

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 - ☐ Alone, ☐ With Family, ☐ Non Relative

VITAL SIGNS	RESPIRATORY	SKIN		GU	CARDIOVASCULAR
<input type="checkbox"/> Temp: _____ <input type="checkbox"/> Pulse: _____ <input type="checkbox"/> Resp: _____ <input type="checkbox"/> Wt: _____ <input type="checkbox"/> BP: _____ _____ right _____ left <input type="checkbox"/> Extremity Pulses _____ <input type="checkbox"/> Glucometer BS: _____ <input type="checkbox"/> Universal Precautions _____ Maintained _____	<input type="checkbox"/> No Deficit _____ <input type="checkbox"/> Rale/Rhonchi _____ <input type="checkbox"/> SOB _____ <input type="checkbox"/> Cough _____ <input type="checkbox"/> Sputum _____ <input type="checkbox"/> O2 at _____ <input type="checkbox"/> O2Sat _____ <input type="checkbox"/> Other _____ Comments: _____ _____ _____ _____	Edema Location _____ TR 1+ 2+ 3+ 4+ <input type="checkbox"/> Non Pitting <input type="checkbox"/> Pitting <input type="checkbox"/> No Deficit <input type="checkbox"/> Warm/Dry <input type="checkbox"/> Cool/Clammy <input type="checkbox"/> Turgor Adequate 1 st Wound Location _____ 2 nd Wound Location _____ L _____ L _____ W _____ W _____ D _____ D _____ DRAINAGE DRAINAGE Amt _____ Amt _____ Color _____ Color _____ Odor _____ Odor _____	<input type="checkbox"/> No Deficit _____ <input type="checkbox"/> Distention _____ <input type="checkbox"/> Retention _____ <input type="checkbox"/> Burning _____ <input type="checkbox"/> Frequency _____ <input type="checkbox"/> Foley cath _____ <input type="checkbox"/> Suprapubic _____ <input type="checkbox"/> Incontinence _____ Size _____ F _____ ml Comments: _____ _____ _____	<input type="checkbox"/> No Deficit _____ <input type="checkbox"/> Chest Pain _____ <input type="checkbox"/> Heart Sounds _____ <input type="checkbox"/> Peripheral Pulses _____ <input type="checkbox"/> Dizziness _____ <input type="checkbox"/> Edema _____ <input type="checkbox"/> Neck Vein Distention _____ <input type="checkbox"/> Arrhythmia _____ Comments: _____ _____ _____	

MUSCULOSKELETAL	NEUROLOGICAL	DIGESTIVE/NUTRITION	PAIN
<input type="checkbox"/> No Deficit <input type="checkbox"/> Weakness <input type="checkbox"/> Balance/Gait Abnormal <input type="checkbox"/> Limited Mobility/ROM <input type="checkbox"/> Pain <input type="checkbox"/> Grip Strength right _____ left _____ <input type="checkbox"/> Bed bound <input type="checkbox"/> Chair bound <input type="checkbox"/> Contracture <input type="checkbox"/> Paralysis <input type="checkbox"/> Assistive/Device Fall Precautions maintained _____ _____ _____ _____	<input type="checkbox"/> No Deficit <input type="checkbox"/> Oriented to Person / Place / Time <input type="checkbox"/> Seizure/Tremors <input type="checkbox"/> Pupillary Reaction Right/Left/Equal _____ SENSORY <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Legally Blind _____ _____ _____	<input type="checkbox"/> No Deficit – Last BM _____ <input type="checkbox"/> N/V <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Tube Feeding <input type="checkbox"/> NPO Type/Amount _____ <input type="checkbox"/> Placement <input type="checkbox"/> Residual/Amt. _____ <input type="checkbox"/> Bowel Sounds Present <input type="checkbox"/> Abd. Girth <input type="checkbox"/> Diet <input type="checkbox"/> Meals Prepared & Administered Appropriately <input type="checkbox"/> Past 24-Hour Diet Recall <input type="checkbox"/> Adequate <input type="checkbox"/> Inadequate _____ _____	Frequency of Pain interfering with patient's activity or movement: <input type="checkbox"/> 0 - Patient has none or pain doesn't interfere with activity or movement <input type="checkbox"/> 1 - Less than daily <input type="checkbox"/> 2 - Daily, but not constantly <input type="checkbox"/> 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	SUPERVISION
Reason for visit: _____	<input type="checkbox"/> LPN
_____	<input type="checkbox"/> 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: _____ ☐ Instructed ☐ Pt/Cg. Verbalized Understanding ☐ 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 _____