option care™

Clinical Note - Adult

Patient Name: _____ **DOB:** _____ **MRN:** _____

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

B/P: _____ ☐ RA ☐ LA ☐ Sitting ☐ Lying ☐ Standing	**Temp:** _____ ☐ PO ☐ Ax ☐ Other: _____	**Heart Rate:**	**Resp:**	**Weight:**	**Date:**

Psychosocial Status: ☐ NPA ☐ Alert ☐ Lethargic ☐ Unresponsive ☐ Flat Affect ☐ Agitated ☐ Anxious ☐ Confused

Communication Issues: ☐ NPA ☐ Vision ☐ Hearing ☐ Language/Literacy ☐ Speech **Memory:** ☐ Good ☐ Fair ☐ Poor

Oriented To: ☐ Person ☐ Place ☐ Time Comments: _____

Cardiovascular: ☐ NPA ☐ Palpitations ☐ Tachycardia ☐ Bradycardia ☐ Angina ☐ Abnormal Heart Sounds ☐ Abnormal Heart Rhythm

☐ Cap refill > 3 sec. ☐ Neck vein distension **Peripheral Pulses:** ☐ Present ☐ Absent Location: _____

☐ Edema ☐ Pitting - Location / Amount: _____ Comments: _____

Respiratory: ☐ NPA ☐ Diminished ☐ Wheezes ☐ Stridor ☐ Rhonchi ☐ Crackles: ☐ Course ☐ Fine ☐ Cough: ☐ Productive ☐ Non-Prod.

☐ Dyspnea: ☐ On Exertion ☐ At Rest ☐ Tachypnea ☐ Orthopnea ☐ Oxygen _____ LPM ☐ Continuous ☐ Intermittent ☐ NC ☐ Mask

Comments: _____

G.I.: ☐ NPA ☐ Nausea ☐ Vomiting ☐ Dysphagia ☐ Constipation ☐ Diarrhea ☐ Abd. Distended ☐ Bleeding **Bowel Sounds:** ☐ Yes ☐ No

Diet: _____ **Appetite:** ☐ Good ☐ Fair ☐ Poor ☐ Wt. Gain/Loss: _____ lbs

☐ Enteral: Tube: _____ Formula: _____ ☐ Intermittent - Volume/Rate/Frequency: _____

☐ Continuous - Rate/Interval: _____ ☐ 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 ☐ ROM Loss ☐ Joint Swelling ☐ Joint Stiffness ☐ Sensory Alteration: _____

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

Pregnant: ☐ Yes ☐ No 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

Patient response to therapy: ☐ Improved ☐ No Change ☐ Worsening*

*Reason/New Problem: _____

Progress towards goals: ☐ Good ☐ Fair ☐ Poor*

Reason*: _____

Changes requiring update in Plan of Treatment (POT): ☐ Yes ☐ No

POT revised with Patient /Caregiver involvement? ☐ Yes ☐ No

Compliant with therapy: ☐ Yes ☐ No*

Reason*: _____

Patient/Caregiver able to provide Tx: ☐ Yes ☐ No*

Reason*: _____

Patient/Caregiver response to Service/Care: ☐ Good ☐ Fair ☐ Poor*

Reason*: _____

SN Required to administer Tx: ☐ Yes ☐ No

Patient/Caregiver needs met: ☐ Yes ☐ No*

Reason*: _____

Nurse Initials: _____

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Clinical Note - Adult (cont.)

Patient Name: _____ **MRN:** _____

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

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: _____

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