**NURSING VISIT REPORT**

**Type of Visit:** [ ] Scheduled  [ ] PRN

**PATIENT:** [ ]

**ID #:** [ ]

**Visit Time From:** [ ]

**To:** [ ]

**VISIT DATE:** [ ]

**NEW ISSUES**

- [ ] New diagnosis
- [ ] S/P Hospitalization
- [ ] S/P Fall
- [ ] Change in psychosocial status
- [ ] Change in mental status

- [ ] Other Specify: [ ]

**Home bound: [ ] Yes [ ] Qualify (if yes): [ ]
- [ ] DOE
- [ ] Unsteady Gait
- [ ] LE Weakness
- [ ] Impaired Mobility
- [ ] W/C bound
- [ ] Poor Endurance
- [ ] Bedbound
- [ ] Paralysis
- [ ] Use of Assistive Device
- [ ] Other

- [ ] No

**Absences from home are for social or non-medical reasons and occur more than once a week**

**TEMP**

- [ ] Oral
- [ ] Rectal
- [ ] Axilla

**Rate**

- [ ] Shallow
- [ ] WNL
- [ ] Laboried
- [ ] Other

**RESP**

- [ ] Sitting
- [ ] Standing
- [ ] Lying

**BLOOD PRESSURE**

- [ ] Right
- [ ] Left

**WEIGHT/HEIGHT**

- [ ] Current Lbs. [ ] Actual
- [ ] ( ) Reported
- [ ] Loss Lbs.
- [ ] Gain Lbs.

**MENTAL STATUS**

- [ ] Alert Oriented to: [ ] Person [ ] Place [ ] Time
- [ ] Disoriented
- [ ] Confused
- [ ] Forgetful

- [ ] Headache
- [ ] Syncope
- [ ] Seizures
- [ ] Tremors of [ ]
- [ ] Visual disturbances OD [ ] OS [ ] OU
- [ ] Speech impairment (describe): [ ]
- [ ] Other

**SOB**

- [ ] Yes [ ] No
- [ ] Chest Pain: [ ] Yes [ ] No
- [ ] Palpitation: [ ] Yes [ ] No
- [ ] Cyanosis: [ ] Yes [ ] No

**DOE**

- [ ] Yes [ ] No

**Cough**

- [ ] Yes [ ] No

**Productive**

- [ ] Yes [ ] No

**Hemoptysis**

- [ ] Yes [ ] No

**Oxygen:** [ ] Yes [ ] No @ [ ] L/min via [ ] continuous/prn

**LUNG SOUNDS**

- [ ] Right
- [ ] Left

**EDEMA**

- [ ] Yes [ ] No

**Measurement if edema is present:**

**ANTERIOR:**

- [ ] Right
- [ ] Left

**Calf cm [ ] cm Ankle cm [ ] cm Pedal cm [ ] cm**

**APPETITE**

- [ ] Good [ ] Poor

**Nausea**

- [ ] Yes [ ] No

**Vomiting**

- [ ] Yes [ ] No

**Compliant with diet:** [ ] Yes [ ] No

**DIET CHANGE:**

- [ ]

**FLUID RESTRICTION OF:** [ ] Compliant: [ ] Yes [ ] No

**BOWEL**

- [ ] Constipation: [ ] Yes [ ] No
- [ ] Diarrhea: [ ] Yes [ ] No

**Last BM:** [ ]

- [ ] Incontinent: [ ] Yes [ ] No
- [ ] Day [ ] Night

**OTHER:**

- [ ]

**PERCEIVED PAIN LEVEL**

- [ ] (Circle) NO PAIN

**Type:**

- [ ] Intractable: [ ] Yes [ ] No

**Duration:**

- [ ] Precipitated by: [ ]

**Frequency:**

- [ ] Instructed by: [ ]

**Rx:**

- [ ]

**Patient response to prescribed treatment:**

- [ ]

**SKIN**

- [ ] Intact
- [ ] Dry / cracking
- [ ] Rash / itching
- [ ] Erythmosis

**Comments/Other**

**Pressure ulcer/wound/incision:**

- [ ] Yes [ ] No

**Location:** [ ]

**Size:** [ ] cm x [ ] cm

**Drainage:** [ ] Yes [ ] No

**Minimal** [ ] Moderate [ ] Copious

**Color:** [ ]

**Odor:** [ ]

**Comments/Other**

**AMBULATORY STATUS**

- [ ] Gait: [ ] Steady [ ] Unsteady

**Comments:**

- [ ]

**MEDICATION**

- [ ] Reviewed: [ ] Yes [ ] No

**Taken as per MD order:** [ ] Yes [ ] No

**Patient demonstrates knowledge:** [ ] Yes [ ] No

**Change of Order/New Prescription:** [ ] Yes [ ] No

**If yes, specify:**

- [ ]

**Instructed in use of:**

- [ ]

**Dosage** [ ] Side Effects [ ] Contraindications [ ] Action [ ] Storage

**Medication profile in home:** [ ] Yes [ ] No

**Updated:** [ ]

**Adequate supply of meds:** [ ] Yes [ ] No

**Needs further instruction in:**

- [ ]

**SAFETY EQUIPMENT**

- [ ] In good repair: [ ] Yes [ ] No

**Specify:**

- [ ]

**Equipment/Supplies needed (itemize):** [ ]

**HH-57**

--- PAGE 1 OF 2 ---

--- Rev. 2/04 ---