

HELPING HANDS HEALTHCARE

Skilled Nursing Visit Note

FOR OFFICE USE ONLY	
Payer	
<input type="checkbox"/> Bill Only	<input type="checkbox"/> Insurance
<input type="checkbox"/> Pay Only	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Pay/Bill	<input type="checkbox"/> Medicare
<input type="checkbox"/> Other: _____	
Reviewer: _____	

Client Name: _____ Date: _____

Time In _____
Time Out _____

- TYPE OF VISIT**
- | | |
|---|---|
| <input type="checkbox"/> SN | <input type="checkbox"/> SN & Supervisory |
| <input type="checkbox"/> Emergency | <input type="checkbox"/> Unannounced |
| <input type="checkbox"/> Supervisory Only | <input type="checkbox"/> Other: _____ |

VITAL SIGNS					
Temp	AX	OR	TYMP	BP	
Pulse	reg	irreg		FSBS	
Resp	reg	irreg		Weight	Reported Observed
				Height	Reported Observed

NURSING ASSESSMENT AND OBSERVATION SIGNS/SYMPTOMS
(Mark all applicable with an "X". Circle appropriate item(s) separated by "/".)

<p>NEUROSENSORY</p> <input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Disoriented <input type="checkbox"/> Aphasia <input type="checkbox"/> Lethargic <input type="checkbox"/> Agitated <input type="checkbox"/> Comatose <input type="checkbox"/> Forgetful <input type="checkbox"/> Depressed <input type="checkbox"/> Confused <input type="checkbox"/> Anxious <input type="checkbox"/> Restless <input type="checkbox"/> Other: _____ <input type="checkbox"/> Syncope <input type="checkbox"/> Headache <input type="checkbox"/> Grasp: R: _____ L: _____ <input type="checkbox"/> Movement: <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE <input type="checkbox"/> PERRLA <input type="checkbox"/> Tremors <input type="checkbox"/> Numbness/ Tingling <input type="checkbox"/> Vertigo <input type="checkbox"/> Speech impairment <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Visual impairment <input type="checkbox"/> Decreased sensitivity <input type="checkbox"/> Seizure Activity	<p>GENTO-URINARY</p> <input type="checkbox"/> Cont/Incont. Bladder <input type="checkbox"/> Voiding QS <input type="checkbox"/> Urine color: _____ <input type="checkbox"/> Consistency: _____ <input type="checkbox"/> Odor: _____ <input type="checkbox"/> Dysuria: _____ <input type="checkbox"/> Frequency/Urgency <input type="checkbox"/> Hesitancy <input type="checkbox"/> Nocturia <input type="checkbox"/> Retention/Distention <input type="checkbox"/> Intermittent Cath. <input type="checkbox"/> Indwelling Cath. <input type="checkbox"/> Catheter Size ____ Fr. ____ cc balloon <input type="checkbox"/> Ileostomy <input type="checkbox"/> Stress Incontinence <p>GASTRIONTESTINAL</p> <input type="checkbox"/> Cont/Incont. Bowels <input type="checkbox"/> Bowel Sounds <input type="checkbox"/> Constipation <input type="checkbox"/> Impaction <input type="checkbox"/> Anorexia <input type="checkbox"/> Laxative Use <input type="checkbox"/> Diarrhea <input type="checkbox"/> Last BM <input type="checkbox"/> Nausea/Emesis <input type="checkbox"/> Pain/ Epigastric Distress <input type="checkbox"/> Abdomen Soft/Firm <input type="checkbox"/> Abdomen Flat/Round <input type="checkbox"/> Abdomen distended <input type="checkbox"/> Colostomy	<p>MUSCULO-SKELETAL</p> <input type="checkbox"/> Balance/ unsteady <input type="checkbox"/> Assistive Device <input type="checkbox"/> Bed/Chair Bound <input type="checkbox"/> Endurance <input type="checkbox"/> Limited ROM <input type="checkbox"/> Contracture Site: _____ <input type="checkbox"/> Weakness Site: _____ <p>SKIN</p> <input type="checkbox"/> Color _____ <input type="checkbox"/> Warm/ Cold <input type="checkbox"/> Dry/ Moist <input type="checkbox"/> Turgor _____ <input type="checkbox"/> MMMP <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Decubitus/ Wound <p>RESPIRATORY</p> <input type="checkbox"/> BS Clear <input type="checkbox"/> Rales <input type="checkbox"/> Rhonchi <input type="checkbox"/> Wheeze <input type="checkbox"/> Diminished <input type="checkbox"/> Cough <input type="checkbox"/> Prod <input type="checkbox"/> Non-Prod <input type="checkbox"/> Sputum color Amount: _____ <input type="checkbox"/> Dyspnea/ SOB <input type="checkbox"/> Orthopnea <input type="checkbox"/> Oxygen <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Other: _____	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Heart Sounds WNL <input type="checkbox"/> Irreg. Heart Sounds <input type="checkbox"/> Murmur <input type="checkbox"/> Chest Pains/Pressure <input type="checkbox"/> Neck Vein Distention <input type="checkbox"/> Palpatations <input type="checkbox"/> JVD <input type="checkbox"/> Peripheral Pulses Palp. <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE <input type="checkbox"/> Edema (specify): _____ <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE <input type="checkbox"/> Fatigue <input type="checkbox"/> Cap Refill <p>NUTRITIONAL</p> <input type="checkbox"/> Diet: _____ <input type="checkbox"/> Appetite: _____ <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Difficulty Chewing <input type="checkbox"/> Fluid intake: _____ <input type="checkbox"/> NG/GT/Mickey <input type="checkbox"/> Weight loss/ gain <input type="checkbox"/> Receives MOW <input type="checkbox"/> Clossman Catering <p>PAIN</p> <input type="checkbox"/> Level (1-10) <input type="checkbox"/> Location: _____ <input type="checkbox"/> Description: _____ <input type="checkbox"/> Frequency: const/interm <input type="checkbox"/> Pain Mgmt: _____ _____ _____
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SUPERVISORY VISIT NOTE

