This visit is mostly for: (Check ONE only)
[ ]Pt Assessment & Observation [ ]Direct Care
[ ]Pt/Cg Teaching [ ]Management & Evaluation

LEGEND: VU - Verbalized Understanding
NFI - Needs Further Instructions

SKILLED NURSING REVISIT FORM

Date: _____ [ ] Check if Additional Note is used
Time In _____ Time Out _____

Nursing Diagnosis / Problem(s) Identified: _____

Is Patient Homebound? ☐ No ☐ Yes (If Yes, Explain): _____

SKILLED ASSESSMENT / OBSERVATION

VITAL SIGNS/CARDIO/VASCULAR/RESPIRATORY STATUS:

Temperature: _____
☐ Oral ☐ Axilla ☐ Rectal
☐ Aural ☐ Temporal

Blood Pressure: ☐ L ☐ R
☐ Sitting: _____
☐ Lying: _____
☐ Standing: _____
☐ Orthostatic Hypotension

Respiration/min: _____
☐ Labored ☐ Regular
☐ Non labored ☐ Irregular

Pulse/min: _____
☐ Regular ☐ Irregular
☐ Apical ☐ Radial

Weight in lbs: _____
☐ Refused
☐ Actual ☐ Reported
☐ Non wt Bearing

Dyspnea:
☐ None ☐ Orthopnea
☐ Exertion ☐ Rest

Lung Sounds:
☐ Right: _____
☐ Left: _____

Cough: ☐ Productive
(☐ Thin ☐ Thick)
☐ Nonproductive

Sputum Color: _____

Pulse Ox: ____ ☐ RA ☐ w/O2 (__ L/min)

Chest Pain this Visit:
☐ Yes ☐ No

Describe: _____

☐ **HF Symptoms Noted This Visit**

Edema: ☐ NO DEFICIT

RIGHT: ☐ Ankle ☐ Calf ☐ Instep ☐ Other:____ LEFT: ☐ Ankle ☐ Calf ☐ Instep Other:____
Size (cm): _____ Pitting: ☐ Yes ☐ No Size (cm):_____ Pitting: ☐ Yes ☐ No
Specify:_____ Peripheral Pulses Present: ☐ Yes ☐ No

SENSORY / PAIN STATUS: ☐ NO DEFICIT

Impairment: ☐ Vision ☐ Hearing ☐ Speech

	#1	#2	#3
Location			
Description/Quality			
Duration			
Present Level (1-10)			
Worst Level (1-10)			
Best Level (1-10)			
Acceptable Level (1-10)			
Aggravated With			
Relieve With			

Pain Medication Last Taken Date: _____ Time: _____
Is the Current Pain Management/Medications Effective? ☐ Y ☐ N ☐ Unknown
Others:_____

NEURO/EMOTIONAL / BEHAVIORAL STATUS: ☐ NO DEFICIT

Orientation: ☐ Time ☐ Place ☐ Person
Sleep Adequate: ☐ Yes ☐ No ☐ Tremors ☐ Alert ☐ Confused ☐ Cognitively Impaired
☐ Forgetful ☐ Disoriented ☐ Lethargic ☐ Agitated ☐ Anxious
☐ Other:_____
☐ **Depressive feelings noted this visit**

ENDOCRINE STATUS/HEMATOLOGY: ☐ NO DEFICIT

Blood Sugar: ☐ Actual ☐ Reported ☐ FBS:_____ ☐ RBS:_____
Performed by: ☐ RN (Calibration Recorded: High: _____ Low: _____ ☐ N/A)
☐ Patient ☐ Caregiver Competent: ☐ Yes ☐ No
☐ S/s of Hypoglycemia ☐ S/s of Hyperglycemia ☐ Anemia _____
☐ Other_____

ELIMINATION / GI / GU STATUS: ☐ NO DEFICIT

Last BM Date:_____ Bowel Sounds: ☐ Normal ☐ Hyperactive ☐ Hypoactive
☐ Constipated ☐ Diarrhea ☐ Ostomy ☐ Incontinent ☐ Nausea ☐ Vomiting ☐ Anorexia
☐ Dysphagia Appetite: ☐ Good ☐ Fair ☐ Poor Feeding Tube:_____
Other:_____
Voiding WNL: ☐ Yes ☐ No Specify: ☐ Hematuria ☐ Frequency ☐ Urgency ☐ Burning
☐ Incontinent ☐ Dysuria ☐ Nocturia ☐ Retention ☐ Ostomy ☐ Other:_____
Type of Cath._____ Size: ___F___cc to ☐ BSD ☐ Legbag Describe Urine Output:_____

