Shuree Home Healthcare, Inc. | **Skilled Nurse Visit**

**Patient Name:** **DOB:** **MR:**
**Visit Date:** **Time In:** **Time Out:**
**Episode Range:** **Associated Mileage:** **Surcharge:**
**Last Physician Visit Date:** **Primary DX:** **Secondary DX:**

## Vital Signs

**Temp.**
**Resp.**
**Apical Pulse**
**Radial Pulse**
**BP** **Lying** **Sitting** **Standing**
**Left** _____ _____ _____
**Right** _____ _____ _____
**Weight**
**Pulse Oximetry**
**Comments**
_____

## Pain Profile

**Pain Intensity**
**Description**
**Duration**
**Primary Site** _____
**Freq. of Interfering Pain**
**Pain Mngmt. Effectiveness**
**Comments**
_____

## Skin

**Color**
☐ Pink/WNL ☐ Pallor
☐ Jaundice ☐ Cyanotic
☐ Other _____
**Temp.**
**Turgor**
**Condition**
☐ Dry ☐ Diaphoret. ☐ Wound
☐ Ulcer ☐ Incision ☐ Rash
☐ Other _____
**Comments**
_____

## Respiratory

**Breath Sounds**
☐ Bilateral ☐ Left ☐ Right
**Dyspnea**
**Cough**
**O2 at** _____
**LPM Via**
**Freq**
☐ O2 Precautions
**Comments**
_____

## Cardiovascular

☐ WNL (Within Normal Limits)
☐ Heart Rhythm
☐ Cap. Refill
☐ Pulses
**Radial**
☐ Bilateral ☐ Left ☐ Right
**Pedal**
☐ Bilateral ☐ Left ☐ Right
☐ Edema
**Location** _____
☐ Non-Pitting

☐ Bilateral ☐ Left ☐ Right
☐ Pitting
☐ Heart Sound
☐ Neck Veins
**Comments**
_____

## Neurological

☐ LOC

**Orientations:**
☐ Person ☐ Place ☐ Time
☐ Behavior Status
☐ WNL ☐ Diff. Coping
☐ Withdrawn ☐ Combative
☐ Exp. Depression ☐ Irritability
☐ Imp. Decision ☐ Other
☐ Pupils

☐ Bilateral ☐ Left ☐ Right
☐ Vision
☐ WNL ☐ Blurred Vision
☐ Cataracts ☐ Wears Corrective Lenses
☐ Glaucoma ☐ Legally Blind
☐ Speech
☐ Paralysis _____
☐ Quadriplegia ☐ Paraplegia
☐ Seizures
☐ Tremors _____
☐ Dizziness ☐ Headache
**HOH** ☐ Bilateral ☐ Left ☐ Right
**Comments**
_____

## Musculoskeletal

☐ WNL (Within Normal Limits)
☐ Grip Strength

☐ Bilateral ☐ Left ☐ Right
☐ Impaired Motor Skill
☐ Limited ROM Location:
☐ Mobility
☐ Type Assistive Device
☐ Cane ☐ Crutches
☐ Walker ☐ Wheelchair
☐ Other _____

☐ Contracture Location:
☐ Weakness
☐ Joint Pain Location:
☐ Poor Balance
☐ Joint Stiffness
☐ Amputation Location:
☐ Weight Bearing Restrictions
☐ Full ☐ Partial
**Location** _____
**Comments**
_____

## Gastrointestinal

☐ WNL (Within Normal Limits)
☐ Bowel Sounds
☐ Ab. Palpation
☐ Bowel Incontinence
☐ Nausea ☐ Vomiting ☐ GERD
☐ Abd Girth _____
**Elimination**
☐ Last BM
**Date** _____
☐ WNL
☐ Abnormal Stool
☐ Gray ☐ Tarry
☐ Black ☐ Fresh Blood
☐ Constipation _____
☐ Diarrhea _____
**Ostomy**
☐ Ostomy Type
☐ Stoma Appear. _____
☐ Surrounding Skin _____
**Comments**
_____

## Nutrition

☐ WNL (Within Normal Limits)
☐ Dysphagia
☐ Decreased Appetite
☐ Weight ☐ Loss ☐ Gain
☐ Diet
☐ Adequate ☐ Inadequate
☐ Diet Type _____
☐ Enteral Feeding

## Genitourinary

☐ WNL (Within Normal Limits)
☐ Incontinence ☐ Bladder Distention
☐ Discharge ☐ Frequency
☐ Dysuria ☐ Retention
☐ Urgency ☐ Oliguria

