

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **MRN:** \_\_\_\_\_

\*NPA = No Problem Assessed ☐ Patient ID Verified ☐ Homebound **Visit Type:** ☐ Home ☐ ATS ☐ PRN ☐ Other:

<b>B/P:</b> _____ <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> Sitting <input type="checkbox"/> Lying <input type="checkbox"/> Standing	<b>Temp:</b> _____ <input type="checkbox"/> PO <input type="checkbox"/> Ax <input type="checkbox"/> Other: _____	<b>Heart Rate:</b> _____	<b>Resp:</b> _____	<b>Weight:</b> _____	<b>Date:</b> _____
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**Psychosocial Status:** ☐ NPA ☐ Alert ☐ Lethargic ☐ Unresponsive ☐ Flat Affect ☐ Agitated ☐ Anxious ☐ Confused  
**Communication Issues:** ☐ NPA ☐ Vision ☐ Hearing ☐ Language/Literacy ☐ Speech **Memory:** ☐ N/A ☐ Good ☐ Fair ☐ Poor  
**Oriented To:** ☐ N/A ☐ Person ☐ Place ☐ Time **Comments:** \_\_\_\_\_

**Cardiovascular:** ☐ NPA ☐ Tachycardia ☐ Bradycardia ☐ Cyanosis ☐ Pallor ☐ Abnormal Heart Sounds ☐ Abnormal Heart Rhythm  
☐ Capillary Refill > 3 seconds **Peripheral Pulses:** ☐ Present ☐ Absent **Location:** \_\_\_\_\_  
☐ Edema ☐ Pitting – **Location / Amount:** \_\_\_\_\_ **Comment:** \_\_\_\_\_

**Respiratory:** ☐ NPA ☐ Diminished ☐ Wheezes ☐ Stridor ☐ Rhonchi ☐ Crackles: ☐ Course ☐ Fine ☐ Nasal-Flare  
☐ Dyspnea: ☐ On Exertion ☐ At Rest ☐ Tachypnea ☐ Orthopnea ☐ Retractions – **Location:** \_\_\_\_\_ ☐ Apnea Monitoring  
☐ Oxygen \_\_\_\_\_ LPM ☐ Continuous ☐ Intermittent ☐ N/C ☐ Mask ☐ Cough: ☐ Productive ☐ Non-Productive  
**Comments:** \_\_\_\_\_

**G.I.:** ☐ NPA ☐ Nausea ☐ Vomiting ☐ Dysphagia ☐ Constipation ☐ Diarrhea ☐ Abd. Distended ☐ Abd. Girth \_\_\_\_\_ cm **Bowel Sounds:** ☐ Yes ☐ No  
☐ Bleeding # Stools/Day: \_\_\_\_\_ **Diet:** \_\_\_\_\_ ☐ Breast Fed ☐ Bottle Fed **Appetite:** ☐ Good ☐ Fair ☐ Poor  
☐ Enteral: Tube: \_\_\_\_\_ Formula: \_\_\_\_\_ ☐ Intermittent – Volume/Rate/Frequency: \_\_\_\_\_  
☐ Continuous – Rate/Interval: \_\_\_\_\_ ☐ Wt. Gain/Loss: \_\_\_\_\_ lbs ☐ Ostomy: \_\_\_\_\_

**Date LBM:** \_\_\_\_\_ **Comments:** \_\_\_\_\_

**G.U.:** ☐ NPA ☐ Frequency ☐ Urgency ☐ Retention ☐ Incontinence ☐ Dysuria ☐ Hematuria **# of wet diapers/day:** \_\_\_\_\_  
**Catheter:** ☐ Indwelling ☐ Intermittent ☐ External ☐ Date placed: \_\_\_\_\_  
**Comments:** \_\_\_\_\_

