NURSING VISIT RECORD

Skilled Nursing Provided This Visit *(per agency policy)* ***Check one:***

- ☐ G0162 – Management/Evaluation
- ☐ G0493 – Observation/Assessment (RN)
- ☐ G0494 – Observation/Assessment (LPN)
- ☐ G0495 – Training/Education (RN)
- ☐ G0496 – Training/Education (LPN)
- ☐ G0299 – Direct Skill (RN)
- ☐ G0300 – Direct Skill (LPN)

Patient Name	Record #

SKILLED OBSERVATION

VITAL SIGNS
T ______
P ______
R ______
Wt ______
BP ______ right
______ left
Glucometer
BS ______
☐ Standard Precautions Maintained

CARDIOVASCULAR
☐ No Deficit
☐ Chest Pain: ______
☐ Heart Sounds: ☐ Reg ☐ Irreg ☐ Reg/Irreg
☐ Peripheral Pulses: ☐ Present ☐ Absent ☐ Faint
☐ Dizziness: ______
☐ Edema: ☐ +1 ☐ +2 ☐ +3 ☐ +4
☐ Site: ______ ☐ Non-Pitting Site: ______
☐ Neck Vein Distention: ______
☐ Tachycardia ☐ Bradycardia
☐ Poor Capillary Refill
☐ Other: ______
Comments

RESPIRATORY
☐ No Deficit
☐ Rale ☐ Rhonchi
☐ SOB ______
☐ Cough: ☐ Non-Productive ☐ Productive
☐ Sputum ______
☐ O_2 at ______
☐ O_2 Sat ______
☐ Hemoptysis ☐ Cyanosis ☐ Orthopnea
☐ Other: ______
Comments

NEUROLOGICAL
☐ No Deficit
☐ Seizures ☐ Tremors
☐ Pupillary Reaction:
☐ Right ☐ Left
☐ Equal

SENSORY
☐ Hearing Impaired
☐ Speech Impaired:
☐ Slurred
☐ Visually Impaired
☐ Legally Blind

GU
☐ No Deficit
☐ Distention
☐ Retention
☐ Burning
☐ Frequency
☐ Hematuria ☐ Oliguria
☐ Polyuria
☐ Foleycath ☐ Suprapubic
☐ Size ______ Fr
______ mL

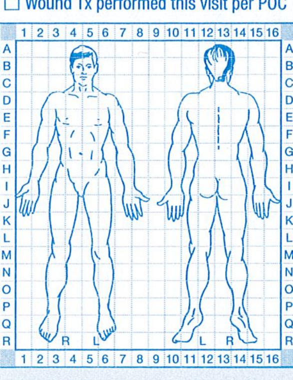
Medication change since last visit? ☐ No ☐ Yes, Specify ______
Homebound? ☐ No ☐ Yes (if yes, reason) ______

☐ See Additional Wound Assessment/ Documentation (per agency policy)
Refer to:

SKIN
☐ No Deficit ☐ Warm/Dry
☐ Cool/Clammy ☐ Turgor Adequate

Wound #1	Wound #2
Location ______	Location ______
L ______	L ______
W ______	W ______
D ______	D ______
DRAINAGE	DRAINAGE
Amt ______	Amt ______
Color ______	Color ______
Odor ______	Odor ______
WOUND BED	WOUND BED
Color ______	Color ______
Tissue ______	Tissue ______
Pain ______	Pain ______

☐ Wound Tx performed this visit per POC



DIGESTIVE/NUTRITION
☐ No Deficit - Last BM: ______
☐ N/V ☐ Diarrhea ☐ Constipation
☐ Tube Feeding: ☐ NG ☐ PEG
☐ Other: ______
☐ NPO Amount: ______
☐ ✓Placement ☐ ✓Residual/Amt. ______
☐ Bowel Sounds Present
☐ Abd. Girth ______
☐ Diet ______
☐ Meals Prepared & Administered Appropriately
☐ Past 24-Hour Diet Recall:
☐ Adequate ☐ Inadequate
Comments

MENTAL HEALTH/AFFECT
☐ No Deficit ☐ Inappropriate Behavior
☐ Depressed ☐ Lethargic ☐ Comatose
☐ Agitated ☐ Disoriented ☐ Forgetful
☐ Oriented to: ☐ Person ☐ Place ☐ Time
Comments

MUSCULOSKELETAL
☐ No Deficit
☐ Weakness
☐ Decreased:
☐ Endurance
☐ Balance
☐ Gait
☐ Tremors
☐ Limited Mobility/ROM
☐ Pain ☐ Cramps
☐ Grip Strength:
☐ Right ☐ Left
☐ Bedbound
☐ Chairbound
☐ Contracture
☐ Paralysis
☐ Assistive Device
☐ Fall Precautions Maintained
Comments

☐ See Additional Pain Assessment/Documentation (per agency policy)
Refer to:

PAIN
Frequency of Pain interfering with patient's activity or movement:
☐ 0 – Patient has no pain
☐ 1 – Patient has pain that does not interfere with activity or movement
☐ 2 – Less often than daily
☐ 3 – Daily, but not constantly
☐ 4 – All of the time

PAIN PROFILE
Primary Site: ______
Intensity: 0 1 2 3 4 5 6 7 8 9 10 (LOW – HIGH)
Pain Description: ☐ Sharp ☐ Dull
☐ Other: ______
Current pain management: ☐ Effective
☐ Not Effective
☐ Pain Management Teaching to patient/family (document below)
Patient's pain goal: ______
Progress toward pain goal: ______

INFUSION
☐ IV Tubing Change
☐ Cap Change
☐ Central Line Dressing Change
☐ IV Site Dressing Change
☐ IV Site Change
☐ Infusion by ______ Pump
☐ Infusion
Comments

ENDOCRINE
☐ No Deficit
☐ Glucometer Reading
☐ Diabetic Skin Care
☐ Insulin Injection
☐ FBS
Comments

SKILLED INTERVENTION / TEACHING / Pt/Cg RESPONSE

Title of Teaching Tool used/given: ______ ☐ Instructed ☐ Pt/Cg. Verbalized Understanding ☐ Pt/Cg. Return Demonstration
Medical Equipment/Adaptive Devices/Supplies used this visit:

SUPERVISION
☐ LPN ☐ Aide
☐ Other

Present on this visit?	☐ Yes	☐ No
Follows the patient's plan of care?	☐ Yes	☐ No
Maintains open communications with patient representative (if any), caregivers and family?	☐ Yes	☐ No
Demonstrates competency with assigned tasks?	☐ Yes	☐ No
Complies with infection prevention and control policies and procedures?	☐ Yes	☐ No
Reports changes in the patient's condition?	☐ Yes	☐ No
Honors patient's rights?	☐ Yes	☐ No
Additional instruction given during visit?	☐ Yes	☐ No

Signature:

COORDINATION / PLAN
Progress Towards Patient Goals: ______
Progress To Patient Outcomes: ______
Conferenced With: SN PT OT SLP MSS HHA (circle one) Name: ______
Regarding: ______

Physician Contacted Re: ______ Date/Time ______
Order Changes: ______
☐ Patient, Caregiver and/or Representative (if any) agreed with and participated in the changes to the POC
Plan For Next Visit: ______
Discharge Planning: ______

Update to Interdisciplinary Plan:
Problem: ______
Intervention: ______
Goal: ______

Nurse Signature & Title	Time In	Time Out	Date
Patient Signature			Date

Signature Validates Nursing Visit Date and Time