# RN - Skilled Nursing Visit

**Clinician:**

| Patient Name (Last Name, First Name) & MRN: | Mileage: | Gender: ☐ M ☐ F | Agency Name/Branch: |
|---|---|---|---|
| | | | |

| Date: / / | Time In: Time Out: | DOB: / / |
|---|---|---|
| | | |

## HCPCS

Select the home health service type that reflects the primary reason for this visit:

- ☐ (G0154) Direct skilled services of a licensed nurse
- ☐ (G0162) Management and evaluation of the plan of care
- ☐ (G0163) Observation and assessment of the patient condition
- ☐ (G0164) Training and/or education of a patient or family member
- ☐ (G0299) Direct skilled nursing services of an RN
- ☐ (G0300) Direct skilled nursing services of an LPN

Select the location where home health services were provided:

- ☐ (Q5001) Care provided in patient's home/residence
- ☐ (Q5002) Care provided in assisted living facility
- ☐ (Q5009) Care provided in place not otherwise specified (NO)

## Skilled Observation

### Vital Signs

**Temp:**
☐ Oral
☐ Axillary
☐ Rectal
☐ Temporal
☐ Otic

**Pulse:** Apical
Radial
O Regular
O Irregular

**Resp:**

**Weight:**

**BP (R):** /
☐ Lying ☐ Sitting ☐ Standing

**BP (L):** /
☐ Lying ☐ Sitting ☐ Standing

**Blood Sugar:**
O Fasting O Non-Fasting

### Cardiovascular

☐ **WNL**
☐ **Chest Pain:**
☐ **Heart Sounds:**
☐ Murmur
☐ Gallop
☐ Click
☐ Irregular
☐ **Peripheral Pulses:**

**Cap Refill:**
O < 3 Sec
O > 3 Sec

☐ **Dizziness:**
☐ **Edema:**
+
+
+
☐ **Neck Vein Distention:**

### Respiratory

☐ **WNL**

**Lung Sound:**
☐ CTA ☐ Rales
☐ Rhonchi ☐ Wheezes
☐ Crackles ☐ Diminished
☐ Absent ☐ Stridor

☐ **SOB:**
☐ **Cough:**
☐ Productive ☐ Nonproductive
☐ **Sputum:**
Enter Amount
Describe color, consistency and odor
**$O_2$ at:**
LPM via:
**$O_2$ Sat:**

### Neurological

**Oriented to:**
☐ Person ☐ Place ☐ Time
☐ **Disoriented** ☐ **Forgetful**
☐ **Lethargic** ☐ **PERRL**
☐ **Seizures**

**Tremors**
Location(s):

**Sensory**
☐ **WNL**

**Hearing Impaired:**
☐ Left ☐ Right
☐ **Deaf** ☐ **Speech Impaired**

**Vision:**
☐ WNL ☐ Glasses
☐ Contact Left ☐ Contact Right
☐ Blurred Vision ☐ Glaucoma
☐ Cataracts
☐ Macular Degeneration

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|---|---|

O 2 Hr PP

☐ Standard/Universal Precautions Maintained

**Comments:**

**Comments:**

☐ Room Air ☐ $O_2$

☐ **Nebulizer:**

**Comments:**

☐ Other:

☐ **Blind**

☐ **Decreased Sensation:**

**Comments:**

**Medication change since last visit?** O No O Yes

**Demonstrated Medication Compliance:** O No O Yes

**Comments:**

**Homebound?** O No O Yes

☐ Residual weakness
☐ Unable to safely leave home unassisted
☐ Severe SOB or SOB upon exertion
☐ Needs assistance for all activities
☐ Confusion, unsafe to go out home alone
☐ Requires max assistance / taxing effort to leave home
☐ Other:

## GU

☐ **WNL** ☐ **Urostomy**
☐ **Incontinence** ☐ **Burning**
☐ **Frequency** ☐ **Dysuria**
☐ **Retention** ☐ **Urgency**
☐ **Bladder distention**

**Catheter:** ☐ Foley ☐ Suprapubic

Last Change / /

Fr cc

**Urine:**

☐ Hematuria ☐ Odorous
☐ Sediment ☐ Cloudy

## Musculoskeletal

☐ **WNL**
☐ **Weakness**
☐ **Ambulation Difficulty**
☐ **Limited Mobility / ROM**
☐ **Joint Pain / Stiffness**
☐ **Poor Balance**

