bio scrip®

Routine Nursing Visit Assessment Note/Care Plan **Form CLIN-GEN025-1**

Patient Name: _____ **DOB:** _____ **Time In:** _____ **Time Out:**_____ **Date:** _____

Reason for Visit (check all that apply): ◻ Assessment ◻ Teach ◻ Line Insertion ◻ Dressing Change ◻ Blood Draw
◻ Medication Administration ◻ Other: _____
◻ Scheduled Visit ◻ Unscheduled Visit ◻ Discharge
Patient/Caregiver Status: ◻ Cooperative ◻ Difficulty Coping ◻ Able ◻ Willing ◻ Available ◻ No Change
WT: _____ BP: _____/_____ TEMP: _____ PULSE: AP_____ PULSE: RP_____ RESP: _____

Neuromuscular ◻ Alert ◻ Confused ◻ Lethargic ◻ Forgetful ◻ Oriented ◻ Disoriented PERLA: ◻ Yes ◻ No
◻ Other: _____ Mobility: _____
Have you fallen since our last visit? ◻ Yes ◻ No
Comments: _____

Cardiac Chest Pain: ◻ None ◻ Yes, describe_____
Heart Sounds: ◻ WNL ◻ Abnormal Edema: ◻ None ◻ Yes, where _____
Pulses: ◻ Regular ◻ Irregular ◻ Quality_____
Comments:_____

Respiratory ◻ Normal ◻ Dyspnea ◻ At Rest ◻ With Exertion
Lung Sounds: _____
Cough: _____ Sputum: _____
Oxygen Use: Liters for hrs/day Comments:

GI Bowels _____ LBM _____ ◻ Normal-no issues noted
Bowel Regime _____
◻ Nausea ◻ Vomiting ◻ Diarrhea Color _____ Frequency _____
Abdomen _____
Bowel Sounds: ◻ None ◻ Hypo ◻ Normal ◻ Hyper Stoma _____
Comments: _____

Genitourinary Voiding pattern _____ Frequency/day:_____
◻ Normal ◻ Incontinent ◻ Retention ◻ Nocturia ◻ Burning ◻ Pain ◻ Frequency
Urine: ◻ Clear ◻ Cloudy ◻ Sediment ◻ Hematuria
Catheter: Size _____ Balloon _____ Change Date _____
Comments: _____

Nutrition Change in Nutritional Status: ◻ Yes ◻ No Diet Type: _____
Oral supplements consumed: Name_____ Amt/Day_____
Loss/gain weight _____lbs in_____day/week
Enteral Tube Feeding: ◻ N/A ◻ Present Rate_____ Pump_____
Change in formula, regimen, administration: ◻ No ◻ Yes, Explain_____
Tolerating: ◻ Yes ◻ No, Explain_____
Parenteral: Total Vol/day_____ml _____days/week _____hrs/day
Signs /symptoms of hyper/hypoglycemia ◻ No ◻ Yes, explain_____
Signs/symptoms of fluid intolerance: ◻ No ◻ Yes, explain_____
Other: _____

Skin Color_____ Integrity_____
Wound/Decub: Location_____ Size/Depth_____
Stage ◻ I ◻ II ◻ III ◻ IV Drainage (Color, Odor, Amount)_____
Comments: _____

Rest Comfort Comfort Assessed: ◻ No problems ◻ Pain Location_____
Rest Assessed: ◻ No problems ◻ Concern:_____
Level Scale 0-10 _____ ◻ Quality ◻ Dull ◻ Sharp ◻ Gnawing ◻ Stabbing ◻ Throbbing
Frequency: ◻ Sporadic ◻ Constant ◻ With Activity
Pain Medication (dose and freq.)_____ Effective: ◻ Yes ◻ No

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Access Access Type_____ Brand _____
Size _____ # of Lumens _____ Location: _____
Site Assessment: ◻ Unremarkable ◻ Red ◻ Drainage ◻ Pain ◻ Edema ◻ Ecchymosis ◻ Sutures Intact
Existing Dressing as found: ◻ Change ◻ Intact ◻ Dry Other_____
◻ Transparent ◻ Gauze ◻ Antimicrobial disc ◻ Locking Device_____
Date dressing last changed _____ External Length _____cm Arm circumference 10 cm from site: _____cm
Comments:_____

Skilled Care Plan Interventions: (Check all that apply and describe)
◻ Teach _____
◻ Reviewed side effects of Medications Supplied by the Company ◻ Yes ◻ No
◻ Dressing Change: ◻ Injection Cap ◻ Extension ◻ Securement device ◻ Antimicrobial disc ◻ Transparent ◻ Gauze
◻ Labs Drawn: _____
Drawn from _____ Delivered to _____
◻Catheter Insertion: Access Type_____ Brand _____
Size _____ # of Lumens _____ Length: _____
Insertion Site _____ # of Attempts _____
◻ Medication Administration: Name of Medication:_____ Diluent/Vol: _____
_____ml (Total Volume) _____mg/ml (Concentration) ◻_____rate/hr or ◻IV push Given over _____
Bolus given _____
Begin time: _____ Pump/Method of Administration: _____
Flush ◻ _____ml NS ◻ _____ml D5W ◻Pre ◻Post _____units/ml_____ml heparin ◻Post
◻Patient independent with Infusion
◻Other Skilled Assessments and Interventions: _____
_____
Comments: _____
_____

Diagnosis: _____
Ongoing Therapy Progress Towards Goals:
_____
_____
_____
_____
_____
_____

Medication Profile Change: ◻No ◻Yes, list _____
_____
Reviewed POT and Orders Current ◻ Yes ◻ No, Physician to be contacted
Next Physician Visit: _____ **Last Physician Visit:** _____
Next RN Visit:_____

Patient Signature: _____ **Date:** _____
(If required by ins.)

Nurse Signature: _____ **Date**_____

Name of Dispensing Pharmacy: _____