**Neuromuscular:** ☐ NPA ☐ Headache ☐ Paresis ☐ Tremors ☐ Seizures ☐ Vertigo ☐ Ataxia ☐ Alt. Level of Consciousness  
☐ Paralysis ☐ Spasticity ☐ Flaccidity ☐ Joint Swelling ☐ Joint Stiffness  
☐ Sensory Alteration: \_\_\_\_\_ ☐ Head Circumference: \_\_\_\_\_ ☐ Fontanels: ☐ Bulging ☐ Sunken  
**Comments:** \_\_\_\_\_

**Integumentary:** ☐ NPA ☐ Dry ☐ Diaphoretic ☐ Pale ☐ Turgor Poor ☐ Rash ☐ Pruritus ☐ Petechiae ☐ Jaundice ☐ Birthmark ☐ Bruises  
☐ Abrasion ☐ Incision ☐ Staples ☐ Sutures ☐ Laceration ☐ Pressure Ulcer ☐ Burns ☐ Patient/Caregiver Independent with Wound Care  
☐ Wound Managed by: ☐ Wound Clinic ☐ MD Office ☐ Other HHA: \_\_\_\_\_  
☐ SN Performing Wound Care/Assessment (see Wound Addendum) ☐ SN treating active Bleed (see Bleeding Disorder Addendum)  
**Comments:** \_\_\_\_\_

**Endocrine:** ☐ NPA ☐ Diabetes – Type: \_\_\_\_\_ ☐ Current FSBS: \_\_\_\_\_ ☐ Thyroid Disorder ☐ Adrenal Disorder  
**Comments:** \_\_\_\_\_

**Pain:** ☐ NPA **Current Pain Level (0 - 10):** \_\_\_\_\_ **Location:** \_\_\_\_\_ **Acceptable Pain Level (0 - 10):** \_\_\_\_\_  
**Pain Description:** \_\_\_\_\_  
**Relief Measures:** \_\_\_\_\_  
**Pain Controlled?** ☐ Yes ☐ No\* **\*Intervention:** \_\_\_\_\_



**Instructed:** ☐ Patient ☐ Caregiver – Specify: \_\_\_\_\_ **Action:** ☐ Introduced ☐ Continued  
**Subject:** \_\_\_\_\_ **Participation:** ☐ Verbal ☐ Demo  
**Patient / Caregiver Level of Understanding:** ☐ Partial ☐ Complete **Patient/Caregiver Independent in Therapy:** ☐ Yes ☐ No  
**Comments:** \_\_\_\_\_

#### Response to Therapy

<b>Patient response to therapy:</b> <input type="checkbox"/> Improved <input type="checkbox"/> No Change <input type="checkbox"/> Worsening* <b>*Reason/New Problem:</b> _____ <b>Progress towards goals:</b> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor* <b>Reason*:</b> _____ <b>Changes requiring update in Plan of Treatment (POT):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>POT revised with Patient /Caregiver involvement?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Compliant with therapy:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No* <b>Reason*:</b> _____	<b>Patient/Caregiver able to provide Tx:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No* <b>Reason*:</b> _____ <b>Patient/Caregiver response to Service/Care:</b> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor* <b>Reason*:</b> _____ <b>SN Required to administer Tx:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Patient/Caregiver needs met:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No* <b>Reason*:</b> _____
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**Nurse Initials:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **MRN:** \_\_\_\_\_

**Developmental / Behavioral**

**Age-Appropriate / Milestones met:** ☐ Yes ☐ No\*

\*Explain: \_\_\_\_\_

**Appropriate bonding with Caregiver:** ☐ Yes ☐ No\*

\*Explain: \_\_\_\_\_

☐ Change/Regression In Development Since Last Visit

☐ Developmental Delay: \_\_\_\_\_

☐ Learning Disability: \_\_\_\_\_

Comments: \_\_\_\_\_

**Access:** ☐ N/A

☐ Peripheral IV start - Attempts x \_\_\_\_\_ ☐ Peripheral line in place Gauge: \_\_\_\_\_ Length: \_\_\_\_\_ Date/Location: \_\_\_\_\_

☐ PICC or ☐ Midline Site: \_\_\_\_\_ Type: \_\_\_\_\_ Lumens: \_\_\_\_\_

Ext. catheter length: \_\_\_\_\_ cm ☐ Arm Circumference: \_\_\_\_\_ cm Measurement: 4cm or \_\_\_\_\_ cm above insertion site.

