ADVANCED
NURSING + HOME SUPPORT

Skill Nursing Visit Note

Client Name:	DOB:	Date:	Time in: _____ Time out: _____

ASSESSMENT

Vital Signs
T_____
Pulse_____
RR_____
BP _____/_____

Neuro
☐ WNL
☐ Vertigo/Light headed
Speech:
☐ Clear ☐ Slurred
Orientation:_____

Respiratory
☐ Clear
☐ O2@____L/m PRN - Cont.
NC – Mask – Trach
☐ Cough ☐ Productive
Color_____
☐ Labored ☐ Unlabored

Cardiovascular
☐ Edema:
LE R____ L_____
UE R____L_____
Skin Temp: ☐ Warm ☐ Cool ☐ Cold ☐ Hot ☐ Diaphoretic
Color: ☐ Pink ☐ Pale ☐ Flushed ☐ Dusky ☐ Cyanotic ☐ Jaundiced

GI
Appetite ☐ G ☐ F ☐ P
☐ Bowel sounds_____
☐ Nausea/Vomit
☐ Difficulty swallowing
Intake: ☐ Adequate ☐ Inadequate
Last BM: _____
☐ Constipation
☐ Diarrhea

Skin
Condition: ☐ Intact ☐ Rash ☐ Redness ☐ Petachiae ☐ Dryness ☐ Bruise
Describe: _____
Wound: ☐ No ☐ Yes Location: _____
Drainage: ☐ None ☐ Bloody ☐ Sero-sanguinous ☐ Seros ☐ Purulent ☐ Odor Wound color:_____
Wound Size:_____
Dressing:_____ Stage:_____

Musculoskeletal
☐ WNL
☐ Ambulates ☐ Needs assist
☐ Unsteady gate
☐ Limited ROM/Mobility
Muscles: ☐ Normal ☐ Weak

Urinary
☐ WNL ☐ Freq:_____ ☐ Incontinence
☐ Retention_____ ☐ S/S UTI_____
☐ Foley Cath: ☐ Intact ☐ Leaking

Pain
☐ None Intensity(0-10)____
Location: _____
Type: ☐ Continuous ☐ Intermit
Alleviated by:_____

Psych
☐ No stated problem ☐ Agitated ☐ Anxious
☐ Depressed
☐ Sleep Disturbances ☐ Suicidal
☐ Other_____

Skilled Nursing Action:

_____

_____

_____

_____

_____

_____

Nurse Signature: _____ Date: _____

Printed Name: _____

Client Signature (if able): _____ Date: _____