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
❑ Apnea Periods _____ sec. ❍ Observed ❍ Reported

Weight: _______ ❍ Actual ❍ Reported

Blood Pressure: Right ____________ Left ____________ ❍ 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
❑ Medication(s) names
❑ Drug/food interactions
❑ Expiration dates
❑ Pill count (if applicable) _____
❑ Proper disposal of sharps
❑ Duration of therapy
❑ Other: ____________________
❑ Missed doses/what to do: ____________________

❑ 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#

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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

Anterior Posterior

	#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):___

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