PACIFIC HOME HEALTH CARE
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ANT 11/10

SKILLED NURSE VISIT NOTE

Patient Name (Last, First, M.I.):	*ID#:*	*Visit Date:*	*Time In:*	*Time Out:*

HOMEBOUND REASON: [_]Needs assistance for all activities [_]Residual weakness [_]Requires assistance to ambulate
[_]Confusion, unable to go out of home alone [_]Unable to safely leave home unassisted
[_]Severe SOB, SOB upon exertion [_]Dependent upon adaptive device(s) [_]Medical restrictions
[_]Other (specify) _____
NURSING DIAGNOSIS / PROBLEM: _____

TYPE OF VISIT:
[_] SN
[_] SN & Supervisory
[_] Supervisory **only**
[_] Other

SKILLED OBSERVATION / ASSESSMENT

(Mark all applicable with an "X". Circle appropriate item(s) separated by "/".
Mental: [_]No change [_]Alert and oriented [_]Confused / Forgetful [_]Disoriented *(describe):* _____ [_]Agitated
Vitals: **Temperature** _____ [_]Oral [_]Axillary [_]Tympanic [_]Rectal Pulse: _____ [_]Radial [_]Apical [_]Brachial
Respirations_____ [_]Regular [_]Irregular [_]Regular [_]Irregular
Blood Pressure: Right_____/ _____ Left_____/ _____ [ ]Lying [ ]Sitting [ ]Standing
Weight:_____ [_]Actual [_]Reported Blood Sugar:_____ [_]Actual [_]Reported by: Patient / Caregiver
Appetite: [_]Good [_]Fair [_]Poor [_]NPO Hydration adequate: [_]Yes [_]No
Vision: : R eye: [_]Good [_]Fair [_]Poor **L eye:** [_]Good [_]Fair [_]Poor Other: _____
Skin: [_] WNL, Turgor: Good / Poor, Itch / Rash / Dry / Scaling / Redness / Bruises / Ecchymosis / Pallor / Jaundice, Other: _____
Breath Sounds: [_]Clear [_]Crackles/Rales [_]Rhonchi/Wheeze [_]Other
[_]Diminished [_]Absent Location_____
O2 saturation at _____%
Bowel sounds: Active / absent / hypoactive / hyperactive x_____quadrants
Last BM_____ [_]Incontinence [_]Diarrhea [_]Constipation [_]Impaction
Pain: [_]None [_]Same [_]Improved [_]Worse Origin_____ Location(s)_____
Duration_____ Intensity 0-10_____ Other_____
Relief Measures_____

CARDIOPULMONARY

[_]**No Problem** [_]Same
Pacemaker: [_] Yes [_] No
Last checked: _____ Type: _____
[_] Chest pain / palpitations
[_] Pitting edema [_] Non-Pitting edema
LUE +1/+2/+3/+4 LLE +1/+2/+3/+4 LUE LLE
RUE +1/+2/+3/+4 RLE +1/+2/+3/+4 RUE RLE
Other: _____
[_] Pedal pulses_____ present / absent
[_] Cough: [_]Non-productive [_]Productive
[_] Color_____ Character_____
[_] Dyspnea [_]Orthopnea [_]Cyanosis
O2 _____ liters/minute via nasal cannula / mask / trach
[_]PRN [_]Continuous
Comments: _____

NEUROMUSCULAR

[_]**No Problem** [_]Same
Pupils: [_]PERRLA [_]Other_____
[_] Decreased sensation [_]Tremors [_]Headache
Grasp: Right [_]Equal [_]Unequal [_]Other _____
Left: [_]Equal [_]Unequal [_]Other _____
[_] Numbness / Tingling [_]Vertigo / Ataxia
[_] Syncope [_]Balance WNL [_]Unsteady gait
[_] Reported fall(s) (describe) _____
_____
[_] Weakness (describe) _____
[_] Change in ADL (describe)_____
Comments: _____
_____
_____
_____

WOUND / OSTOMY CARE

[_] **No Problem**
[_] Wound care/dressing change performed by: [_]Self [_]Nurse
[_] Family/caregiver [_] Other_____
[_] Soiled dressing removed/disposed of properly
[_] Wound cleaned (specify) _____
[_] Wound irrigated (specify) _____
[_] Type of dressing(s) used _____
[_] Wound debridement
[_] Drainage collection container emptied. Volume_____
[_] Patient tolerated procedure well _____
[_] Medicated prior to wound care _____
[_] Patient/family caregiver instructed on wound care/ostomy/disposal of soiled dressing
[_] Patient/family/caregiver to perform wound care/ostomy/dressing change

(Measure per organizational guidelines)

WOUND	#1	#2	#3
Location			
Stages			
Length			
Width			
Depth			
Drainage			
Tunneling			
Odor			
Stoma			

Comments: _____
_____