Family/Caregiver to perform:
❑ Wound care ❑ Dressing change

Denote Location / Size of Wounds / Pressure Injury / Measure Extremity Edema Bilateral



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

SKILLED INTERVENTIONS/INSTRUCTIONS (Select all applicable items)

❑ Skilled observation & assessment
❑ Foley: ❑ care ❑ change
❑ Urine testing
❑ Wound: ❑ care ❑ dressing
❑ Observe signs & symptoms of infection
❑ Venipuncture
❑ Pain management
❑ Bowel/Bladder training
❑ Digital exam with manual removal/Enema
❑ Change: ❍ NG ❍ G tube
❑ Administer injection:
❍ SC ❍ IM
_____
❑ Administer other medication:
_____

❑ Insulin prep ❑ Insulin administer
❑ Diabetic observation and assessment
❑ Teach diabetic care
❑ Teach: ❑ Administer ❑ IVs ❑ Clysis
❑ Teach: ❑ Ostomy care
❑ Ileal conduit care
❑ Teach ❑ Administer tube feedings
❑ Teach ❑ Administer care of tracheostomy
❑ Teach ❑ Administer inhalation treatment
❑ Teach care - terminally ill
❑ Observe and assess medication compliance/administration
❑ Teach medication: ❑ purpose
❑ side effects ❑ administration
❑ Teach diease process:
_____
Evaluate: ❑ diet ❑ fluid intake

❑ Diet teaching
❑ Assess ADLs/Functionality
❑ Teach Safety precautions
❑ Teach skin care/pressure injury prevention
❑ Psychological intervention
❑ Chest physiotherapy/postural drainage
❑ Prenatal assessment
❑ Post-partum assessment
❑ Teach infant/child care
❑ Other:

LAB WORK

❑ None ❑ Blood drawn from:_____ for_____
❑ Other:_____ Delivered to:_____

Analysis/Interventions/Instructions/Patient Response:

SUMMARY CHECKLIST

Care Plan: ❑ Reviewed ❑ Revised with patient involvement
❑ Outcome achieved ❑ PRN order obtained
Plan for Next Visit:

Next Physician Visit:_____
Approximate Next Visit Date: _____
Discharge Planning Discussed: ❍ Yes ❍ No ❍ Long Term ❍ Hospice
Discharge Plan: ❍ Verified ❍ Revised
Billable Supplies Recorded: ❍ Yes ❍ No
Care Coordination: ❑ Physician/Provider ❑ PT ❑ OT ❑ ST
❑ MSW ❑ SN ❑ Other (specify)_____

AIDE SUPERVISORY VISIT (Complete if applicable)

Aide: ❍ Present ❍ Not present
Supervisory Visit: ❍ Scheduled ❍ Unscheduled
Is Patient/Family Satisfied: ❍ Yes ❍ No Explain:

Is Aide Following Care Plan: ❍ Yes ❍ No
Aide Care Plan Updated: ❍ Yes ❍ No
Observation of:

Teaching/Training of:

SIGNATURE/DATE–Complete **TIME OUT** (on front) prior to signing below.

Nurse Signature/Title:_____ Date:_____

Patient Signature (optional):_____