NURSING VISIT RECORD

Skilled Nursing Provided This Visit *(per agency policy)* ***Check one:***

- ☐ G0154 – Direct Skill
- ☐ G0163 – Observation/Assessment
- ☐ G0162 – Management/ Evaluation
- ☐ G0164 – Education/Training

Patient Name | Record #

SKILLED OBSERVATION

VITAL SIGNS
T ______
P ______
R ______
Wt ______
BP ______ right
______ left
Glucometer
BS ______
☐ Standard Precautions Maintained

CARDIOVASCULAR
☐ No Deficit ______
☐ Chest Pain ______
☐ Heart Sounds ______
☐ Peripheral Pulses ______
☐ Dizziness ______
☐ Edema ______
☐ Neck Vein Distention ______
☐ Arrhythmia ______

Comments

RESPIRATORY
☐ No Deficit ______
☐ Rale/Rhonchi ______
☐ SOB ______
☐ Cough ______
☐ Sputum ______
☐ O_2 at ______
☐ O_2 Sat ______
☐ Other ______

Comments

NEUROLOGICAL
☐ No Deficit
☐ Oriented to Pers...
Place/Time
☐ Seizures/T...rs
☐ Pupillar... action
Righ...t/Equal
SEN...Y
☐ ...ring Impaire...
☐ Sp...h Impaired
☐ Vis... Impaired
☐ Legal... lind

...U
☐ ...o Deficit
☐ ...tention
☐ ...tention
☐ Bu...
☐ ...y
☐ ...oley
☐ S...pub...
☐ ...e ... Fr
...ml

Medication change since last visit? ☐ No ☐ Yes, Specify ______
Homebound? ☐ No ☐ Yes (if yes, reason) ______

SKIN
☐ No Deficit ☐ Warm/Dry
☐ Cool/Clammy ☐ Turgor Adequate

Wound #1 Location	Wound #2 Location
L ______	L ______
W ______	W ______
D ______	D ______
DRAINAGE	DRAINAGE
Amt ______	Amt ______
Color ______	Color ______
Odor ______	Odor ______
WOUND BED	WOUND BED
Color ______	Color ______
Tissue ______	Tissue ______
Pain ______	Pain ______

☐ Wound Tx performed this visit per POC

Comments

DIGESTIVE/NUTRITION
☐ No Deficit - Last BM ______
☐ N/V ☐ Diarrhea ☐ Constipation
☐ Tube Feeding ☐ NPO
Type/Amt. ______
☐ ✓Placement ☐ ✓Residual/Amt. ______
☐ Bowel Sounds Present
☐ Abd. Girth ______
☐ Diet ______
☐ Meals Prepared & Administered Appropriately
☐ Past 24-Hour Diet Recall
☐ Adequate ☐ Inadequate

Comments

MENTAL HEALTH/AFFECT
☐ No Deficit
☐ Depressed ☐ Inappropriate B...vior
☐ Angry ☐ Lethar...

Comments

MUSCULOSKELETAL
☐ No Deficit
☐ Weakness
☐ Balance /Gait Abnormal
☐ Limited Mobility/ROM
☐ Pain
☐ Grip Strength
right ______
☐ Bedboun...
☐ Chair...d
☐ Co...cture
☐ Par...is
...sis...Device
☐ ...Pr...tions
m...ai...

Comm...

PAIN
Frequen...f Pain interf...g with p...
activity or ...vement:
☐ ... Patie...as no pain
☐ 1 ...tien...s pain that do...not interfere
w...c...y or movement
☐ 2 - Less ...e...an daily
☐ 3 - Daily, ...n...onstantly
☐ 4 - All of t...im...

...N PROFILE
P...ary Site
I...sity: 0 ... 3 4 5 ... 7 8 9 10 HIGH
Curren...n management & effectiveness:

☐ ...ain Management Teaching to patient/ ...amily *(document below)*
P...nt's pain goal:
☐ ...ess toward pain goal:

Comments

See Add...l Pain Assessment/ ...ument... (per agency policy)

...NFUSION
☐ IV Tubing Change
☐ Cap Change
☐ Central Line Dressing Change
☐ IV Site Dressing Change
☐ IV Site Change
☐ Infusion by ______ Pump
☐ Infusion

Comments

ENDOCRINE
☐ No Deficit
☐ Glucometer Reading
☐ Diabetic Skin Care
☐ Insulin Injection

Comments

SKILLED INTERV...NTION / TEA...ING .../Cg R...PONSE

Medical ...pment/Ada... Devic... Supplies use... visit:

SUPERVISION
☐ **LPN** ☐ **Aide**
☐ **Other** ______

Present on this visit?	☐ Yes	☐ No
Aide following care plan?	☐ Yes	☐ No
Courteous and polite?	☐ Yes	☐ No
Report changes in patient status to HHA?	☐ Yes	☐ No
Patient satisfied with care?	☐ Yes	☐ No
Changes made to aide care plan?	☐ Yes	☐ No
Additional instruction given during visit?	☐ Yes	☐ No

Signature:

COORDINATION / PLAN
...gress To G... ______
...itle of Teach...sed/given: ______ ☐ Instructed ☐ Pt/Cg. Verbalized Understanding ☐ Pt/Cg. Return Demonstration
Conferenced with: SN PT OT ...SS HHA (circle one) Name: ______
...arding: ______
Physician ...acted R... ______ Date/Time ______
Order C...nes: ______
Plan For N...t: ______
Discharge Planning: ______

Update to Nursing Care Plan: Problem: ______
Intervention: ______
Goal: ______

Nurse Signature & Title	**Time In**	**Time Out**	**Date**
Patient Signature			**Date**

Signature Validates Nursing Visit Date and Time

WHITE – Clinical Record **YELLOW** – Office Copy

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SAMPLE