Aide name _____ is:	<input type="checkbox"/> Documentation is appropriate	<input type="checkbox"/> Written information was helpful
<input type="checkbox"/> Professional/Courteous	<input type="checkbox"/> Adheres to Policies/procedures	<input type="checkbox"/> Staff provided service needs
<input type="checkbox"/> Communicates changes	<input type="checkbox"/> Utilizes proper body mechanics	<input type="checkbox"/> Staff available when needed
<input type="checkbox"/> Positive/Cooperative	<input type="checkbox"/> Demonstrates competent skills	<input type="checkbox"/> Uses proper technique for PCS/HMK
	<input type="checkbox"/> Adheres to Plan of Care	<input type="checkbox"/> Overall, services are good

Interventions (Mark all applicable with an "x". Circle appropriate item(s) separated by "/".)

- | | |
|---|--|
| <input type="checkbox"/> Skilled observation & assessment | <input type="checkbox"/> Respiratory care |
| <input type="checkbox"/> Wound Care/ dressing change | <input type="checkbox"/> Foley Care |
| <input type="checkbox"/> Decubitus Care | <input type="checkbox"/> Urine testing |
| <input type="checkbox"/> Venipuncture | <input type="checkbox"/> Digital exam/ manual removal of stool |
| <input type="checkbox"/> Admin. Insulin | <input type="checkbox"/> Admin, enema |
| <input type="checkbox"/> Admin IM injection | <input type="checkbox"/> Psych/ social intervention |
| <input type="checkbox"/> Change feeding tube | <input type="checkbox"/> Monitor s/s infection |
| <input type="checkbox"/> Bowel/ bladder training | <input type="checkbox"/> Diabetic observation |
| <input type="checkbox"/> Other | <input type="checkbox"/> Evaluate diet/ I and O |

Teaching

- | | |
|--|--|
| <input type="checkbox"/> Teach diabetic care | <input type="checkbox"/> Teach care of trach |
| <input type="checkbox"/> Observe/ teach medication | <input type="checkbox"/> Teach admin. of medications |
| <input type="checkbox"/> Observe/ teach side effects | <input type="checkbox"/> Teach admin. of tube feedings |
| <input type="checkbox"/> Teach disease process | <input type="checkbox"/> Teach infant/ child care safety |
| <input type="checkbox"/> Teach anatomy/ physiology | <input type="checkbox"/> Teach admin. of breathing Rx |
| <input type="checkbox"/> Teach nutrition/ diet | <input type="checkbox"/> Teach end of life care |
| <input type="checkbox"/> Teach/ review safety | <input type="checkbox"/> Teach ostomy/ cath. care |
| <input type="checkbox"/> Teach fall preventions | <input type="checkbox"/> Other |

- Homebound D/T: Needs assistance for all activities Severe SOB, SOB upon exertion Requires assistance to ambulate
 Medical Restrictions Confusion, unable to go out of home alone Dependent upon adaptive device(s)
 Residual weakness Unable to safely leave home unassisted Other _____

Patient/CG Response to Teaching: _____

Phone Call To: _____ Time: _____ Regarding: _____

Responses/ Orders: _____

BILLABLE SUPPLIES RECORDED

- | | | | | | |
|---|---|--|---|--|--|
| <input type="checkbox"/> 2x2's | <input type="checkbox"/> 4x4's | <input type="checkbox"/> Refer to list below | <input type="checkbox"/> N/A | <input type="checkbox"/> Cotton tipped applicators | <input type="checkbox"/> Wound cleanser |
| <input type="checkbox"/> Gloves | <input type="checkbox"/> Kerlix: size _____ | <input type="checkbox"/> ABD's | <input type="checkbox"/> Saline | <input type="checkbox"/> Transparent dressings | <input type="checkbox"/> Tape |
| <input type="checkbox"/> Sterile urine cups | <input type="checkbox"/> IV start kit | <input type="checkbox"/> Alcohol swabs | <input type="checkbox"/> Syringes: size _____ | <input type="checkbox"/> Underpads | <input type="checkbox"/> Urinary Catheters |
| <input type="checkbox"/> Straight catheter | <input type="checkbox"/> Irrigation tray | <input type="checkbox"/> Chemstrips | <input type="checkbox"/> Steri strips | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

CARE PLAN: Reviewed/ revised with patient/ client involvement Outcome achieved PRN order obtained

MEDICATION STATUS: No change Order obtained

DISCHARGE PLANNING DISCUSSED: Yes No N/A

CARE COORDINATION: Physician PT OT ST SW SN Other: _____

NARRATIVE COMMENTS

WOUNDS

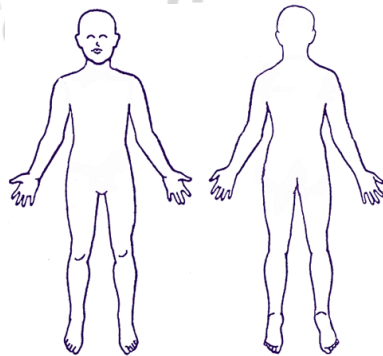
Width: _____

Length: _____

Depth: _____

Drainage: _____

Treatment: _____



Employee Signature: _____

Employee Printed Name: _____

I Have Been Seen by the Nurse Today:
(Client signature verifies visit)

Client Signature: _____