Nursing Visit Record

_____ _____
Patients Name   Record Number

OBSERVATION

Allergies:_____
Medication change since last visit? □ No □ Yes, Specify_____
Homebound? □ No □ Yes (If yes, reason)_____Patient Lives - o Alone,   o With Family,   o Non Relative

VITAL SIGNS	RESPIRATORY	SKIN		GU	CARDIOVASCULAR
o Temp:_____	o No Deficit _____	Edema Location_____ TR 1+ 2+ 3+ 4+		o No Deficit	o No Deficit _____
o Pulse: _____	o Rale/Rhonchi_____	o Non Pitting o Pitting		o Distention	o Chest Pain _____
o Resp: _____	o SOB_____	o No Deficit o Warm/Dry		o Retention	o Heart Sounds _____
o Wt: _____	o Cough _____	o Cool/Clammy o Turgor Adequate		o Burning	o Peripheral Pulses _____
o BP:	o Sputum _____	1st Wound Location	2nd Wound Location	o Frequency	o Dizziness _____
_____ right	o O2 at_____			o Foleycath	o Edema _____
_____ left	o O2Sat_____	L _____	L _____	o Suprapubic	o Neck Vein Distention _____
o Extremity Pulses	o Other _____	W _____	W _____	o Incontinence	o Arrhythmia _____
_____	Comments: _____	D _____	D _____	Size _____ F	Comments: _____
o Glucometer	_____	DRAINAGE	DRAINAGE	_____ ml	_____
BS: _____	_____	Amt _____	Amt _____	Comments:	_____
o Universal	_____	Color _____	Color _____	_____	_____
Precautions	_____	Odor_____	Odor _____	_____	_____
Maintained					

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

INTERVENTION	SUPERVISION		
Reason for visit:	o LVN		
	o 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
	Changes made to care plan?	Yes	No
	Additional instruction given?	Yes	No

GOALS / PLAN

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

_____
Nurse Signature & Title   Time In   Time Out   Date

_____
Patient Signature   Date