MUSCULO-SKELETAL STATUS: ☐ NO DEFICIT

☐ Independent ☐ Bedbound ☐ Wheelchair-Bound ☐ Device:_____ ☐ Person Assist
Gait: ☐ Steady ☐ Unsteady ☐ Weak ☐ Upper ☐ Lower ☐ R ☐ L ☐ Other _____

INTEGUMENTARY STATUS: Skin Color_____ Turgor_____ Rash_____

Wound No. #	Type	Stage	New (N) Old (O)	Location	Size (in cm.)	Drainage	Amount	Odor	Surrounding Skin

Response to Medication Compliance: New or Change Medication Since Last Visit ☐ Yes ☐ No
Compliant with Medication/tx Regimen ☐ Yes ☐ No Specify_____
Potential Significant Medication Issues Identified ☐ Yes ☐ No Specify _____
Knowledge Deficit: ☐ Patient ☐ CG on _____

SKILLED INTERVENTION

Skilled Teaching(s) Given:	Specify Details	VU	NFI	Remarks
☐ Disease Process				
☐ Disease Management				
☐ Notification Parameters				
☐ S/s of Complications to Report				
☐ Medication Regimen/Therapy				
☐ Medication Administration				
☐ Pain Management				
☐ Diet				
☐ S/s of Infection				
☐ Infection Control				
☐ Wound Care				
☐ Nutrition/Hydration/Enteral Feedings				
☐ Diabetes Care				
☐ Behavioral Modifications				
☐ Bowel/Bladder Program				
☐ Other Treatments				
☐ Appliance Care				
☐ Safety Measures/Precautions				
☐ Fall Safety				
☐ ER Management				
☐ Discharge Plan				
☐ Other:				

SN Skilled Administration of : (use additional wound/treatment sheets, when applicable)
☐ Wound Care:

Wound #	Location	Clean(C)/ Sterile(S)	Irrigate with	Cleanse with	Apply	Cover
1						
2						
3						

☐ Catheter: (fr/balloon) _____ Irrigate with _____
☐ Pulse Oximetry _____ ☐ Fingerstick _____
☐ Venipuncture Draw _____
☐ Injection Medication (Dose/Route)_____
☐ Intravenous Infusion (Dose) _____ ☐ SASH Method
☐ Parenteral Nutrition (Dose) _____ ☐ SASH Method
☐ IV/PICC/Central Catheter Dressing Change _____
☐ Nasogastric/Gastrostomy Feeding _____
☐ Ostomy Care (Circle: Trache/Colostomy/Ileostomy/Urostomy)_____
☐ Disimpaction/Enema _____
☐ Management and Evaluation of Care Plan _____
☐ Others (Specify)_____

Patient ☐ Tolerated ☐ Did not Tolerate the Above Procedure(s) Performed.

Supervisory Visit: ☐ LPN ☐ Hha ☐ Present ☐ Not Present
Care Rendered According to Care Plan ☐ Yes ☐ No
Patient/CG Satisfied with Care ☐ Yes ☐ No
Care Plan Reviewed/Revised (circle one) ☐ Yes ☐ No

CARE PLANNING/CARE COORDINATION

Care Plan ☐ Reviewed ☐ Revised with Patient/CG Involvement ☐ Yes ☐ No
Plan for Next Visit: _____
Approx. Date of Next Visit: _____
Heart Failure Follow-Up Done ☐ Yes ☐ No Describe_____
CARE COORDINATION: ☐ Physician ☐ PT ☐ OT ☐ ST ☐ MSW ☐ SN
☐ Other (Specify): _____
Regarding (Specify Details): _____
Order Obtained ☐ Yes ☐ No

Nurse Signature/Title/Date _____

Environmental Safety Issues: ☐ No Deficit
Fall Reported/Observed ☐ Yes, Specify Details _____ ☐ No
Safety Issues Noted ☐ Yes, Specify Details_____ ☐ No
Other Pertinent Assessment/Problem(s): _____

PATIENT NAME: I.D. NUMBER:

PATIENT SIGNATURE (per Agency Policy): DATE: