Your Company Logo

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

NURSING VISIT REPORT

PATIENT: _____ ID #: _____ VISIT DATE: _____

NURSING INTERVENTION

PERFORMANCE/ASSESSMENT OF:

- ❑ Foley catheter insertion
- ❑ Pain
- ❑ Bowel/bladder training
- ❑ Injection
- ❑ Prepour medications
- ❑ Management & eval. of POC
- ❑ Other_____
- ❑ Ambulatory Status

INSTRUCTION/SUPERVISION OF PATIENT/CAREGIVER IN:

- ❑ Medication regimen
- ❑ Diet regimen
- ❑ Use of Equipment
- ❑ Ostomy care
- ❑ Fluid restriction
- ❑ Disease process
- ❑ FS
- ❑ Tracheostomy care
- ❑ Diabetic care
- ❑ Home safety
- ❑ Wound care
- ❑ Cardiac precautions
- ❑ Skin care
- ❑ Self Breast Exam
- ❑ Self Testicular Exam
- ❑ Foley catheter care
- ❑ Standard precautions
- ❑ Transfer
- ❑ ROM
- ❑ Personal care
- ❑ 02 Safety
- ❑ Pain management
- ❑ P.E.R.S.
- ❑ Other_____

Teaching Method: ❑ Verbal ❑ Literature ❑ Audio/Video ❑ Pictorial Aids ❑ Other _____

PATIENT/CAREGIVER RESPONSE:

Verbal feedback of knowledge: _____ ❑ Good/Minimal cueing ❑ Fair/Moderate cueing ❑ Poor/Maximum cueing
Return demonstration of: _____ ❑ Good/Minimal cueing ❑ Fair/Moderate cueing ❑ Poor/Maximum cueing
Needs further instruction/intervention in: _____

PATIENT STATUS/OUTCOMES:

❑ Remains unchanged: (specify) _____
❑ Needs revised goals: (specify) _____
❑ Progressing towards goals: (specify) _____
❑ Outcome achieved: (specify) _____
Rehab potential for: _____ ❑ Good ❑ Fair ❑ Poor

COMMUNICATION: ❑ Telephone report ❑ Voice mail ❑ E-mail
❑ Office conference with _____ Date _____

REVISION IN POC: ❑ Yes ❑ No Specify (if yes): _____
Changes discussed with patient/caregiver: ❑ Yes ❑ No

ANCILLARY SERVICES: ❑ PCW ❑ HHA ❑ PRESENT ❑ NOT PRESENT
Aide Name: _____ Days / Hours: _____ Agency: _____
Follows plan of care: ❑ Yes ❑ No Patient/Caregiver Satisfaction ❑ Yes ❑ No Frequent Aide Changes ❑ Yes ❑ No
Comments: _____

INSTRUCTED/SUPERVISED IN:

❑ Standard Precautions ❑ Plan of Care ❑ TPR: Read & Record ❑ BP: Read & Record ❑ Environmental cleanliness safety ❑ Diet/Fluid Intake Preparation/Compliance
❑ Emergency procedures ❑ Patient rights and confidentiality ❑ Recognizing the client's needs/limitations ❑ Weighing Patient
❑ Personal Care:__Bathing (bed/shower/sponge) __Shampoo (sink/tub/bed) __Nail Care/Skin Care __Oral Hygiene __Toileting/Elimination (bedpad/urinal/commode)
❑ Safe Transfer/Ambulation: __ROM/Positioning __Assistive device (cane/walker/grab bars) __Hydraulic Lift __Wheelchair
❑ Other _____

Verbal feedback of knowledge: ❑ Good/Minimal cueing ❑ Fair/Moderate cueing ❑ Poor/Maximum cueing
Return demonstration: ❑ Good/Minimal cueing ❑ Fair/Moderate cueing ❑ Poor/Maximum cueing
Needs further instruction in: _____

❑ No discharge date set at present ❑ Expected discharge date: _____
Discharge Plan: _____ ❑ Plan reviewed with Pt/Caregiver/MD
Recommended referral to: ❑ PT ❑ OT ❑ RT ❑ MSW ❑ SLT ❑ RD
Additional Comments: _____

Last M.D. Visit: _____ Next M.D. Visit: _____

_____ PT/Caregiver Signature
_____ Aide Signature
_____ RN Signature

Revisit Date_____