

DATE OF VISIT _____

TIME IN _____ OUT _____

HOMEBOUND REASON: Needs assistance for all activities Residual weakness Requires assistance to ambulate
 Confusion, unable to go out of home alone Unable to safely leave home unassisted
 Severe SOB, SOB upon exertion Dependent upon adaptive device(s) Medical restrictions
 Other (specify) _____

NURSING DIAGNOSIS/PROBLEM _____

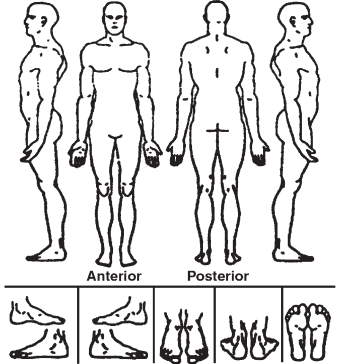
TYPE OF VISIT: SN SN & Supervisory
 Supervisory Only Other

VITALS

T° _____ Wt. _____
 Resp. _____ Reg. Irreg.
 Pulse: A _____ R _____
 Regular Irregular

B/P	LYING	SITTING	STANDING
Right			
Left			

Denote Location / Size of Wounds / Pressure Sores / Measure Ext. Edema Bil.



	#1	#2	#3	#4
Length				
Width				
Depth				
Drainage				
Tunneling				
Odor				
Sur. Tis.				
Edema				
Stoma				

NURSING ASSESSMENT AND OBSERVATION SIGNS/SYMPTOMS
 (Mark all applicable with an "X". Circle appropriate item(s) separated by "/".)

CARDIOVASCULAR	GENITOURINARY	MUSCULOSKELETAL
Fluid retention	Burning	Balance/Unsteady gait
Chest pain	Distension/Retention	Weakness
Neck vein distension	Frequency/Urgency	Other: _____
Edema (specify)- <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE	Hesitancy	NEUROSENSORY
Peripheral pulses	Hematuria	Syncope
Other: _____	Bladder incontinence	Headache
	Catheter	Grasp- Right: _____ Left: _____
	Urine- Color: _____ Consistency: _____ Odor: _____	Movement <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE
RESPIRATORY	Pain	Pupil reaction- Right: _____ Left: _____
Rales/Rhonchi/Wheeze	Discharge	Tremors
Cough	Diabetic urine testing	Vertigo
Dyspnea/SOB	Other: _____	Speech impairment
Orthopnea	SKIN	Hearing impairment
Other: _____	Color: Jaundiced	Visual impairment
DIGESTIVE	Temperature	Decreased sensitivity
Bowel sounds	Chills	Other: _____
Nausea/Vomiting	Decubitus/Wound	EMOTIONAL STATUS
Anorexia	Rash/Itching	Disoriented
Epigastric distress	Turgor	Lethargic
Difficulty swallowing	Other: _____	Oriented
Abdominal distension	PAIN	Comatose
Colostomy	Origin: _____	Forgetful
Diarrhea	Location: _____	Depressed
Constipation/Impaction	Duration: _____	Other: _____
Bowel incontinence	Intensity: (0-10): _____	
Other: _____	Other: _____	

INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X". Circle appropriate item(s) separated by "/".)

Skilled observation & assessment	Chest physio./Postural drainage	IM injection	Evaluate diet/fluid intake
Foley care	Change NG/G tube	Psych. intervention	Diet teaching
Urine testing	Admin. of vitamin B 12	Observe S/S infection	Safety factors
Wound care/dressing	Prep./Admin. insulin	Diabetic observation	Prenatal assessment
Decubitus care	Teach/Admin. IVs/Clysis	Teach diabetic care	Post-partum assessment
Venipuncture	Teach ostomy/ileo. conduit care	Observe/Teach medication (N or C) effects/side effects	Teach infant/child care
Post-cataract care	Teach/Admin. tube feedings	Physiology/Disease process teaching	Pain Management
Bowel/Bladder training	Teach/Admin. care of trach.	Observe ADLs	Other: _____
Digital exam with manual removal/ Enema	Teach/Admin. Inhalation Rx		
	Teach care - terminally ill		

ANALYSIS/INTERVENTIONS/INSTRUCTIONS/PATIENT RESPONSE _____

CARE PLAN: Reviewed/Revised with patient involvement
 Outcome achieved PRN order obtained
 PLAN FOR NEXT VISIT _____
 APPROXIMATE NEXT VISIT DATE ____/____/____
 MEDICATION STATUS: No change Order obtained
 DISCHARGE PLANNING DISCUSSED? Yes No N/A
 BILLABLE SUPPLIES RECORDED? Yes No
 CARE COORDINATION: Physician PT OT ST SS
 SN Other (specify) _____

SIGNATURE/DATE- Complete TIME OUT (above) prior to signing below.
 X _____ / _____ / _____
 Nurse (signature/title) _____ Date _____ Time _____
 Patient Signature _____ / _____ / _____
 _____ Date _____ Time _____

AIDE SUPERVISORY VISIT (Complete if applicable.)

AIDE: Present Not present
 SUPERVISORY VISIT: Scheduled Unscheduled
 AIDE CARE PLAN UPDATED? Yes No
 OBSERVATION OF _____

 TEACHING/TRAINING OF _____

 NEXT SCHEDULED SUPERVISORY VISIT ____/____/____

PART 1 - Clinical Record PART 2 - Care Coordination

PATIENT NAME - Last, First, Middle Initial _____ ID# _____

