COUNTY HOSPITAL
HOME HEALTH

Date_____
☐ Home Visit ☐ Phone Visit ☐ Payor Source Verified

Visit Code	Title	Time In	Time Out

SKILLED NURSE VISIT NOTE

SKILLED NURSING VISIT ASSESSMENT

Patient's Name _____
Patient MR #_____Diagnosis _____
Vital Signs: Temp_____Pulse (radial)_____
Pulse (apical)_____Respirations _____
B/P Left Lying _____Sitting_____Standing_____
Right Lying _____Sitting_____Standing_____
☐ Hgt_____ ☐ Wgt_____ ☐↓ ☐↑ _____ lbs.

CARDIOVASCULAR

☐ Apical Pulse ☐ Regular ☐ Irregular ☐ Chest Pain ☐ Vertigo
☐ JVD ☐ Pedal Pulse Right_____ Left _____
☐ Edema ☐ Site_____ ☐ Pitting 1+ 2+ 3+ 4+
☐ Non-Pitting ☐ See Comments

PULMONARY

☐ Respirations ☐ Regular ☐ Irregular ☐ Cheyne Stokes
☐ "Death Rattle" ☐ Apnea Period _____ Seconds
☐ Breath Sounds ☐ Clear ☐ Adventitious ☐ Diminished ☐ Absent
☐ Anterior ☐ Left ☐ Right ☐ Upper ☐ Lower
☐ Posterior ☐ Left ☐ Right ☐ Upper ☐ Lower
☐ Accessory Muscles Used ☐ Oxygen Rate _____
☐ Device _____
☐ Oxygen Saturation_____ ☐ Room Air ☐ On O2
☐ Dyspnea ☐ Rest ☐ Exertion ☐ During ADL's
☐ Cough ☐ Dry ☐ Acute ☐ Chronic ☐ Productive
☐ Thick ☐ Thin ☐ Color_____
☐ Amount_____ ☐ Unable to Cough up Secretions
☐ See Comments

SKIN

☐ Color: ☐ Normal ☐ Abnormal ☐ Pale ☐ Cyanotic ☐ Turgor
☐ Good ☐ Fair ☐ Poor ☐ Warm ☐ Dry ☐ Cold ☐ Clammy
☐ Diaphoretic ☐ Lesion ☐ Wound ☐ See Wound Documentation Sheet
☐ See Comments

GASTROINTESTINAL

☐ Diet: ☐ NAS ☐ NCS ☐ Regular ☐ 1800 Calorie ADA
☐ Cardiac ☐ Fluid Restricted ☐ Other _____
☐ Appetite: ☐ Good ☐ Fair ☐ Poor ☐ Fluids: ☐ Good ☐ Fair ☐ Poor
☐ Nausea ☐ Vomiting ☐ Abd. Distension ☐ Abd. Girth _____
☐ Last BM_____ ☐ Normal ☐ Abnormal ☐ Ostomy
☐ Bowel Sounds ☐ Active / Absent / Hypo / Hyperactive Times _____Quadrants
☐ Incontinence ☐ Supplemental Feeding ☐ Gastrostomy ☐ Naso-Gastric
☐ Oral ☐ TPN ☐ See Comments

VENIPUNCTURE

☐ N/A ☐ # of Sticks _____ Location _____
☐ Pt. Tolerated Well ☐ Needle Size_____
☐ Labs Drawn _____ ☐ See Comments

NEUROLOGICAL

☐ Oriented ☐ Place ☐ Person ☐ Time ☐ Alert ☐ Awake ☐ Drowsy
☐ Lethargic ☐ Stuporous ☐ Comatose ☐ Aphasia ☐ Receptive ☐ Expressive
☐ Tremors ☐ Fine ☐ Gross ☐ Site _____
☐ Weakness ☐ Upper Extremity / Site _____
☐ Lower Extremity / Site _____ ☐ Paralysis ☐ Hemiplegia ☐ Paraplegia
☐ Quadraplegia
☐ PERRLA ☐ Handgrips ☐ Equal / Unequal_____
☐ Strong / Weak _____ ☐ Speech ☐ Clear ☐ Slurred
☐ Swallowing ☐ Dysphagia ☐ See Comments