**Grip Strength:**

O Equal O Unequal

☐ **Bedbound** ☐ **Chairbound**

## Psychosocial

☐ **WNL**
☐ **Poor Home Environment**
☐ **Poor Coping Skills**
☐ **Agitated**
☐ **Depressed Mood**
☐ **Impaired Decision Making**
☐ **Demonstrated / Expressed Anxiety**
☐ **Inappropriate Behavior**
☐ **Irritability**

**Comments:**

## Pain

**Frequency of pain interfering with patient's activity or movement:**

☐ Patient has no pain or pain does not interfere with activity
☐ Less often than daily
☐ Daily, but not constantly
☐ All of the time

**Pain Profile For This Visit**

**Primary Site:**

**Pain Intensity:**

☐ 0 Low ☐ 1 ☐ 2

☐ Other:

**External Genitalia:**

☐ Normal

☐ Abnormal

As per:

☐ Clinical Assessment

☐ Pt/CG Report

**Comments:**

☐ **Contracture:**

**Paralysis:** O Dominant

O Nondominant

☐ **Assistive Device**

**Comments:**

## Skin

☐ **WNL** ☐ **Warm**

☐ **Dry** ☐ **Cool**

☐ **Clammy** ☐ **Pallor**

**Turgor:** ☐ Good / Elastic

☐ Decreased ☐ Poor

**Comments:**

☐ 3 ☐ 4 ☐ 5 Medium

☐ 6 ☐ 7 ☐ 8

☐ 9 ☐ 10 Severe

**Current Pain Management & Effectiveness:**

**What Makes Pain Worse:**

☐ **Pain management teaching to patient / family**

**Progress Towards Pain Goal:**

## Digestive Nutrition

☐ **WNL**

☐ **NPO**

☐ **Diarrhea**

☐ **Bowel Incontinence**

☐ **Dysphagia**

☐ **Nausea / Vomiting**

☐ **Reflux / Indigestion**

☐ **Constipation**

☐ **Decreased appetite**

**Weight Loss / Gain Amount:**

**Bowel Sounds:** ☐ Hyperactive ☐ Hypoactive ☐ Normal

**Abd Girth:**

**Last BM:** / /

As per: ☐ Clinician Assessment ☐ Pt/CG Report

☐ WNL

☐ Abnormal Stool: ☐ Gray ☐ Tarry ☐ Fresh Blood ☐ Black

☐ Constipation: O Chronic O Acute O Occasional

**Ostomy:**

Ostomy Type(s) :

☐ Stoma Appearance:

☐ Stool Appearance:

☐ Surrounding Skin: ☐ Intact

☐ Meals Prepared & Administered Appropriately:

☐ Diet: ☐ Diet Inadequate

**Tube Feeding**

☐ Formula:

☐ Bolus: cc, every hour(s)

☐ Continuous@ cc / hours ☐ Gravity ☐ Pump

☐ Placement Checked

☐ Lax / Enema Use:

☐ Hemorrhoids: ☐ Internal ☐ External

☐ Residual Checked, Amount:

**Comments:**

## Skilled Intervention

**Assessment / Instruction / Performance**

**Response To Skilled Intervention**

Verbalized Understanding ☐ Pt % ☐ CG

Return Demonstration: ☐ Pt % ☐ CG

Require Further Teaching: ☐ Pt ☐ CG

**Comments:**

**Title of Teaching Tool Used / Given:**

## Coordination Plan

**Progress to Goals:**

**Conferenced with:** ☐ MD ☐ SN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ HHA **Name:**

**Regarding:**

**Physician Contacted Re:**

**Order Changes:**

**Plans for Next Visit:**

**Next Physician Visit:**

**Discharge Planning:**

☐ Written notice of discharge provided to patient. Discharge scheduled for: / /

**Update to Nursing Care Plan**

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|---|---|

| | |
|---|---|
| **Problem:** | |
| **Intervention:** | |
| **Goal:** | |

**Signature and Title:** **Date:** / /