Shant Home Health Care, Inc

Reset Form | E-mail Form | Print Form

Skilled Nurse Visit Note

PURPOSE OF VISIT

- ☐ HOMEBOUND REASON
- ☐ NEEDS ASSISTANCE FOR ALL ACTIVITIES
- ☐ DEPENDENT UPON ADAPTIVE DEVICE(S)
- ☐ CONFUSION, UNABLE TO GO OUT OR HOME ALONE
- ☐ REQUIRES ASSISTANCE TO AMBULATE
- ☐ MEDICAL RESTRICTIONS
- ☐ UNABLE TO SAFELY LEAVE HOME UNASSISTED
- ☐ SEVERE SOB
- ☐ SOB UPON EXERTION
- ☐ RESIDUAL WEAKNESS
- ☐ OTHER

DIET -- Cal ☐ ADA ☐ NCS ☐ NAS ☐ Low Fat ☐ Low Cholesterol ☐ Renal ☐ Low Purine

VISION ☐ PARTIALLY IMPAIRED ☐ SEVERELY IMPAIRED ☐ Hearing Impaired ☐ Mildly ☐ Moderately ☐ Severely ☐ Speech Impaired ☐ Minimal ☐ Moderate ☐ Severe

- ☐ STANDARD PRECAUTIONS
- ☐ GLUCOMETER CALIBRATED
- ☐ SCALE CALIBRATED
- ☐ TWO IDENTIFIERS USED TO VERIFY PATIENT

VITALS

T° _____ O / R /A WT. _____

RR _____ ☐ REG ☐ IRREG

HR _____ ☐ REG ☐ IRREG

A _____ R _____

B / P	LYING	SITTING	STANDING
RIGHT			
LEFT			

Denote Location / Size of Wounds / Pressure Sores

CARDIOVASCULAR

- ☐ NO PROBLEM ASSESSED
- ☐ CHEST PAIN
- ☐ PALPITATION
- ☐ EDEMA (Piting / Non Piting) +1 / +2 / +3 / +4
- ☐ RUE ☐ LUE
- ☐ RLE ☐ LLE
- ☐ PERIPHERAL PULSES ☐ Present ☐ Absent
- ☐ **OTHER:**

RESPIRATORY

- ☐ NO PROBLEM ASSESSED
- LUNG SOUNDS
- ☐ RALES ☐ RHONCHI ☐ WHEEZES
- ☐ COUGH ☐ SPUTUM
- ***SOB*** ☐ MINIMAL ☐ MODERATE
- OXYGEN NC/Mask L/Min
- Oxygen Saturation %
- ☐ **OTHER:**

MENTAL

- ☐ ALERT
- ☐ ORIENTED
- ☐ FORGETFUL
- ☐ CONFUSED
- ☐ ANXIOUS
- ☐ AGITATED ☐ DEPRESSED
- ☐ COMATOSE ☐ SEMI- COMATOSE
- ☐ **OTHER:**

GASTROINTESTINAL

- ☐ NO PROBLEM ASSESSED
- APPETITE ☐ GOOD ☐ FAIR ☐ POOR
- BOWEL SOUNDS ☐ PRESENT ☐ ABSENT
- ☐ EPIGASTRIC DISTRESS
- ☐ NAUSEA ☐ VOMITING
- ☐ ABDOMINAL DISTENSION
- ☐ COLOSTOMY ☐ FEEDING TUBE
- ☐ DIARRHEA
- ☐ CONSTIPATION ☐ IMPACTION
- ☐ BOWEL INCONTINENCE
- ☐ LBM
- ☐ **OTHER:**

GENITOURINARY

- ☐ NO PROBLEM ASSESSED
- ☐ BURNING ☐ PAIN
- ☐ DISTENSION ☐ RETENTION
- ☐ FREQUENCY ☐ URGENCY
- ☐ HESITANCY ☐ NOCTURIA
- ☐ HEMATURIA ☐ INCONTINENT
- ☐ CATHETER/SIZE FR
- ☐ CONDOM CATHETER S / M/ L
- URINE COLOR
- CONSISTENCY
- ☐ ODOR
- ☐ **OTHER:**

