☐ SUPERVISORY VISIT

209 E. Alameda Ave. #203, Burbank, CA 91502 * TEL: (818) 557-8777 * FAX: (818) 557-8788

NURSING ASSESSMENT: Mark pertinent Physical Examination and Review of Systems findings with a "✓" or a "X"

Patient's Name: ______________________ MR#: __________
BP: ☐Rt ☐Lt Lying ________ Sitting ________ Standing ________
Temp: _______ ☐Oral ☐Axillary HR ________ ☐Radial ☐Apical
Last MD visit:: ___________ Next MD visit:: __________

SN Signature: ______________________________ ☐ RN ☐ LVN
SN Name (print): ______________________________
RR: __________ Weight: ________ FBS: _______ RBS: _________
DATE: ____________ TIME IN: ___________ TIME OUT: ___________

MENTAL STATUS
Alert ☐
Forgetful ☐
Anxious ☐
Confused ☐
Depressed ☐
Disoriented ☐
Lethargic ☐
Restless ☐
Poor cognition ☐
WNL ☐

SENSORY
Poor Vision ☐
↓ Hearing ☐
Slurred Speech ☐
WNL ☐

INTEGUMENTARY
Clammy ☐
Chills ☐
Decubitus ☐
Wound ☐
Flushed ☐
Jaundiced ☐
Pallor ☐
Rash/Itching ☐
Poor Turgor ☐
Cyanosis ☐
Dry ☐
WNL ☐

INTRAVENOUS
Peripheral ☐
Central Line ☐
Site
Site

NERVOUS SYSTEM
Syncope ☐
Headache ☐
Grasp ☐
Right: ☐
Left: ☐
Hand Tremors ☐
☐↓Motor ☐↓Sensory
☐RUE ☐LUE
☐RLE ☐LLE
Abnormal Pupillary Rxn: ☐
☐Rt ☐Lt
Tremors ☐
Vertigo/Dizzy ☐
WNL ☐

SHUNT
AV shunt ☐
Groshunt ☐

MUSCULOSKELET.
Gait Unsteady ☐
Weakness ☐
Bedbound ☐
W/C Bound ☐
Assist Device: ☐
WNL ☐

CARDIOVASCULAR
Arrhythmia ☐
Chest Pain ☐
Neck V. Dist. ☐
Pedal Edema ☐
Location:
Periph. Pulse: ☐N
☐↓ ☐Absent
WNL ☐

RESPIRATORY
Rales ☐
Cough ☐
Dyspnea ☐
SOBE ☐
Orthopnea ☐
Wheezing ☐
Tracheostomy ☐
On Oxygen ☐
Hand H Neb. ☐
WNL ☐

ENDOCRINE
☐ IDDM ☐ NIDDM
☐ Unable to self-inject
Insulin admin and/or
Fingerstick by: SN ☐
Pcg ☐ pt ☐

DIGESTIVE
Nausea ☐
Vomiting ☐
Anorexia ☐
Colostomy ☐
Diarrhea ☐
Constipated ☐
Impaction ☐
Dysphagia ☐
Incontinent ☐
NG Tube ☐
G - Tube ☐
T.P.N. ☐
WNL ☐
Last B.M:

GENITO-URINARY
Burning ☐
Distention ☐
Retention ☐
Frequency ☐
Urgency ☐
Hematuria ☐
Incontinent ☐
Dysuria ☐
Hesitancy ☐
Catheter Type
French No:
Date changed
Urine: Color:
WNL ☐

PAIN ASSESSMENT
Pain scale (0-10): WNL ☐
Pain loc:
Pain management::

Homebound Status:
☐ bedbound
☐ poor/ limited endurance
☐ paralysis of lower extremity(ies)
☐ patient confused, disoriented, unsafe to leave home unsupervised
☐ w/c bound w/ inaccessible stairs to exit home
☐ poor/limited strength
☐ unable to tolerate sitting
☐ angina w/ exertion greater than: ☐10 ft ☐20ft ☐30ft
☐ shuffling/unsteady gait requiring mod/max assist of 1-2 persons for safety
☐ maximum assist of one to ambulate
☐ SOB on minimal exertion
☐ amb. ____ft. then requires rest/stop
☐ unable to tolerate prolonged activity to exit home
☐ Unstable BS level causing weakness, dizziness
☐ Unable to leave home without assistance
☐ Requires assistive device to ambulate
☐ Unable to perform personal care/ambulate increase in BP &/or HR

Instructions & Periodic Review Regarding: ☐Grievance Procedure ☐1-800 number of **DHS** & **Caritas Home Health Providers**
☐Patient's Rights & Responsibilities ☐Confidentiality of Medical Record ☐Participation in Plan of Care Pt has Advanced Directives? ☐Yes ☐No
Pt has Caregiver? ☐No ☐Yes, but ☐unwilling ☐unable ☐unavailable to perform skilled care ☐Pcg overwhelmed w/ care

NURSING DIAGNOSIS / PROBLEMS:

☐ ***Please see ADDENDUM***

SKILLED INTERVENTIONS:

☐ ***Please see ADDENDUM***

EVALUATION:

☐ ***Please see ADDENDUM***

Communication with: MD☐ PT☐ OT☐ MSW☐ CHHA☐ SUPERVISOR☐
Regarding: New Order(s) this Visit:
Universal Precautions Utilized: ☐Hand washing ☐Gloves ☐Mask ☐Goggles ☐Medical Waste Disposal ☐Others, specify:

DECUBITUS / WOUND ⇒	*Number 1*	*Number 2*	*Number 3*
Location			
(for Decubitus only) **Stage**			
(red or pink, black, green, yellow) **Wound Bed Color**			
(edematous, non-edematous) **Surrounding Tissue**			
(clear or serosanguineous, yellow, or green) **Drainage Color**			
(foul ,non-foul) **Odor**			
(L x W x Depth x Undermining, if any, & indicate the "clock" location) **Measurements**			

Medication(s) Administered during this Visit:		WOUND CARE	Date Ordered:	Date Ordered:	Date Ordered:
Drug Name:	Dose:	1. Cleansed with			
Drug Name:	Dose:	2. Irrigated with			
Drug Name:	Dose:	3. Packed with			
Route:	Site:	4. Applied with			
Route:	Site:	5. Covered with			
Route:	Site:	6. Secured with			

SKILLED NURSE VISIT NOTES ADDEDUM

DECUBITUS / WOUND⇒	***#4***	***#5***	***#6***	***#7***
Location				
(for Decubitis only) **Stage**				
(red or pink, black, green, yellow) **Wound Bed Color**				
(edematous, non-edematous) **Surrounding Tissue**				
(clear or serosanguineous, yellow, or green) **Drainage Color**				
(foul, non-foul) **Odor**				
(Do Measurement Q Week) **Measurements**				
WOUND CARE	**Date Ordered**	**Date Ordered**	**Date Ordered**	**Date Ordered**
1. Cleaned with				
2. Irrigated with				
3. Packed with				
4. Applied with				
5. Covered with				
6. Secured with				

☐ *Nursing Diagnosis/Problems Addendum:*

☐ *Skilled Interventions Addendum:*

☐ *Evaluation:*

Patient's Name:		
SN Print Name:	☐ RN ☐ LVN	Date of Visit:
SN Signature:	Time In:	Time Out: