PATIENT NAME: _____ **DATE:** _____
(Last, First, Middle Initial) **IN:** _____ **OUT:** _____
*Mark all applicable with an "X". Circle appropriate item(s) separated by "/ " **VISIT #:**_____**OF**_____

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Residual weakness ☐ Requires assistance to ambulate ☐ Medical contraindications ☐ Confusion, unable to go out of home alone ☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon ambulating > _____ft ☐ Confined to bed ☐ Confined to chair ☐ Requires transportation by ambulance ☐ Coordination or balance problems ☐ _____% wt. Bearing R/L ☐ Dependent upon adaptive device(s) ☐ Other (specify)_____
Outdoor activities since last visit? ☐ N/A ☐ Yes (Specify place & action)_____
Assistance used:_____
REASON FOR VISIT:_____

OFFICE USE ONLY
TYPE OF VISIT:
☐ Direct Hands-On Care: SN/LPN
☐ Mgt/Eval: SN only
☐ O/A: SN/LPN
☐ Teachings: SN

SKILLED OBSERVATION / ASSESSMENT

MENTAL: ☐ No change ☐ Alert and oriented ☐ Confused/Forgetful ☐ Disoriented ☐ Agitated ☐ Lethargic ☐ Depressed
WEIGHT: _____ ☐ Actual ☐ Reported
VITALS: ***Temperature***: _____ °F/°C ***Blood Pressure***: _____/_____ ☐ R ☐ L ***Pulse***: _____/min ☐ Rest ☐ Activity ***Respirations***: _____ ☐ Regular ☐ Irregular
☐ Oral ☐ Tympanic ☐ Temporal ☐ Sitting ☐ Lying ☐ Standing ☐ Apical ☐ Radial ☐ Carotid ☐ Labored ☐ Non-Labored
☐ Axillary ☐ Rectal ☐ Regular ☐ Irregular ☐ Apnea every: _____/sec
BLOOD SUGAR: _____ ☐ FBS ☐ RBS ☐ Actual ☐ Reported **SKIN:** *Turgor*: ☐ Good ☐ Poor *Color*: ☐ Normal ☐ Pale ☐ Jaundice
By: ☐ Patient/Caregiver (Competent: ☐ Yes ☐ No) ☐ Itch ☐ Redness ☐ Rash ☐ Bruises ☐ Ecchymosis ☐ Other: _____
☐ Skilled nurse (Quality Control Check – High: _____ Low: _____) *Texture*: ☐ Normal ☐ Dry

Teaching/Intervention:_____
_____
Response: _____

CARDIOPULMONARY

☐ **Within Normal Limits:** *heart rhythm reg., peripheral pulses +3/4 bilat., no edema, capillary refill <3sec., Extremities warm, S1/S2, resp. unlabored & symmetrical, reg. rhythm & depth, normal breath sounds, no accessory device.*
Heart Sounds: ☐ Regular ☐ Irregular
☐ **Chest Pain:** ☐ Anginal ☐ Postural ☐ Sharp ☐ Vice-like ☐ Radiating ☐ Substernal ☐ Dull ☐ Acute
Capillary Refill: ☐ Normal<3 sec ☐ High>3 sec **Peripheral Pulses:** ☐ Normal ☐ Weak
Intermittent Claudication: ☐ Left ☐ Right
☐ **Edema:** LUE +1 / +2 / +3 / +4 LLE +1 / +2 / +3 / +4
RUE +1 / +2 / +3 / +4 RLE +1 / +2 / +3 / +4
Lung Sounds: ☐ R ☐ L
☐ Clear ☐ Crackles/Rales ☐ Rhonchi/Wheeze ☐ Diminished ☐ Absent
Dyspnea: ☐ Orthopnea ☐ Exertion ☐ Rest
Cough: ☐ Productive ☐ Non-Productive
Pulse Ox: _____**%** ☐ RA ☐ **O2** @ _____LPM (Route: _____)
☐ **CPAP/BiPAP:** @_____ setting
☐ **Trach size:** _____
Intermittent Inhalation Treatments: _____
Teaching/Intervention:_____
_____
_____
Response: _____