NEUROLOGICAL

- ☐ NO PROBLEM ASSESSED
- ☐ HEADACHE
- ☐ TREMOR SITE
- ☐ VERTIGO
- ☐ CHANGE IN LOC
- ☐ SEIZURES
- ☐ SLURRED SPEECH
- ☐ NUMBNESS
- ☐ HAND GRIPS ☐ Equal ☐ Unequal
- ☐ Strong ☐ Weak
- ☐ UNEQUAL PUPILS
- ☐ **OTHER:**

ENDOCRINE

- ☐ NO PROBLEM ASSESSED
- ☐ FASTING BG ☐ RANDOM BG mg/dl
- ☐ S/S of HYPOGLYCEMIA
- ☐ POLYDIPSIA ☐ PLYPHAGIA
- ☐ POLYURIA
- ☐ BLURED VISION
- ☐ DIABETIC FOOT EXAM PERFORMED
- ☐ **OTHER:**

MUSCULOSKELETAL

- ☐ NO PROBLEM ASSESSED
- ☐ BALANCE ☐ UNSTEADY GAIT
- ☐ CANE ☐ WHEELCHAIR ☐ WALKER
- ☐ PAIN Y / N Location
- ☐ INTENSITY
- ☐ FREQUENCY
- ☐ PAIN MANAGEMENT
- ☐ **OTHER:**

SKIN

- ☐ NO PROBLEM ASSESSED
- ☐ WARM ☐ COLD ☐ HOT
- ☐ JAUNDICED ☐ PALLOR ☐ REDNESS
- ☐ RASH ☐ ITCHING ☐ DRY
- ☐ TURGOR ☐ Good ☐ Fair ☐ Poor
- ☐ DECUBITUS ☐ WOUND ☐ LESION
- ☐ PERINEAL ☐ PERINASAL ☐ SKIN INTACT
- ☐ **OTHER:**

	# 1	# 2	# 3	# 4
LENGTH				
WIDTH				
DEPT				
DRAINAGE				
TUNNELING				
ODOR				
SUR. TIS.				
EDEMA				
STOMA				

INTRAVENEOUS THERAPY

- ☐ N/A ☐ NO PROBLEM ASSESSED
- ☐ PICC ☐ PIV ☐ Port-A-Cath
- ☐ OTHER IV ACCESS
- ☐ WEEKLY PICC DRESSING PERFORMED
- ☐ FLASHED WITH SASH PROTOCOL
- ☐ PATIENT TOLERATED PROCEDURE WELL
- ☐ **OTHER:**

INJECTION ADMINISTRATION

- ☐ SUBCUTANEOUS ☐ INTRAMUSCULAR
- ☐ INSULIN SITE
- ☐ VITAMIN B12 SITE
- ☐ VITAMIN B COMPLEX SITE
- ☐ LOVENOX SITE
- ☐ SAFE DISPOSAL OF SHARPS
- ☐ PATIENT TOLERATED PROCEDURE WELL

MEDICATIONS

- ☐ CURRENTLY NO MEDS
- ☐ NO PROBLEM ASSESSED AT THIS TIME
- ☐ PT / PCG COMPLIANT WITH MEDICATION REGIMEN
- ☐ PT / PCG LACK KNOWLEDGE REGARDING MEDICATION REGIMEN
- ☐ MEDICATIONS ARE EFFECTIVE
- ☐ NO DRUG INTERACTION NOTED
- ☐ STARTED ON NEW MEDICATION

Abnormal Findings / Skilled Care Provided Instructions

REQUIRES SN since: ☐ No willing and able PCG to administer insulin ☐ No wiling and able PCT to provide wound care / administer IM/IV medication

PT /PCG RESPONSE: ☐ PT/PCG verbalized understanding of teaching % ☐ PT/PCG needs further instructions

☐ PT/PCG demonstrated procedure properly without cues ☐ PT/PCG demonstrated procedure properly with cues

CARE COORDINATION ☐ PHYSICIAN ☐ PT ☐ OT ☐ ST ☐ RD ☐ MSW ☐ RN ☐ SUPERVISOR OTHERS (Specify) _____

RE: _____ ☐ NO NEW ORDER

PLAN FOR NEXT VISIT

MEDICATION STATUS ☐ NO CHANGE ☐ ORDER OBTAINED

DISCHARGE PLANNING DISCUSSED? ☐ YES ☐ NO ☐ N/A

PATIENT NAME (Last, First, Middle Initial): _____ MR # _____ **DATE** _____

NURSE NAME / TITLE _____ SIGNATURE _____ **TIME** IN _____ OUT _____