

# 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 <sup>st</sup> Wound Location _____ 2 <sup>nd</sup> Wound Location _____ L _____ L _____ W _____ W _____ D _____ D _____ 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: _____ <input type="checkbox"/> Instructed <input type="checkbox"/> Pt/Cg. Verbalized Understanding <input type="checkbox"/> 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 \_\_\_\_\_