First Community Health Services
Tel: (937)247-0400
Fax: (937)247-0575

SKILLED NURSING VISIT NOTE

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 ____________________

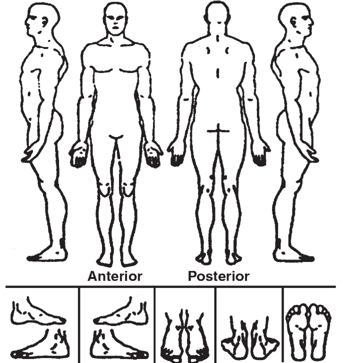
TYPE OF VISIT: ❑ SN ❑ SN & Supervisory ❑ Supervisory Only ❑ Other

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
- Fluid retention
- Chest pain
- Neck vein distension
- Edema (specify)- ❑ RUE ❑ LUE ❑ RLE ❑ LLE
- Peripheral pulses
- Other:

RESPIRATORY
- Rales/Rhonchi/Wheeze
- Cough
- Dyspnea/SOB
- Orthopnea
- Other:

DIGESTIVE
- Bowel sounds
- Nausea/Vomiting
- Anorexia
- Epigastric distress
- Difficulty swallowing
- Abdominal distension
- Colostomy
- Diarrhea
- Constipation/Impaction
- Bowel incontinence
- Other:

GENITOURINARY
- Burning
- Distension/Retention
- Frequency/Urgency
- Hesitancy
- Hematuria
- Bladder incontinence
- Catheter
- Urine- Color: ________ Consistency: ________ Odor: ________
- Pain
- Discharge
- Diabetic urine testing
- Other:

SKIN
- Color:
- Jaundiced
- Temperature
- Chills
- Decubitus/Wound
- Rash/Itching
- Turgor
- Other:

PAIN
- Origin:
- Location:
- Duration:
- Intensity: (0-10):
- Other:

MUSCULOSKELETAL
- Balance/Unsteady gait
- Weakness
- Other:

NEUROSENSORY
- Syncope
- Headache
- Grasp- Right: ________ Left: ________
- Movement ❑ RUE ❑ LUE ❑ RLE ❑ LLE
- Pupil reaction- Right: ________ Left: ________
- Tremors
- Vertigo
- Speech impairment
- Hearing impairment
- Visual impairment
- Decreased sensitivity
- Other:

EMOTIONAL STATUS
- Disoriented
- Lethargic
- Agitated
- Oriented
- Comatose
- Forgetful
- Depressed
- Other:

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

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

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*

Patient Signature/Date ____________________ ______/______/______

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#

Critical Note

☐Home Visit Follow Up

☐Care Coordination ☐Other________________
(Check Below) Page____ of ____

Date/Time	ENTER NAME TITLE DATE AND TIME FOR EACH ENTRY

COORNITATION OF CARE (if applicable): ☐Physician ☐RN/LPN ☐Aide ☐PT ☐OT ☐Community Resource ☐Other (specify)_______________________________

Part 1 – Clinical Record	Part 2 – Care Coordination
Patient Name- Last, First, Middle Initial	ID #: