Nursing Visit Record _____ _____

Patients Name | Record Number

OBSERVATION

Allergies:_____

Medication change since last visit? □ No □ Yes, Specify_____

Homebound? □ No □ Yes (If yes, reason)_____Patient Lives - o Alone, o With Family, o Non Relative

VITAL SIGNS

- o Temp:_____
- o Pulse: _____
- o Resp: _____
- o Wt: _____
- o BP: _____ right _____ left
- o Extremity Pulses _____
- o Glucometer BS: _____
- o Universal Precautions Maintained

RESPIRATORY

- o No Deficit _____
- o Rale/Rhonchi_____
- o SOB _____
- o Cough _____
- o Sputum _____
- o O2 at _____
- o O2Sat _____
- o Other _____

Comments: _____

SKIN

Edema Location_____ TR 1+ 2+ 3+ 4+

o Non Pitting o Pitting

- o No Deficit
- o Cool/Clammy
- o Warm/Dry
- o Turgor Adequate

1st Wound Location	2nd Wound Location
_____	_____
L _____	L _____
W _____	W _____
D _____	D _____
DRAINAGE	DRAINAGE
Amt _____	Amt _____
Color _____	Color _____
Odor_____	Odor _____

GU

- o No Deficit
- o Distention
- o Retention
- o Burning
- o Frequency
- o Foleycath
- o Suprapubic
- o Incontinence

Size _____ F _____ ml

Comments: _____

CARDIOVASCULAR

- o No Deficit _____
- o Chest Pain _____
- o Heart Sounds _____
- o Peripheral Pulses _____
- o Dizziness _____
- o Edema _____
- o Neck Vein Distention _____
- o Arrhythmia _____

Comments: _____

MUSCULOSKELETAL

- o No Deficit
- o Weakness
- o Balance/Gait Abnormal
- o Limited Mobility/ROM
- o Pain
- o Grip Strength right_____ left _____
- o Bed bound
- o Chair bound
- o Contracture
- o Paralysis
- o Assistive/Device

Fall Precautions maintained

_____

NEUROLOGICAL

- o No Deficit
- o Oriented to Person / Place / Time
- o Seizure/Tremors
- o Pupillary Reaction Right/Left/Equal

SENSORY

- o Hearing Impaired
- o Speech Impaired
- o Visually Impaired
- o Legally Blind

_____

DIGESTIVE/NUTRITION

- o No Deficit – Last BM _____
- o N/V
- o Diarrhea
- o Constipation
- o Tube Feeding
- o NPO Type/Amount _____
- o Placement
- o Residual/Amt._____
- o Bowel Sounds Present
- o Abd. Girth
- o Diet
- o Meals Prepared & Administered Appropriately
- o Past 24-Hour Diet Recall
- o Adequate
- o Inadequate

_____

PAIN

Frequency of Pain interfering with patient's activity or movement:

- o 0 - Patient has none or pain doesn't interfere with activity or movement
- o 1 - Less than daily
- o 2 – Daily, but not constantly
- o 3 – All of the time

PAIN PROFILE

Primary Site: _____

Intensity

0 1 2 3 4 5 6 7 8 9 10

low high

Current pain management & effectiveness:

_____

Pain Management Teaching to patient/family (document below)

Patients pain goal: _____

Progress toward pain goal: _____

INTERVENTION

Reason for visit:

SUPERVISION

o LPN		
o Aide		
Present on this visit?	Yes	No
Aide following care plan?	Yes	No
Courteous and polite?	Yes	No
Report changes in status?	Yes	No
Patient satisfied with care?	Yes	No
Changes made to care plan?	Yes	No
Additional instruction given?	Yes	No

GOALS / PLAN

Progress toward goals: _____

Teaching Tools used/given: _____o Instructed o Pt/Cg. Verbalized Understanding o Pt/Cg. Return Demonstration

Conference with: SN PT OT SLP MSS HHA (circle one) Name: _____ Regarding: _____

_____

Plan for Next Visit: _____

_____

_____

Nurse Signature & Title | Time In | Time Out | Date

_____

Patient Signature | Date