Your Company Logo

Your Company Name
123 Company Lane
New York, NY 12345
Tel. (123) 456-7890
Fax. (123) 456-7890

NURSING VISIT REPORT

Type of Visit: ❑ Scheduled ❑ PRN Visit Time From:_____ To:_____
PATIENT: _____ ID #: _____ VISIT DATE: _____

NEW ISSUES (please check all that apply since last visit)

❑ New diagnosis ❑ New equipment in home ❑ Change in environment/caregiver
❑ S/P hospitalization ❑ Change in functional status ❑ Change in M.D.
❑ S/P fall ❑ Safety Issues ❑ Change in plan of care
❑ Change in psychosocial status ❑ Change in prescribed diet/medications ❑ Noncompliance
❑ Change in mental status ❑ Patient report of pain ❑ Maintains optimal clinical status
❑ Other Specify: _____

Home bound: ❑ Yes Qualify (if yes): ❑ DOE ❑ Unsteady Gait ❑ LE Weakness ❑ Impaired Mobility ❑ W/C bound
❑ Poor Endurance ❑ Bedbound ❑ Paralysis ❑ Use of Assistive Device ❑ Other_____
❑ No Absences from home are for social or non-medical reasons and occur more than once a week

TEMP	PULSE	RESP	BLOOD PRESSURE		WEIGHT/HEIGHT
			Right	Left	
Oral _____	Apical _____	Rate_____	Sitting _____	_____	Current _____ Lbs. ( ) Actual
Rectal _____	Radial _____	[ ] Shallow	Standing _____	_____	( ) Reported
Axilla _____	[ ] Regular	[ ] WNL	Lying _____	_____	Loss _____ Lbs.
	[ ] Irregular	[ ] Labored			Gain _____ Lbs.
		[ ] Other			

MENTAL STATUS:
❑ Alert Oriented to: _____Person _____Place _____Time
❑ Disoriented ❑ Confused ❑ Forgetful

❑ Headache ❑ Syncope ❑ Seizures ❑ Tremors of_____
❑ Visual disturbances ___OD ___ OS ___OU
❑ Speech impairment (describe) _____
❑ Other _____

SOB: ❑ Yes ❑ No Chest Pain: ❑ Yes ❑ No
Orthopnea: ❑ Yes ❑ No Palpitation: ❑ Yes ❑ No
DOE: ❑ Yes ❑ No Cyanosis: ❑ Yes ❑ No
Cough: ❑ Yes ❑ No
Productive: ❑ Yes ❑ No
Hemoptysis: ❑ Yes ❑ No
Oxygen: ❑ Yes ❑ No @___ L/min via___ continuous/prn

LUNG SOUNDS

	Right	Left
Anterior:	_____	_____
Posterior:	_____	_____

EDEMA: ❑ Yes ❑ No
Measurement if edema is present:

	RIGHT	LEFT
Calf	_____ cm	_____ cm
Ankle	_____ cm	_____ cm
Pedal	_____ cm	_____ cm

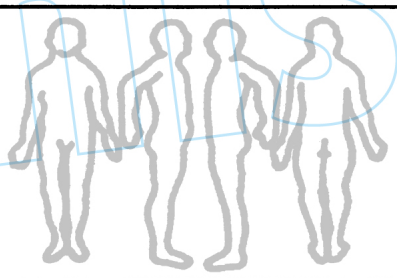
APPETITE: ❑ Good ❑ Fair ❑ Poor
Nausea: ❑ Yes ❑ No Vomiting: ❑ Yes ❑ No
Compliant with diet: ❑ Yes ❑ No
DIET CHANGE: _____
FLUID RESTRICTION OF: _____ Compliant: ❑ Yes ❑ No
BOWEL: Constipation: ❑ Yes ❑ No Diarrhea: ❑ Yes ❑ No
Last BM: _____
Incontinent: ❑ Yes ❑ No ___Day ___ Night
Other: _____

BLADDER: Incontinent: ❑ Day ❑ Night
Dysuria: ❑ Yes ❑ No Frequency: ❑ Yes ❑ No Burning: ❑ Yes ❑ No Nocturia: ❑ Yes ❑ No
❑ Foley Catheter: Date of last F/C Change: _____
❑ Catheter changed this visit:#_____French. With _____ cc balloon
❑ Suprapubic catheter: ❑ ileal conduit ❑ Nephrostomy __Left __Right

DIABETES: ❑ Yes ❑ No
FS: Actual___ Reported___ done by: ❑ Pt ❑ RN ❑ Caregiver _____
Quality Control: ❑ Reviewed ❑ Done by RN
Comment: _____

PERCIEVED PAIN LEVEL: (Circle) NO PAIN 0 1 2 3 4 5 6 7 8 9 10 MOST SEVERE PAIN
Type: _____ Location: _____ Frequency: _____
Intractable: ❑ Yes ❑ No Duration _____
Precipitated by: _____
Rx: _____
Patient response to prescribed treatment: _____

SKIN: ❑ Intact ❑ Pt. at risk for breakdown ❑ Poor turgor ❑ Swelling
❑ Dry / cracking ❑ Rash / itching ❑ Jaundice ❑ Petechiae
❑ Ecchymosis ❑ Cyanosis ❑ Redness ❑ Lesions/Infection
Comments/Other _____



Pressure ulcer/wound/incisions: ❑ Yes ❑ No Location: _____
Size: _____ cm x _____ cm x _____ cm
Drainage: ❑ Yes ❑ No _____Minimal _____Moderate _____Copious
Color _____ Odor _____
Comments/Other _____

AMBULATORY STATUS: Gait: ❑ Steady ❑ Unsteady Device: _____
Comments: _____
MEDICATION: Reviewed: ❑ Yes ❑ No Taken as per MD order: ❑ Yes ❑ No Patient demonstrates knowledge: ❑ Yes ❑ No
Change of Order/New Prescription: ❑ Yes ❑ No If yes, specify: _____
Instructed in use of: _____ ❑ Dosage ❑ Side Effects ❑ Contraindications ❑ Action ❑ Storage
Medication profile in home: ❑ Yes ❑ No ❑ Updated Adequate supply of meds: ❑ Yes ❑ No
Needs furhter Instruction in: _____
SAFETY EQUIPMENT in good repair: ❑ Yes ❑ No Specify: _____
Equipment/Supplies needed (itemize): _____