

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

NURSING VISIT REPORT

Signature	[] Caregiver's				Relationship			
L] Patient's	[] Care	giver's					
PATIENT: M.R. #:								
DIAGNOSIS:								
Visit Date:		<u> </u>		Time in	:		Time out:	
BP	PULSES	TEMP		RR	WT	LUNG SOUNDS	PAIN	
R	Apical	O/R/A				RIGHT	Location:	
L	Radial						Severity: (1-10)	
NURSING ASSESSMENT: CARDIOVASCULAR: [] WNL								
GASTROINTESTINAL [] WNL] [] []	GENITOURINARY [] WNL [] Frequency [] Pain [] Burning [] Discharge [] Odor [] Color [] Hematuria [] Incontinence [] Catheter DIABETIC [] Inculin Adm. [] N/A Diet Adherence		
[] WNL [] Pain [] Ambulation/Gait [] Weakness [] Numbness [] Tingling [] Paralysis [] Deformities [] Amputee [] Cast Care Describe above: Is Patient receiving PT/OT=Y/N?					is	[] Insulin Adm. [] N/A Diet Adherence [] Skin Care [] Foot Care [] s/s Hypo/Hyperglycemia Blood Glucose:mg/dl [] AC [] PC MD NOTIFied: [] YES [] NO		
NEUROLOGICAL [] WNL					V [S S C	WOUND/SKIN [] Wound		
BEHAVIOR Type: [] Aggressive [] Tantrums [] NA [] Self-Mutilation [] Violent Outburst Other: Duration: Min/Sec/Hours Frequency: times per hr/day/wk Trigger:					A A M T	MENTAL HEALTH Appearance: [] Neat		
G CODES:	[] Direct Car [] Observatio [] Training 8	on & Asses						