☐ SUPERVISORY VISIT

209E ALAMEDA AVE. #203, BURBANK, CA. 91502 Ph# 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#: _____ | **SN Signature:** ______ ☐RN ☐LVN

BP: ☐Rt ☐Lt Lying _____ Sitting _____ Standing _____ | SN Name (print): _____

Temp: _____ ☐Oral ☐Axillary HR_____ ☐Radial ☐Apical | RR: _____ Weight: _____ FBS: _____ RBS_____

Last MD visit:: _____ Next MD visit::_____ | DATE: _____ TIME IN: _____ TIME OUT: _____

MENTAL STATUS	INTEGUMENTARY	NERVOUS SYSTEM	MUSCULOSKELET.	RESPIRATORY	DIGESTIVE	GENITO-URINARY
Alert ☐	Clammy ☐	Syncope ☐	Gait Unsteady ☐	Rales ☐	Nausea ☐	Burning ☐
Forgetful ☐	Chills ☐	Headache ☐	Weakness ☐	Cough ☐	Vomiting ☐	Distention ☐
Anxious ☐	Decubitus ☐	Grasp ☐	Bedbound ☐	Dyspnea ☐	Anorexia ☐	Retention ☐
Confused ☐	Wound ☐	Right: ☐	W/C Bound ☐	SOBE ☐	Colostomy ☐	Frequency ☐
Depressed ☐	Flushed ☐	Left: ☐	Assist Device:	Orthopnea ☐	Diarrhea ☐	Urgency ☐
Disoriented ☐	Jaundiced ☐	Hand Tremors ☐	**SHUNT**	Wheezing ☐	Constipated ☐	Hematuria ☐
Lethargic ☐	Pallor ☐	☐↓Motor ☐↓Sensory	AV shunt ☐	Tracheostomy ☐	Impaction ☐	Incontinent ☐
Restless ☐	Rash/Itching ☐	☐RUE ☐LUE	Groshunt ☐	On Oxygen ☐	Dysphagia ☐	Dysuria ☐
Poor cognition ☐	Poor Turgor ☐	☐RLE ☐LLE	**CARDIOVASCULAR**	Hand H Neb. ☐	Incontinent ☐	Hesitancy ☐
	Cyanosis ☐	Abnormal Pu-	Arrhythmia ☐		NG Tube ☐	Catheter Type:
SENSORY	Dry ☐	pillary Rxn: ☐	Chest Pain ☐	**ENDOCRINE**	G - Tube ☐	French No:
Poor Vision ☐	**INTRAVENOUS**	☐Rt ☐Lt	Neck V. Dist. ☐	☐ IDDM ☐ NIDDM	T.P.N. ☐	Date changed:
↓ Hearing ☐	Peripheral ☐	Tremors ☐	Edema ☐	☐ Unable to self-inject	Last B.M:	Urine: Color:
Slurred Speech ☐	Central Line ☐	Vertigo/Dizzy ☐	Location:	Insulin admin and/or	**PAIN ASSESSMENT**	
	Site		Periph. Pulse:☐N	Fingerstick by: SN ☐	Pain loc:	Pain scale (0-10):
	Site		☐↓ ☐Absent	Pcg ☐ pt ☐	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, Inc.**
☐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 ⇒	***#3***	***#4***	***#5***	***#6***
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: