

Carelink Health Care Services, LLC

Nursing Visit Record

Patients Name _____

Medical Record Number _____

OBSERVATION

Allergies: _____
 Medication change since last visit? ☐ No ☐ Yes, Specify _____
 Homebound? ☐ No ☐ Yes (If yes, reason) _____ Patient Lives - ☐ Alone, ☐ With Family, ☐ Non Relative

VITAL SIGNS	RESPIRATORY	SKIN		GU	CARDIOVASCULAR
☐ Temp: _____ ☐ Pulse: _____ ☐ Resp: _____ ☐ Wt: _____ ☐ BP: _____ _____ right _____ left ☐ Extremity Pulses _____ ☐ Glucometer _____ BS: _____ ☐ Universal _____ Precautions _____ Maintained _____	☐ No Deficit _____ ☐ Rale/Rhonchi _____ ☐ SOB _____ ☐ Cough _____ ☐ Sputum _____ ☐ O2 at _____ ☐ O2Sat _____ ☐ Other _____ Comments: _____ _____ _____ _____	Edema Location _____ TR 1+ 2+ 3+ 4+ ☐ Non Pitting ☐ Pitting ☐ No Deficit ☐ Warm/Dry ☐ Cool/Clammy ☐ Turgor Adequate <u>1st Wound Location</u> <u>2nd Wound Location</u> L _____ L _____ W _____ W _____ D _____ D _____ DRAINAGE DRAINAGE Amt _____ Amt _____ Color _____ Color _____ Odor _____ Odor _____	☐ No Deficit _____ ☐ Distention _____ ☐ Retention _____ ☐ Burning _____ ☐ Frequency _____ ☐ Foley cath _____ ☐ Suprapubic _____ ☐ Incontinence _____ Size _____ F _____ ml Comments: _____ _____ _____ _____	☐ No Deficit _____ ☐ Chest Pain _____ ☐ Heart Sounds _____ ☐ Peripheral Pulses _____ ☐ Dizziness _____ ☐ Edema _____ ☐ Neck Vein Distention _____ ☐ Arrhythmia _____ Comments: _____ _____ _____ _____	

MUSCULOSKELETAL	NEUROLOGICAL	DIGESTIVE/NUTRITION	PAIN
☐ No Deficit ☐ Weakness ☐ Balance/Gait Abnormal ☐ Limited Mobility/ROM ☐ Pain ☐ Grip Strength right _____ left _____ ☐ Bed bound ☐ Chair bound ☐ Contracture ☐ Paralysis ☐ Assistive/Device Fall Precautions maintained _____ _____ _____ _____	☐ No Deficit ☐ Oriented to Person / Place / Time ☐ Seizure/Tremors ☐ Pupillary Reaction Right/Left/Equal SENSORY ☐ Hearing Impaired ☐ Speech Impaired ☐ Visually Impaired ☐ Legally Blind _____ _____ _____ _____	☐ No Deficit – Last BM _____ ☐ N/V ☐ Diarrhea ☐ Constipation ☐ Tube Feeding ☐ NPO Type/Amount _____ ☐ Placement ☐ Residual/Amt. _____ ☐ Bowel Sounds Present ☐ Abd. Girth ☐ Diet ☐ Meals Prepared & Administered Appropriately ☐ Past 24-Hour Diet Recall ☐ Adequate ☐ Inadequate _____ _____ _____	Frequency of Pain interfering with patient's activity or movement: ☐ 0 - Patient has none or pain doesn't interfere with activity or movement ☐ 1 - Less than daily ☐ 2 – Daily, but not constantly ☐ 3 – All of the time PAIN PROFILE Primary Site: _____ Intensity 0 1 2 3 4 5 6 7 8 9 10 low high Current pain management & effectiveness: _____ _____ Pain Management Teaching to patient/family (document below) Patients pain goal: _____ Progress toward pain goal: _____

INTERVENTION

SUPERVISION

Reason for visit:	☐ LPN
	☐ Aide
	Present on this visit? Yes No
	Aide following care plan? Yes No
	Courteous and polite? Yes No
	Report changes in status? Yes No
	Patient satisfied with care? Yes No
Patient response to care:	Changes made to care plan? Yes No
	Additional instruction given? Yes No

GOALS / PLAN

Progress toward goals: _____
 Teaching Tools used/given: _____ ☐ Instructed ☐ Pt/Cg. Verbalized Understanding ☐ Pt/Cg. Return Demonstration
 Conference with: SN PT OT SLP MSS HHA (circle one) Name: _____ Regarding: _____

 Plan for Next Visit: _____

Patient Signature _____

Date _____

Nurse Signature & Title _____

Time In _____

Time Out _____

Date _____

Nursing Supervisor Review _____

Supervisor Name _____

Supervisor Signature _____

Date _____