MENTAL / EMOTIONAL

☐ Forgetful ☐ At Times ☐ Always ☐ Angry ☐ Withdrawn ☐ Flat Effect
☐ Anxious ☐ Difficulty Coping ☐ Discouraged ☐ Cooperative ☐ Depressed
☐ Recent ☐ Long Term ☐ Sleep / Rest ☐ Adequate ☐ Inadequate
☐ Invested in Sick Role ☐ Inappropriate Response to Caregiver / Clinician
☐ Evidence of Abuse ☐ Potential ☐ Actual ☐ Verbal / Emotional
☐ Physical ☐ Financial ☐ Substance Abuse ☐ Drugs ☐ Alcohol
☐ Tobacco ☐ See Comments

GENITOURINARY

☐ Burning ☐ Pain ☐ Frequency ☐ Urgency ☐ Nocturia ☐ Hematuria
☐ Anuria ☐ Incontinence ☐ Retention ☐ Odor ☐ Yes ☐ No
☐ Urinary Catheter ☐ Type _____ ☐ Size _____
☐ Date Last Changed_____
☐ Catheter Change ☐ Type _____ ☐ Size _____
☐ Balloon Inflated _____ml ☐ Without Difficulty ☐ Tolerated Well
☐ Suprapubic ☐ Condom Catheter ☐ Catheter Irrigation _____
☐ See Comments

MUSCULOSKELETAL / MOBILITY

☐ Endurance ☐ Good ☐ Fair ☐ Poor ☐ Gait Steady ☐ Gait Impaired
☐ Weight Bearing ☐ FWB ☐ NWB / Site _____ ☐ Partial / Site _____
☐ Assistive Device ☐ Cane ☐ Quadcane ☐ Hemi-Walker ☐ Walker
☐ Rolling Walker ☐ Wheelchair ☐ Other _____
☐ Falls: See Comments ☐ Fracture / Location_____
☐ Weakness / Location_____ ☐ Amputation BK / AK UE / LE R / L
☐ Shuffling Wide Based Gait ☐ Contracture
☐ Joint ☐ Location _____
☐ Decreased ROM ☐ Poor Conditioning ☐ See Comments

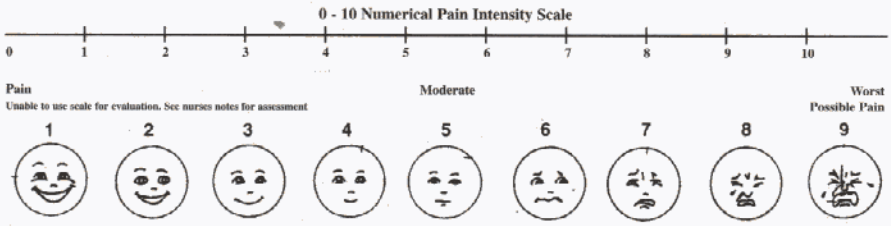
MEDICATION COMPLIANCE / REGIMEN

☐ Instructed on Med Teaching Regimen and Side Effects ☐ Medications Reviewed
☐ Compliance ☐ Compliant ☐ Non-Compliant - See Comments
☐ Fill Medi-Planner _____ Days with Meds from Med Profile
☐ Fill Syringes _____ Days with _____
Medication Count Correct ☐ Yes ☐ No Syringe Count Correct ☐ Yes ☐ No
☐ Patient / Caregiver Able to Verbalize Med Teaching, Regimen and Side Effects
☐ Instructed on Signs / Symptoms of Anticoagulant Therapy and Precautions
☐ Financial Ability to Pay for Med ☐ Yes ☐ No ☐ See Comments

PAIN ASSESSMENT

☐ Pain ☐ Yes ☐ No ☐ Unable to Communicate ☐ Location_____

RATING ON PAIN SCALE



Frequency: ☐ Occasionally ☐ Continuous ☐ Intermittent ☐ Other_____ Aggravating ☐ Movement ☐ Ambulation ☐ Other_____
Relieving: ☐ Heat / Ice ☐ Massage ☐ Repositioning ☐ Rest / Relaxation ☐ Medication ☐ Diversions ☐ Other_____
☐ Nonverbal Demonstrations of Pain: ☐ Diaphoresis ☐ Grimacing ☐ Moaning / Crying ☐ Guarding ☐ Irritability ☐ Anger ☐ Tense ☐ Restlessness
☐ Change in Vital Signs ☐ Present Pain Management Regimen_____
Effectiveness: ☐ Current Pain Control / Medication Adequate ☐ Not Adequate - See Comments Pain Management History: ☐ Oral Medications ☐ Topical
Medications: ☐ Injectable Medications ☐ Implanted Pump ☐ Intravenous Medications ☐ Other _____ ☐ See Comments

