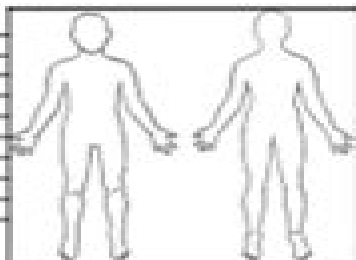


Skilled Nursing Note

☐ Initial Assessment ☐ Follow up visit ☐ Supervisory visit

Name of Patient: _____ Date: _____

Vital Signs Ht: _____ Wt: _____ Temp: _____ Pulse: A/R: _____ ☐ Regular ☐ Irregular Resp: _____ B/P: _____ ☐ Lying ☐ Sitting ☐ Standing ☐ Right ☐ Left																																											
<i>Nursing assessment and observation of signs/symptoms (Mark all applicable with an "X" or circle; items separated by "Y")</i>																																											
CARDIOVASCULAR ☐ WNL ☐ Edema (Specify): _____ ☐ R/L: ☐ L/L: ☐ R/L: ☐ L/L: ☐ M/D/A: ☐ Flitting ☐ Non-flitting ☐ Other: _____	RESPIRATORY ☐ WNL ☐ Dyspnea/SOB ☐ Cough/Sputum ☐ Other: _____	PAEN ☐ None ☐ Location: _____ Severity (0-10): _____ Other: _____	SKIN ☐ WNL ☐ Cellulitis ☐ Pressure sore ☐ Rash ☐ Skin tear ☐ Wound ☐ Incision <table border="1"> <thead> <tr> <th></th> <th>#1</th> <th>#2</th> <th>#3</th> </tr> </thead> <tbody> <tr> <td>Length</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Width</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Depth</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Drainage</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Tissue/ing</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Odor</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Nat tissue</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Wound bed</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Stoma</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> ☐ Steri-strips ☐ Sutures ☐ Staples ☐ JP drain ☐ IV line Type: _____		#1	#2	#3	Length				Width				Depth				Drainage				Tissue/ing				Odor				Nat tissue				Wound bed				Stoma			
	#1	#2	#3																																								
Length																																											
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Nat tissue																																											
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Stoma																																											
EMOTIONAL STATUS ☐ WNL ☐ Disoriented ☐ Fearful ☐ Depressed ☐ Other: _____	GENITOURINARY ☐ WNL ☐ Incontinence ☐ Catheter/Blas ☐ Hematuria ☐ Other: _____	DEGESTIVE ☐ WNL ☐ Nausea/Vomiting ☐ Difficulty Swallowing ☐ Diarrhea/Constipation ☐ Colostomy ☐ Incontinence ☐ Last BM: _____																																									
NEUROSENSORY ☐ WNL ☐ Syncope/Vertigo ☐ Visual Impairment ☐ Other: _____	MUSCULOSKELETAL ☐ WNL ☐ ROM ☐ RUE LUE RUE LLE ☐ Unsteady gait ☐ Generalized weakness ☐ Other: _____	SAFETY CONCERNS: ☐ Clear pathways/adequate ambulation ☐ Fall precautions ☐ Home safety ☐ Medication management ☐ IV safety ☐ Sharps disposal ☐ Oxygen safety ☐ Bleeding precautions ☐ Infection control ☐ Other: _____																																									
SUPERVISORY VISITS: Follows Std Precautions ☐ Yes ☐ No Follows Plan of Care ☐ Yes ☐ No Performs Care Properly ☐ Yes ☐ No Patient satisfied ☐ Yes ☐ No HHA Present ☐ Yes ☐ No																																											
Personal Needs (Circle): ☐ Bathing ☐ Grooming ☐ Dressing ☐ Eating ☐ Transferring ☐ Patient/line independent in ADLs/IADLs																																											
Reason for Visit: ☐ Assessment ☐ Teaching/training ☐ Wound care ☐ IV Therapy ☐ Lab draw ☐ HHA/Companion services ☐ PT/OT/ST/MSW services ☐ Medication management ☐ Other: _____ Recent history pertinent to reason for visit: _____ ☐ Patient is homebound Why? _____																																											
Interventions/Instructions: Teaching/training re: ☐ Medication regimen, actions, side effects ☐ Disease process ☐ Bleeding precautions ☐ Wound/diagnosis care ☐ IV therapy ☐ Infection control measures ☐ Complications to report ☐ Physician follow up ☐ Home safety ☐ Oxygen safety ☐ Diet ☐ Elevating legs to decrease edema ☐ Off loading techniques ☐ Sharps disposal ☐ Plan of care review ☐ Medication management ☐ Inability to void post foley removal ☐ Discharge instructions																																											
Wound Care Performed: ☐ Aseptic technique ☐ Sterile technique ☐ Cleansed with NS ☐ Cleansed with: _____ Product applied: _____ Covered with: ☐ Gauze ☐ ABD pad ☐ Telfa ☐ Packed: _____ ☐ Wet to dry-NS ☐ Secured with tape/face wrap/stockinette ☐ Wound vac applied with ☐ Black ☐ White ☐ Silver foam ☐ Canister changed ☐ Constant suction ☐ Intermittent suction ☐ Pressure: _____ mmHg ☐ Approx. drainage in canister: _____ mL Color: _____																																											
IV Therapy: Drug given: (name) _____ (dose) _____ (via) _____ (over) _____ minutes Flushed line: ☐ NS _____ mL ☐ Before ☐ After med/blood draw ☐ Final flush with Heparin _____ mL Peripheral IV inserted (site): _____ using (catheter): _____ Site prepped with ☐ alcohol ☐ betadine ☐ chloraprep _____ line dressing changed on using sterile technique ☐ 3 alcohol swabs ☐ 3 providone swabs ☐ chloraprep swab ☐ antimicrobial patch Applied ☐ Occlusive dressing ☐ Gauze dressing ☐ Extension set ☐ Injection site ☐ Site free of complications ☐ Flushes easily ☐ Good blood return ☐ Line removed (type) _____ Length _____ cm ☐ Tip intact ☐ Pressure dressing applied ☐ Lab draw of: _____ from (site): _____ Taken to (Lab name): _____ ☐ Administered: _____ ☐ IM ☐ SQ Site: _____ ☐ Pq/CG taught to administer: _____																																											

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DJ Losen



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