

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

Patient Name: _____ DOB: _____ Date: _____

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: _____