HOMEBOUND STATUS

☐ Acute Illness ☐ Surgically Restricted ☐ Medically Restricted
☐ Impaired Mobility ☐ Needs Assist for All Activities ☐ Severe Dyspnea
☐ Decreased Endurance ☐ Impaired Mentation
☐ Unable to Leave Safely Unassisted ☐ Severe Pain ☐ Immunosuppression
☐ No Longer Homebound ☐ See Comments

☐ Accucheck Fasting _____ Random _____
3 Day Average _____ Done per _____ ☐ See Comments
Patient / Caregiver check(s) controls? ☐ Yes ☐ No If no, pt. refuses? ☐ Yes ☐ No

HOME HEALTH AIDE REVIEW

☐ N/A ☐ Supervisory with Aide ☐ Non-Supervisory without Aide
☐ Waiver Homemaking ☐ Waiver Personal Care ☐ Waiver Respite ☐ Personal Care
☐ With Aide Present ☐ Without Aide Present
☐ POC Followed ☐ Appropriate ☐ Goal Being Met ☐ Revised
☐ Patient / Family Response_____
☐ See Comments

CASE COMMUNICATION

☐ Physical Therapy: Date / Time_____
☐ Speech Therapy: Date / Time_____
☐ Occupational Therapy: Date / Time_____
☐ Physician_____ Date / Time_____
☐ Physician_____ Date / Time_____
☐ Home Health Aide: Date / Time_____ ☐ Dietitian: Date / Time_____
☐ Lab Results: Reported to_____Date / Time_____
☐ Case Manager: Date / Time_____
☐ Infusion / DME:_____Date / Time_____
☐ Other:_____Date / Time_____ ☐ See Comments

☐ Discharge Plan Reviewed with Patient / Caregiver
☐ Need for Continued Service ☐ Skilled Assessment
☐ Nursing Care Plan Appropriate ☐ Care Plan Revised / Updated
☐ Skilled Nursing Frequency Reviewed ☐ Current Frequency_____
☐ Progressing Towards Goals
☐ Barriers Towards Goals _____
☐ Continue Teaching ☐ Discharge

SAFETY MEASURES

Instructed and Verbalizes Understanding:
☐ Bleeding Precautions ☐ Oxygen Precautions ☐ Seizure Precautions
☐ Fall Precautions ☐ Aspiration Precautions ☐ Side Rails Up
☐ Elevate Head of Bed ☐ 24 Hour Supervision ☐ Clear Pathways
☐ Lock Wheelchair with Transfers ☐ Infection Control Measures
☐ Assistive Devices ☐ Smoke Detectors on All Levels ☐ More than 1 Exit
☐ Plan for Power Failure ☐ Discussed Emergency Safety Planning
☐ Other _____ ☐ See Comments

EQUIPMENT

Type_____
Alarms Heard from Next Room by Patient / Caregiver: ☐ Yes ☐ No

_____
Nurse's Signature / Date

_____
Patient's Signature / Date

INSTRUCTION / TEACHING

☐ Disease Process of _____ ☐ Taught: ☐ Verbally ☐ Written ☐ Information: ☐ New ☐ Continued
☐ Retention: ☐ Demonstrated ☐ Verbally Demonstrated ☐ Goals Met: ☐ Yes ☐ No
☐ Diet_____ ☐ Taught: ☐ Verbally ☐ Written ☐ Information: ☐ New ☐ Continued
☐ Retention: ☐ Demonstrated ☐ Verbally Demonstrated ☐ Goals Met: ☐ Yes ☐ No
☐ Other_____ ☐ Taught: ☐ Verbally ☐ Written ☐ Information: ☐ New ☐ Continued
☐ Retention: ☐ Demonstrated ☐ Verbally Demonstrated ☐ Goals Met: ☐ Yes ☐ No

COMMENTS _____