☐ CVAD Site: \_\_\_\_\_ Type: \_\_\_\_\_ Lumens: \_\_\_\_\_ ☐ Tunneled ☐ Non-tunneled

☐ Accessed Port this SNV ☐ Port access in place: Non-coring needle size: \_\_\_\_\_ gauge \_\_\_\_\_ inch ☐ Port de-accessed

☐ Subcutaneous ☐ NGT / GT / JT Location: \_\_\_\_\_ Type: \_\_\_\_\_ ☐ Other: \_\_\_\_\_

Access site clean/dry & free of s/sx infection ☐ Yes ☐ No - Describe: \_\_\_\_\_

☐ Access discontinued – Reason: ☐ Site rotation ☐ Infiltration ☐ Erythema ☐ Leak ☐ Occlusion ☐ Thrombosis ☐ Infusion complete

☐ Therapy concluded ☐ Prescriber order Comments: \_\_\_\_\_

**Dressing / Flush:** Access Dressing Change: ☐ N/A

☐ Access flush pre/post med: \_\_\_\_\_ ml of ☐ NS ☐ D5W

Access flush pre/post lab: ☐ \_\_\_\_\_ ml NS ☐ Access flush for maintenance: ☐ NS \_\_\_\_\_ ml ☐ Heparin: \_\_\_\_\_ ml

Antiseptic Agent: ☐ 3 Alcohol ☐ 3 Betadine ☐ Chloraprep ☐ Other: \_\_\_\_\_

Dressing: ☐ Transparent ☐ Gauze & tape ☐ Other: \_\_\_\_\_ ☐ Antibacterial dressing changed

☐ Securement device changed ☐ Needleless connector changed x \_\_\_\_\_ Lumens ☐ Extension tubing changed x \_\_\_\_\_ Lumens

**Lab Work:** ☐ N/A ☐ BMP ☐ CMP ☐ Pro-time ☐ ESR ☐ Trough ☐ Peak ☐ CBC ☐ Other: \_\_\_\_\_

Specimen obtained from: ☐ Peripheral Venipuncture ☐ Venous Access Device \_\_\_\_\_ ml blood discarded

Specimen delivered to: \_\_\_\_\_

**INFUSION RECORD**

☐ N/A

☐ Rx Properly Stored ☐ Anaphylaxis Kit Expiration: \_\_\_\_\_ ☐ N/A

**Medication:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Volume:** \_\_\_\_\_

**Medication:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Volume:** \_\_\_\_\_

**Method of administration:** ☐ IVP ☐ INJ ☐ Gravity-Flow Controlled ☐ Pump ☐ Disp. Pump ☐ Other: \_\_\_\_\_

**Pump Program #1:** \_\_\_\_\_ **Pump Program #2:** \_\_\_\_\_

**Factor:** Lot #: \_\_\_\_\_ **Exp. Date:** \_\_\_\_\_ **Labeling checked with orders:** SN initial \_\_\_\_\_

☐ Pre-medication (dose & time): \_\_\_\_\_

TIME	TEMP.	PULSE	RESP.	B/P	RATE	(Patient status / condition / comments)

☐ Medication Profile reviewed: ☐ No Changes ☐ Updated ☐ Inventory completed: ☐ Adequate supplies ☐ Ordering

☐ Discharge Plan discussed with patient/caregiver. Plan for next visit: \_\_\_\_\_

Communication with: ☐ MD ☐ RPh ☐ Other: \_\_\_\_\_

Skilled Intervention Note: \_\_\_\_\_

**Patient Visit Time:** Start: \_\_\_\_\_ End: \_\_\_\_\_ **Lab Time:** Start: \_\_\_\_\_ End: \_\_\_\_\_ **Total Time:** \_\_\_\_\_

Nurse Printed Name

Nurse Signature

Date

Patient/Representative Signature: \_\_\_\_\_