

SKILLED NURSING VISIT NOTE

Patient Name: _____ MR No.: _____

Date: _____
Time In: _____ Time Out: _____

HOMEBOUND REASON: Needs assistance for all activities Residual weakness Requires assistance to ambulate
 Confusion, unable to go out of home alone Unable to safely leave home unassisted Severe SOB, SOB upon exertion
Dependent upon adaptive device(s) Medical restrictions Other (specify): _____

TYPE OF VISIT: SN Medicare
 Medicaid SN & Supervisory Suprv. Only
Other: _____

CARDIOVASCULAR <input type="checkbox"/> Chest Pain Edema: <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE <input type="checkbox"/> Abnormal Rhythm <input type="checkbox"/> Pulses <input type="checkbox"/> Anticoagulant Therapy <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____	PULMONARY <input type="checkbox"/> Lungs <input type="checkbox"/> SOB/Dysp <input type="checkbox"/> Cough <input type="checkbox"/> Sputum <input type="checkbox"/> Oxygen <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____	INTEGUMENTARY <input type="checkbox"/> Warm <input type="checkbox"/> Dry <input type="checkbox"/> Cool <input type="checkbox"/> Chills <input type="checkbox"/> Intact <input type="checkbox"/> Wound <input type="checkbox"/> Ulcer <input type="checkbox"/> Incision <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Tumor <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____	MUSCULOSKELETAL <input type="checkbox"/> Poor Balance <input type="checkbox"/> Limited Movement <input type="checkbox"/> Chair or <input type="checkbox"/> Bed Bound <input type="checkbox"/> Walks with: <input type="checkbox"/> Contracture <input type="checkbox"/> Paralysis <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____
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VITAL SIGNS and WOUND ASSESSMENT

T: _____ A: _____ G: _____ R: _____
HT: _____ WT: _____

Resp: _____ (REG/ RR)
Pulse A: _____ R: _____ (REG/ RR)

B/P	LYING	SITTING	STANDING
RIGHT			
LEFT			

REG/RR: _____ via Glucometer

GASTROINTESTINAL <input type="checkbox"/> Bowel Sounds Abdomen <input type="checkbox"/> Dist <input type="checkbox"/> Tender <input type="checkbox"/> Discolored <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> NPO <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Incontinence <input type="checkbox"/> Ostomy: <input type="checkbox"/> PEG <input type="checkbox"/> Feeding <input type="checkbox"/> Flushing <input type="checkbox"/> Last BM <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____	GENITOURINARY <input type="checkbox"/> Burning <input type="checkbox"/> Dysuria <input type="checkbox"/> Odor <input type="checkbox"/> Distention <input type="checkbox"/> Retention <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Incontinence <input type="checkbox"/> Incontinence <input type="checkbox"/> Itching <input type="checkbox"/> Color: <input type="checkbox"/> Catheter: <input type="checkbox"/> FR: <input type="checkbox"/> OC: <input type="checkbox"/> Last Changed: <input type="checkbox"/> Irrigation <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____	NEUROLOGICAL <input type="checkbox"/> Headache <input type="checkbox"/> Syncope <input type="checkbox"/> Vertigo Gang: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Movement: Pupils: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Hand Tremor <input type="checkbox"/> Aphasia <input type="checkbox"/> Dysphasia <input type="checkbox"/> Speech Impairment <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Visual Impairment <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____	MENTAL <input type="checkbox"/> Oriented X: <input type="checkbox"/> Forgetful <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input type="checkbox"/> Lethargic <input type="checkbox"/> Comatose <input type="checkbox"/> Restless <input type="checkbox"/> Agitated <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> Altered LOC <input type="checkbox"/> Impaired Memory <input type="checkbox"/> Psych HX <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____
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Remember to assess / Size of Wounds / Pressure Sores / Moles / Tattoos / Scars

	#1	#2	#3	#4
Length				
Width				
Depth				
Drainage				
Tenderness				
Other				
Sec. Rx				
Refers				
Notes				

PAIN <input type="checkbox"/> No Pain <input type="checkbox"/> Less often than DAILY <input type="checkbox"/> DAILY but not constant <input type="checkbox"/> Constant <input type="checkbox"/> Pain Level (1-10): <input type="checkbox"/> Site: Believed w. Meds: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other: _____	INTERVENTIONS <input type="checkbox"/> Skilled Assessment <input type="checkbox"/> Foley Change <input type="checkbox"/> Irrigation <input type="checkbox"/> Wound <input type="checkbox"/> Ulcer <input type="checkbox"/> Incision <input type="checkbox"/> Prep <input type="checkbox"/> Admin Insulin Injection: <input type="checkbox"/> IM <input type="checkbox"/> SQ <input type="checkbox"/> PEG <input type="checkbox"/> ST Site Care <input type="checkbox"/> Diet <input type="checkbox"/> Med Instruction <input type="checkbox"/> S/S Disease Process <input type="checkbox"/> Other: _____	TECHNIQUE(S) USED <input type="checkbox"/> Universal Precautions <input type="checkbox"/> Aseptic Technique <input type="checkbox"/> Proper Sharp Objects Disp. <input type="checkbox"/> Proper Waste Disposal <input type="checkbox"/> QC of Glucometer <input type="checkbox"/> Glucometer Caliber: <input type="checkbox"/> Other: _____	INFUSION / IV SITE <input type="checkbox"/> IV Tubing Change <input type="checkbox"/> Cap Change <input type="checkbox"/> Catheter Site Change <input type="checkbox"/> IV Site Change From: To: <input type="checkbox"/> Med: <input type="checkbox"/> Rate: <input type="checkbox"/> WA: <input type="checkbox"/> Other: _____
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CHANGE IN PATIENT CONDITION N/A

MD Notified (name): _____
Supervisor Notified: Yes No N/A
New Orders / Comments: Yes No

SKILLED INTERVENTION & TEACHING

SN ADMINISTERED _____ IM/SQ _____
(CONTINUE TO VISIT FOR: OBSERVATION ASSESS INSTRUCTIONS FOLEY WOUND CARE LABS PREP
 ADMIN INJECTION MAX TEACHING ATTAINED REINSTRUCT UNATTAINED

QUALITY CONTROL / GLUCOSE CONTROL SOLUTION N/A | RANGE: High: _____ Low: _____

Expiration Date: _____ | Date Open: _____ | Control Indicator: _____

PT/CG verbalized understanding of instructions given | Compliant with Present Prior Instructions
 PT/CG able to demonstrate correct Technique/Procedure

PT unable to: perform wound care | administer injection due to:
CG unable to: perform wound care | administer injection due to:
 No able CG available at this time to assist with:

Treatment/injection tolerated well by patient Compliant with Diet Compliant with Medication Regimen

PT ability with Oral Meds: Unable Able Demonstrates Understanding

Supplies Used: Syringes Lancets N/5 Gloves Alcohol Pads Glucometer Strips 4x4 Other: _____

Discharge Planning Discussed:

SUPERVISORY VISITS N/A LPN HHA

	Yes	No
Following Care Plan	<input type="checkbox"/>	<input type="checkbox"/>
Patient's Needs Met	<input type="checkbox"/>	<input type="checkbox"/>
Assignment Updated	<input type="checkbox"/>	<input type="checkbox"/>
Service Change Request	<input type="checkbox"/>	<input type="checkbox"/>
Show. & Safety Proc. Followed	<input type="checkbox"/>	<input type="checkbox"/>
Employee Present	<input type="checkbox"/>	<input type="checkbox"/>
Patient Satisfied With Service	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Nurse Printed Name: _____ Nurse Signature: _____ RN LPN

Sample Of Skilled Nurse Visit Note

Tao Wei



Sample Of Skilled Nurse Visit Note:

This book delves into Sample Of Skilled Nurse Visit Note. Sample Of Skilled Nurse Visit Note is an essential topic that needs to be grasped by everyone, ranging from students and scholars to the general public. The book will furnish comprehensive and in-depth insights into Sample Of Skilled Nurse Visit Note, encompassing both the fundamentals and more intricate discussions.

1. This book is structured into several chapters, namely:
 - Chapter 1: Introduction to Sample Of Skilled Nurse Visit Note
 - Chapter 2: Essential Elements of Sample Of Skilled Nurse Visit Note
 - Chapter 3: Sample Of Skilled Nurse Visit Note in Everyday Life
 - Chapter 4: Sample Of Skilled Nurse Visit Note in Specific Contexts
 - Chapter 5: Conclusion
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 6. In chapter 5, the author will draw a conclusion about Sample Of Skilled Nurse Visit Note. This chapter will summarize the key points that have been discussed throughout the book.
- The book is crafted in an easy-to-understand language and is complemented by engaging illustrations. It is highly recommended for anyone seeking to gain a comprehensive understanding of Sample Of Skilled Nurse Visit Note.

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