NEUROMUSCULAR

☐ **Within Normal Limits:** *alert, active, oriented to person, place, time; follows commands, speech clear, steady gait.*
Disoriented to: ☐ Person ☐ Place ☐ Time
☐ **Syncope** ☐ **Weakness** ☐ **Vertigo** ☐ **Unequal Grasp** ☐ **Unsteady Gait**
Pupils: ☐ Equal ☐ Unequal Reactive to light: ☐ Yes ☐ No
Paresis/Weakness: ☐ RUE ☐ LUE ☐ RLE ☐ LLE
Paralysis/Hemiplegic: ☐ RUE ☐ LUE ☐ RLE ☐ LLE
Foot Drop: ☐ R ☐ L
Involuntary Movements: ☐ Tremors ☐ Jerking ☐ Tics
Difficulty Sleeping: ☐ Yes ☐ No
*Specify site for the following.
☐ **Spasticity/Rigidity:** _____ ☐ **Contracture:** _____
☐ **Fracture:** _____ ☐ **Cast:**_____
☐ **Amputation:** _____ ☐ **Prosthesis:**_____
Any Falls Reported: ☐ No ☐ Yes (Describe):_____
_____
_____
_____
Teaching/Intervention:_____
_____
_____
Response: _____

GASTROINTESTINAL

☐ **Within Normal Limits:** *abdomen soft, non-tender, non-distended, bowel sounds present all four quadrants, no N/V, diarrhea, or constipation.*
APPETITE: ☐ Good ☐ Fair ☐ Poor ☐ NPO
Hydration Adequate: ☐ Yes ☐ No
Fluid Requirements: _____/daily
Supplements: _____/daily
Type of Feeding: ☐ Nasogastric ☐ PEG ☐ Jejunostomy ☐ Other: _____
☐ Bolus ☐ Formula: _____
☐ Continuous Rate: _____ ☐ Pump Type: _____
☐ **Ostomy:** ☐ Intact/Patent/No infection ☐ Other: _____
Bowel Sounds: ☐ Normal ☐ Hyperactive ☐ Hypoactive **Last BM:**_____/_____/_____
☐ **Nausea** ☐ **Vomiting** ☐ **Heartburn** ☐ **Indigestion** ☐ **Reflux**
☐ **Diarrhea** ☐ **Constipation** ☐ **Incontinence**
☐ **Abdominal Pain** ☐ **Distention** ☐ **Ascites** ☐ **Hemorrhoids**
Teaching/Intervention:_____
_____
_____
Response: _____

GENITOURINARY

☐ **Within Normal Limits:** *voiding without difficulty, no bladder distention, urine clear.*
Urine Color: ☐ Yellow/Amber ☐ Bloody ☐ Other: _____
Consistency: ☐ Clear ☐ Cloudy ☐ Sedimentary ☐ Mucousy
Odor: ☐ Normal ☐ Mild/Strong
Incontinence: ☐ Day ☐ Night ☐ Stress
Symptoms: ☐ Burning ☐ Urgency/Frequency ☐ Retention/Hesitancy ☐ Hematuria ☐ Oliguria/Anuria ☐ Nocturia
☐ **Urostomy** ☐ **Ileal Conduit** ☐ **Nephrostomy** ☐ **Ureterostomy**
☐ **Urinary Catheter:** ☐ Indwelling ☐ Intermittent ☐ Suprapubic ☐ External
French #: _____ Balloon Size: _____/ml
Irrigation solution: _____
Frequency of change: _____
Due date for catheter change: _____/_____/_____
Teaching/Intervention:_____
_____
_____
Response: _____

PATIENT NAME: _____
(Last, First, Middle Initial)

*Mark all applicable with an "X". Circle appropriate item(s) separated by "/ "

STANDARD PAIN ASSESSMENT

☐ **No Deficit** ☐ **Unknown Due to:** _____

☐ **Wong-Baker FACES Pain Rating Scale:**
(Seven or more = Severe)

*From Hockenberry-Eatin M.I., Wilson D., Winkelstein M.L.: Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005, p. 1259. Used with permission. Copyright Mosby.

☐ **Numerical Rating Scale:**
(Seven or more = Severe)

	1	2	3	4
Location				
Description				
Duration				
Present Level (1-10)				
Worst Level (1-10)				
Best Level (1-10)				
Acceptable Level (1-10)				
Aggravated with				
Relief Measures				

Non-Verbal Symptoms: ☐ Grimacing ☐ Moaning/Crying ☐ Tense ☐ Guarding Part of Body ☐ Restlessness ☐ Irritability ☐ Change in Vital Signs ☐ Diaphoresis
Daily Status: ☐ Improved ☐ Same ☐ Deteriorated **Pain Medication Last Taken (Date/Time):** _____/_____ **Breakthrough Meds Used:** ☐ Yes ☐ No
Is the Current Pain Management Effective?: ☐ Yes ☐ No If no, has the physician been notified?: ☐ Yes ☐ No Outcome: _____

WOUND ASSESSMENT

Describe Type of Wound as Pressure Ulcers **(PU)***, Stasis Ulcers* **(SU)***, and Surgical Wounds* **(SW)***:*

Wound #	Type	Stage	Location	Size: L x W x D	Drainage	Amount	Odor	Surrounding Skin
1								
2								
3								
4								
5								

Describe Applicable Fields:

Wound #	Describe Current Treatment(s)	Performed By?	Patient/CG Competent in Wound Care/Tx(s)
1			☐ Y ☐ N
2			☐ Y ☐ N
3			☐ Y ☐ N
4			☐ Y ☐ N
5			☐ Y ☐ N

MEDICATION

☐ **New or changed since last visit:** ☐ N/A ☐ Updated Med Profile ☐ Order Obtained
☐ **Administered by:** ☐ Self ☐ Family/caregiver ☐ Nurse ☐ Other: _____
☐ **Medication administered this visit:** _____
☐ **Medication setup for:** _____
☐ **Instructed on:**
☐ Medication(s) names (list) _____
☐ S/S allergic reactions ☐ Drug/Food interactions
☐ Missed doses/what to do ☐ Drug/Drug interactions
☐ Proper sharps disposal ☐ Ample supply
☐ Expiration dates ☐ Duration of therapy
☐ Other: _____
Teaching/Intervention: _____
_____
Response: _____

IV

☐ **Peripheral** ☐ **PICC** ☐ **Central Line** ☐ **Port**
Insertion site: _____ Insertion date: _____/_____/_____
Site/Skin condition: _____
Flush solution/Frequency: _____
Caps change/Frequency: _____
Dressing change/Frequency: _____ ☐ Sterile ☐ Clean
☐ **PICC Specific:** Catheter length: _____cm Arm circumference: _____cm
☐ **Central Line Specific:** ☐ Groshong ☐ Non-Groshong ☐ Tunnelled ☐ Non-Tunnelled
☐ **Implanted Port Specific:** Huber Gauge/Length _____ Access Date: _____
Administered by: ☐ Self ☐ Caregiver ☐ RN ☐ Other: _____
Purpose of Intravenous Access: _____
Teaching/Intervention: _____
_____
Response: _____

CLINICAL MANAGEMENT DATA

Reviewed with Patient: ☐ Care plan ☐ State hotline # ☐ Patient rights ☐ DC Plans
New Problems: ☐ Identified this visit ☐ Added to care plan ☐ N/A
Plan for next visit: _____
_____
_____
Next visit date: _____/_____/_____ **Next MD visit:** _____/_____/_____
Care Coordination: ☐ Physician ☐ PT ☐ OT ☐ SLP ☐ MSW ☐ HHA ☐ Other: _____
Regarding: _____
Billable Supplies Used: ☐ No ☐ Yes (Specify): _____

AIDE SUPERVISORY VISIT (Complete if applicable)

Supervisory visit: ☐ Scheduled ☐ Unscheduled **Aide:** ☐ Present ☐ Not present
Is patient/family satisfied? ☐ Yes ☐ No Explain: _____
_____
Aide care plan updated? ☐ Yes ☐ No
Observation of: _____
_____
Teaching/training of: _____
_____
Date of next supervisory visit: _____/_____/_____

SIGNATURES/DATES

_____ _____
Patient *(Signature)* ***Nurse*** *(Signature/Title)* ***Date*** *(mm/dd/yy)*