## Diabetic Care

☐ N/A
**Blood Sugar**
**AM** _____mg/dl
**Noon** _____mg/dl
**PM** _____mg/dl
**HS** _____mg/dl
**Performed by**

## IV

☐ N/A
**IV Access**
**IV Location** _____
**Cond. of IV Site**
**Cond. of Dress.**
**Dress. changed this visit**

Clinician Signature: Date:

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### Nutrition

☐ NG ☐ PEG ☐ Dobhoff
☐ Tube Placement Checked
☐ Residual Checked
Amount: ml

**Comments**

### Genitourinary

☐ Catheter/Device

**Last Changed** _____

_____ Fr _____ml

☐ Urine
☐ Clear ☐ Cloudy
☐ Odorous ☐ Sediment
☐ Hematuria ☐ Other _____

**Comments**

### Diabetic Care

**Site** _____ ☐ Left ☐ Right

**Diabetic Management**
☐ Diet ☐ Oral Hypogly.
☐ Exercise ☐ Insulin

**Insulin Administered by**
☐ N/A ☐ Pt ☐ CG ☐ SN

**S&S of Hyperglycemia**
☐ Fatigue ☐ Blurred Vision
☐ Polydipsia ☐ Polyuria
☐ Polyphagia ☐ Other _____

**S&S of Hypoglycemia**
☐ Anxious ☐ Dizziness
☐ Fatigue ☐ Perspiration
☐ Weakness ☐ Other _____

| Type | Dose | Site | Route |
|---|---|---|---|
| | | | |
| | | | |

**Comments**

### IV

**Flush**
☐ Yes ☐ No
Flushed with _____/ml of
_____

**Comments**

### Infection Control

☐ Universal Precautions Observed
☐ Sharps/Waste Disposal

**New infection** ☐ Yes ☐ No

**Comments**

### Care Coordination

**Care Coordination with**
☐ SN ☐ PT ☐ ST
☐ MSW ☐ HHA ☐ MD
☐ Other

**Regarding**

### Care Plan

**Care Plan**

**Goals Progress**

**New/Change Orders/Care Plan**
☐ Yes ☐ No

**Comments**

### Discharge Planning

**Discharge Planning Discussed**
☐ Yes ☐ No

**Discharge Planning Discussed with**

**Reason for Discharge**

**Physician Notified of Discharge**
☐ Yes ☐ No
☐ Patient received discharge notice

**Comments**

### Interventions

| | | | |
|---|---|---|---|
| ☐ Skilled Observation/Assessment | | ☐ Instructed on Safety Precautions | |
| ☐ Medication Adminstration | | ☐ Diabetic Monitoring/Care | |
| ☐ Foley Change | | ☐ IV Tubing Change | |
| ☐ Patient/CG teaching | | ☐ Inst. on Emergency Preparedness | |
| ☐ Prep./Admin. Insulin | | ☐ Administer Enteral nutrition | |
| ☐ Glucometer calibration | | ☐ Trachea care | |
| ☐ IV Site Dressing Change | | ☐ IM Injection/SQ Injection | |
| ☐ Peg/GT Tube Site care | | ☐ Foot care performed | |
| ☐ Wound Care / Dressing Change | | ☐ IV Site Change | |
| ☐ Foley Irrigation | | ☐ Diet Teaching | |
| ☐ Venipuncture/Lab | | ☐ Instructed on Medication | |
| ☐ Instructed on Disease Process inc. | | | |

**Comments**

Clinician Signature: Date:

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**Narrative & Teaching**

**Narrative**

**Response to Teaching/Interventions**

☐ Verbalize _____ understanding of verbal instructions/teaching given.
☐ Able to return _____ correct demonstration of procedure/technique instructed on.
☐ Treatment/Procedure well tolerated by patient.
☐ Infusion well tolerated by patient.
☐ Other _____

**Homebound Status**

☐ Exhibits considerable & taxing effort to leave home
☐ Requires assistance to get up/move safely
☐ Severe Dyspnea
☐ Unable to safely leave home unassisted
☐ Unsafe to leave home, cognitive or psychiatric impairments
☐ Unable to leave home due to medical restriction(s)
☐ Other _____

**Home Environment**

**Phlebotomy**

☐ N/A

**Labs** _____

**Venipuncture**

_____ (# of attempts) to _____ (site) with _____ ga. needle/vacutainer using aseptic technique. Applied pressure for _____ minutes.

☐ Pt tolerated procedure
☐ No bleeding
☐ No bruising
☐ Sharps Disposal

**Delivered to**

☐ Lab ☐ Hospital ☐ MD ☐ Other _____

**Comments**

Clinician Signature: Date: