

# 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

☐ Chest Pain  
 Edema: ☐ RUE ☐ LUE  
☐ RLE ☐ LLE  
☐ Abnormal Rhythm  
☐ Pulses  
☐ Anticoagulant Therapy  
☐ WNL  
☐ Other:

## PULMONARY

☐ Lungs  
☐ SOB/Dysp  
☐ Cough  
☐ Sputum  
☐ Oxygen  
☐ WNL  
☐ Other:

## INTEGUMENTARY

☐ Warm ☐ Dry ☐ Cool ☐ Chills  
☐ Intact  
☐ Wound ☐ Ulcer ☐ Incision  
☐ Rash ☐ Itching  
☐ Turgor  
☐ WNL  
☐ Other:

## MUSCULOSKELETAL

☐ Poor Balance  
☐ Limited Movement  
☐ Chair or Bed Bound  
☐ Walks with:  
☐ Contracture ☐ Paralysis  
☐ WNL  
☐ Other:

## VITAL SIGNS and WOUND ASSESSMENT

T: A: E: R:  
 HT: WT:  
 Resp: ☐ REG ☐ IRR  
 Pulse: A: R: ☐ REG ☐ IRR  
 B/P: LYMING SITTING STANDING  
 RIGHT LEFT  
☐ PFS / RBS: via Glucometer

## GASTROINTESTINAL

☐ Bowel Sounds  
 Abdomen: ☐ Soft ☐ Tender  
☐ Distended  
☐ Nausea ☐ Vomiting ☐ NPO  
☐ Diarrhea ☐ Constipation  
☐ Incontinence  
☐ Ostomy:  
☐ PEG  
☐ Feeding  
☐ Flushing  
☐ Last BM  
☐ WNL  
☐ Other:

## GENITOURINARY

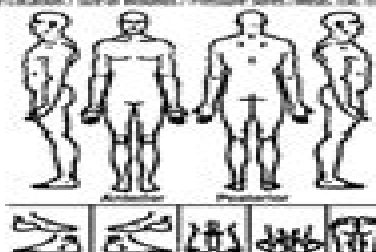
☐ Burning ☐ Dysuria ☐ Odor  
☐ Discharge ☐ Retention  
☐ Frequency ☐ Urgency  
☐ Incontinence ☐ Hesitance  
☐ Itching  
☐ Color:  
☐ Catheter:  
☐ FR: ☐ OC:  
☐ Last Changed:  
☐ Irrigation  
☐ WNL  
☐ Other:

## NEUROLOGICAL

☐ Headache  
☐ Syncope ☐ Vertigo  
☐ Gait: ☐ Equal ☐ Unequal  
☐ Movement:  
☐ Pupils: ☐ Equal ☐ Unequal  
☐ Hand Tremors  
☐ Aphasia ☐ Dysphasia  
☐ Speech Impairment  
☐ Hearing Impairment  
☐ Visual Impairment  
☐ WNL  
☐ Other:

## MENTAL

☐ Oriented X:  
☐ Forgetful ☐ Confused  
☐ Disoriented  
☐ Lethargic ☐ Comatose  
☐ Restless ☐ Agitated  
☐ Anxious ☐ Depressed  
☐ Altered LOC  
☐ Impaired Memory  
☐ Psych HX  
☐ WNL  
☐ Other:



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

## PAIN

☐ No Pain  
☐ Less often than DAILY  
☐ DAILY but not constant  
☐ Constant  
☐ Pain Level (1-10):  
☐ Site:  
 Believed w. Meds: ☐ Yes ☐ No  
☐ Other:

## INTERVENTIONS

☐ Skilled Assessment  
☐ Foley Change ☐ Irrigation  
☐ Wound ☐ Ulcer ☐ Incision  
☐ Prep ☐ Admin Insulin  
☐ Injection: ☐ IM ☐ SQ  
☐ PEG ☐ ST Site Care  
☐ Diet ☐ Med Instruction  
☐ S/S Disease Process  
☐ Other:

## TECHNIQUE(S) USED

☐ Universal Precautions  
☐ Aseptic Technique  
☐ Proper Sharp Objects Disp.  
☐ Proper Waste Disposal  
☐ QC of Glucometer  
☐ Glucometer Caliber:  
☐ Other:

## INFUSION / IV SITE

☐ IV Tubing Change  
☐ Cap Change  
☐ Catheter Site Change  
☐ IV Site Change  
 From:  
 To:  
☐ Med:  
☐ Rate:  
☐ WIA:

## SKILLED INTERVENTION & TEACHING

## SN ADMINISTERED

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/S Gloves ☐ Alcohol Pads ☐ Glucometer Strips ☐ 4x4 ☐ Other:  
☐ Discharge Planning Discussed:

## CHANGE IN PATIENT CONDITION

☐ N/A

MD Notified (name):

 Supervisor Notified: ☐ Yes ☐ No ☐ N/A

New Orders / Comments:

☐ Yes ☐ No

Nurse Printed Name:

Nurse Signature:

RN ☐ LPN ☐

# Sample Of Skilled Nurse Visit Note

**JR Anderson**



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