

NURSING VISIT SUMMARY

PATIENT NAME _____ PATIENT SIGNATURE _____ VISIT DATE ____/____/____
 TIME IN: _____ am/pm TIME OUT: _____ am/pm TOTAL TIME: _____ HRS

Therapy: <input type="checkbox"/> ABX <input type="checkbox"/> TPN <input type="checkbox"/> IVIG <input type="checkbox"/> Steroids <input type="checkbox"/> SCIG <input type="checkbox"/> Other _____ Delivery via: <input type="checkbox"/> Gravity <input type="checkbox"/> Pump: <input type="checkbox"/> CAAD <input type="checkbox"/> BODYGUARD <input type="checkbox"/> CURLIN <input type="checkbox"/> OTHER	<input type="checkbox"/> Scheduled <input type="checkbox"/> Unscheduled REASON FOR VISIT: <input type="checkbox"/> Instruction <input type="checkbox"/> Lab Draw <input type="checkbox"/> Assessment <input type="checkbox"/> IV re-start <input type="checkbox"/> Line Care <input type="checkbox"/> Port Access <input type="checkbox"/> Medication Admin.	Vital signs: BP ____/____ Pulse ____ RR ____ Temp ____ Weight ____
NEURO/PSYCH <input type="checkbox"/> WDL: A&O x 3, speech spontaneous; denies anxiety, depression, headache, blurred vision, dizziness, tremors, numbness, tingling. <input type="checkbox"/> WDL except deviations noted→		<input type="checkbox"/> lethargic <input type="checkbox"/> sluggish <input type="checkbox"/> confusion <input type="checkbox"/> restlessness <input type="checkbox"/> memory loss <input type="checkbox"/> difficulty concentrating <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed, hopeless
CARDIOVASCULAR <input type="checkbox"/> WDL: HR and rhythm regular, denies chest pain & palpitations, skin warm & dry. + pulses in all extremities, no edema. <input type="checkbox"/> WDL except deviations noted→		<input type="checkbox"/> Irregular HR <input type="checkbox"/> Edema <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> +4 Location _____ <input type="checkbox"/> Peripheral pulse(s) not palpable (specify) _____ <input type="checkbox"/> Extremities equal in color, temperature and sensation
RESPIRATORY <input type="checkbox"/> WDL: Regular rate depth and pattern, no cough or shortness of breath; breath sounds equal and clear. <input type="checkbox"/> WDL except deviations noted→		<input type="checkbox"/> adventitious lung sounds <input type="checkbox"/> crackles wheezes <input type="checkbox"/> diminished <input type="checkbox"/> short of breath at rest/exertion <input type="checkbox"/> use of supplemental oxygen ____ L <input type="checkbox"/> cough <input type="checkbox"/> productive <input type="checkbox"/> dry <input type="checkbox"/> persistent
GASTROINTESTINAL <input type="checkbox"/> WDL: Appears well nourished, regular stool pattern, BS present in 4 quadrants, abdomen soft/NT, good appetite. <input type="checkbox"/> WDL except deviations noted→		<input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> heartburn <input type="checkbox"/> fair appetite <input type="checkbox"/> poor appetite <input type="checkbox"/> <input type="checkbox"/> abdomen firm to palpitation <input type="checkbox"/> distended abdomen <input type="checkbox"/> incontinence
GENITOURINARY <input type="checkbox"/> WDL: no abnormalities in voiding/ability to empty bladder, color or characteristics of urine <input type="checkbox"/> WDL except deviations noted→		<input type="checkbox"/> urgency <input type="checkbox"/> dysuria <input type="checkbox"/> nocturia <input type="checkbox"/> oliguria <input type="checkbox"/> urinary frequency <input type="checkbox"/> urine odor <input type="checkbox"/> incontinence <input type="checkbox"/> cloudy <input type="checkbox"/> hematuria
MUSKOSKELETAL <input type="checkbox"/> WDL: no swelling or tenderness in joints; no overt deficits noted, full active movement of all extremities. Not at risk for falls; no recent falls. <input type="checkbox"/> WDL except deviations noted→		<input type="checkbox"/> unsteady gait <input type="checkbox"/> impaired ROM <input type="checkbox"/> weakness <input type="checkbox"/> requires assistance to ambulate <input type="checkbox"/> to transfer OOB/OOC <input type="checkbox"/> ambulatory assist drives <input type="checkbox"/> walker <input type="checkbox"/> crutches <input type="checkbox"/> cane <input type="checkbox"/> wheelchair <input type="checkbox"/> Fall prevention reinforcement
