GASTROINTESTINAL

[ ] No Problem [ ] Same
[ ] Anorexia [ ] Nausea/Vomiting [ ] Difficulty swallowing
[ ] Tube feeding (specify) ____________________
[ ] Continuous [ ] Intermittent
Comments: ____________________
____

GENITOURINARY

[ ] No Problem [ ] Same
[ ] Burning [ ]Frequency/Urgency [ ]Retention/Hesitancy
[ ] Odor [ ]Hematuria [ ]Incontinence
[ ] Catheter (specify) type___________ French _______
Balloon inflated ________ml [ ]Changed [ ]Inserted [ ]Removed
Irrigated with (specify) ____________________
Comments: ____________________

MEDICATION

(New or changed since last visit)
[ ] None [ ]Update Medication Profile [ ]Order obtained
Administered by: [ ]Self [ ]Family/caregiver [ ]Nurse
[ ]Other ____________________
[ ] Medication administered this visit
Name____________________
Dose____________________ Route____________________
Instructed on:
[ ] Medication(s) names (list) ____________________
[ ] S/S allergic reaction [ ] Pill count (if applicable)
[ ] Drug/food interactions [ ] S/E contraindications
[ ] Drug/drug interactions [ ] Ample supply
[ ] Expiration dates [ ] Proper disposal of sharps
[ ] Prescription refill by ______ [ ] Duration of therapy
[ ] Missed doses/what to do [ ] Other__________________
Medication setup for____________________
[ ] Prefill insulin syringes for _______days

ASSISTIVE DEVICES

[ ] Cane
[ ] Walker
[ ] Crutches
[ ] Wheelchair
[ ] Bedside Commode
[ ] Shower Bench

Requires Assistance for:
[ ] Transfers Bed/Chair
[ ] Ambulation
[ ] Positioning
[ ] Personal Care

DIABETIC FOOT EXAM *(Check all that apply)*

Frequency of diabetic foot exam ____________________
Done by: [ ] Patient [ ] Caregiver (name) ____________________
[ ] RN/PT [ ] Other: ____________________
Exam by clinician visit: [ ] Yes [ ] No
Integument findings: ____________________
Loss of sense of: [ ] Warm right / left [ ] Cold right / left
Comment: ____________________
____
Neuropathy right / left
[ ] Tingling right / left [ ] Burning right / left

INTERVENTIONS / INSTRUCTIONS

[ ] Lab: [ ]None [ ]Blood drawn from _________ for _____________
[ ] Other _______________ Delivered to ____________________
[ ] Standard precautions [ ] Observed S/S
Observe / Teach:
[ ] Disease process (specify) ____________________
[ ] Diet: ____________________
[ ] Safety: [ ]Fall [ ]Medications [ ]Fire Other ___________
When to call: [ ]Agency [ ]Physician [ ]911
[ ] Medication (N or C) effects/side effects ____________________
Teach / Admin:
[ ] Tube feedings: ____________________
[ ] Care of trach: ____________________
[ ] Inhalation Rx: ____________________

[ ] Foley Care
[ ] Urine Testing
[ ] Decubitus care
[ ] Venipuncture
[ ] Post-cataract care
[ ] Bowel/Bladder Training

[ ] Chest physio./Postural drainage
[ ] Change NG/G Tube
[ ] Admin of Vit. B12
[ ] Prep./Admin. Insulin
[ ] IM / Subcutaneous injection
[ ] Depression Intervention
[ ] Observe S/S infection
[ ] Diabetic observation

[ ] Teach diabetic care/foot care
[ ] Hypo / Hyperglycemia S / Sx / Complication
[ ] Physiology/Disease process / management teaching
[ ] Evaluate diet/fluid intake
[ ] Diet teaching ____________________
[ ] Safety factors
[ ] Pain Management ______________

Other Skilled Intervention / Instruction:____________________
____
____
____
____
____
____
____
____

AIDE SUPERVISORY VISIT *(Complete if applicable)*

AIDE: [ ] Present [ ] Not Present
IS PATIENT/FAMILY SATISFIED? [ ] Yes [ ] No
Explain: ____________________
Follows and implements care plan [ ] Yes [ ] No
Maintains and implements standard precaution per agency policy [ ] Yes [ ] No
Is prompt, stays required length of time and is reliable [ ] Yes [ ] No
Appears competent in the delivery of service [ ] Yes [ ] No
Performs tasks as requested by the patient within job description [ ] Yes [ ] No
Relates well with the patient/family [ ] Yes [ ] No
Adheres to dress code [ ] Yes [ ] No
Reports complications and problems to the case [ ] Yes [ ] No
Is caring and sympathetic to the patient's needs [ ] Yes [ ] No
Does patient have continued need for Aide services [ ] Yes [ ] No
AIDE CARE PLAN UPDATE? [ ] Yes [ ] No

RESPONSE TEACHING:

[ ] Verbalizes Understanding [ ] PT/PCG Comprehension
25% or Less_____ 50% or Less_____ 75% or Less_____ 85% or Less_____

[ ] Return Demonstration [ ] PT/PCG Demonstration
25% or Less_____ 50% or Less_____ 75% or Less_____ 85%-95%_______

NURSING REVIEW

[ ] Nursing Care Plan appropriate [ ] Discharge Plan reviewed
[ ] Care Plan revision/update [ ] Need for continued service
[ ] S.N. Frequency Reviewed [ ] Skilled Assessment
[ ] Progressing toward goal [ ] Continue teaching
[ ] Barriers toward Progress [ ] Procedure as ordered
Care Coordination: [ ]Physician [ ]SN [ ]PT [ ]OT [ ]ST
[ ]MSW [ ]HHA [ ]Other (specify) ____________________
Regarding ____________________

Patient's Signature:	*Date:*	*Employee's Signature*	*Date:*