SKIN <input type="checkbox"/> WDL: No skin breakdown noted, color consistent with ethnicity. No abnormalities in temperature, moisture, turgor. <input type="checkbox"/> WDL except deviations noted→		<input type="checkbox"/> dry skin <input type="checkbox"/> dry mucus membranes <input type="checkbox"/> discoloration: location _____ <input type="checkbox"/> skin breakdown: describe _____ <input type="checkbox"/> incision, location & description _____
PAIN/COMFORT <input type="checkbox"/> Denies pain <input type="checkbox"/> Pain currently present→ <input type="checkbox"/> Pain experienced since last visit→		Pain location _____ relief measures _____ Precipitating factors _____ Quality/description _____ Radiates _____ Severity <input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-10 Timing: onset, frequency, duration _____
ENDOCRINE <input type="checkbox"/> N/A if no history of diabetes <input type="checkbox"/> WDL: Glucose well controlled. No episodes of hypoglycemia or hyperglycemia		<input type="checkbox"/> Last FS _____ <input type="checkbox"/> FS Range _____
<input type="checkbox"/> Medication Changes, see nursing notes for changes <input type="checkbox"/> N/A		<input type="checkbox"/> Medication profile updated <input type="checkbox"/> Pharmacy/Agency notified
ACCESS DEVICE CARE: <input type="checkbox"/> PIV <input type="checkbox"/> Port <input type="checkbox"/> Tunneled Catheter <input type="checkbox"/> PICC <input type="checkbox"/> Midline <input type="checkbox"/> SC Line Brand _____ Length _____ Gauge _____ Internal length _____ cm Access Location _____ Date Placed ____/____/____	Exact Cath Measurement _____ cm Arm circ, 2" above site _____ cm <input type="checkbox"/> Dressing CDI <input type="checkbox"/> + blood return <input type="checkbox"/> patient No. of lumens _____ <input type="checkbox"/> Sutures intact x _____ <input type="checkbox"/> flush: saline _____ ml Heparin _____ units _____ ml <input type="checkbox"/> n/a	<input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Redness <input type="checkbox"/> Drainage <input type="checkbox"/> Occluded <input type="checkbox"/> Swelling <input type="checkbox"/> Cording <input type="checkbox"/> Tenderness <input type="checkbox"/> Flinching
LABS DRAWN <input type="checkbox"/> → <input type="checkbox"/> N/A		<input type="checkbox"/> Sterile site care: <input type="checkbox"/> Chlorhexidine <input type="checkbox"/> Alcohol/betadine <input type="checkbox"/> Skin prep <input type="checkbox"/> Steri-strips <input type="checkbox"/> Biopatch <input type="checkbox"/> Securement device <input type="checkbox"/> Tegaderm <input type="checkbox"/> Sorbaview <input type="checkbox"/> Opsite <input type="checkbox"/> Gauze/tape dressing <input type="checkbox"/> Other _____ <input type="checkbox"/> Cap Change x _____ <input type="checkbox"/> Extension tubing change x _____ Access insertion x _____ attempts
Medications Administered: Pre-Meds _____ Include drug, dose, diluent, rate, infusion time: _____ MEDICATION _____ MEDICATION _____ MEDICATION _____		Peripheral site _____ Central Line draw _____ Processing lab _____ X _____ attempts Administered by: <input type="checkbox"/> Patient <input type="checkbox"/> RN <input type="checkbox"/> Caregiver TIME: _____ TIME: _____ TIME: _____
<input type="checkbox"/> PATIENT EDUCATION PROVIDED <input type="checkbox"/> Medication management (specify) _____ <input type="checkbox"/> Access device care <input type="checkbox"/> Nutrition <input type="checkbox"/> Safety enhancement <input type="checkbox"/> Bag change <input type="checkbox"/> Infection control <input type="checkbox"/> Aseptic technique, hand washing <input type="checkbox"/> Pump alarms and troubleshooting <input type="checkbox"/> Hydration <input type="checkbox"/> Disease process <input type="checkbox"/> Pain management <input type="checkbox"/> other _____		
Next Nursing Visit ____/____/____ RN Name, credentials _____ RN Signature _____		