SN PROGRESS NOTE FOR REMOTE VISIT USING TELECOMMUNICATION TECHNOLOGY

	Type of Visit: Remote with telecommunications technology
Start Time: AM PM End Time: AM PM	Caregiver Name if appropriate:
Patient Name:	
Vital Signs as monitored or reported by pt/cgr: B/P Lying Sitting Standing	Temp Resp O_2 Sat % Apical HR Radial Pulse Weight

Pain Assessment: Pain Scale: ❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 Location:
Description of pain:______________________________ Duration: ______________
Current pain medication: ______________________________ Other pain management interventions: ______________
Effectiveness of pain management:
Other symptom(s) and management: ______________________________
____

Review of Systems Observed by Clinical Staff or Reported by Patient/Caregiver

Respiratory	Gastro Intestinal
☐ No Problem ☐ Apnea ☐ Resp Uneven ☐ Dyspnea ☐ At rest ☐ With activity______________ ______________ ☐ Cough ☐ Sputum ______________ _ O_2 use ☐Continuous ☐HS ☐PRN ☐Mask ☐Cannula @________LPM	☐ No Problem ☐ Appetite Decreased ☐ Weight Loss/Gain: ______________ ☐ Constipation ☐ Incontinent ☐ Last BM ______________ ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Dysphagia Abdomen: ☐ Soft ☐ Firm ☐ Distended ☐ Diet Compliance: ☐ Yes ☐ No ☐ Ostomy Care Taught
Neuro	**Ears/Eyes/Nose/Throat**
☐ No Problem ☐ Alert ☐ Lethargic ☐ Forgetful ☐ Disoriented ☐ Dizziness ☐ Tremors ☐ Agitated Oriented to: ☐ Time ☐ Place ☐ Person	☐ No Problem ☐ Impaired Vision ☐ Cataract/Glaucoma ☐ Deaf ☐ Impaired Speech ☐ Blind ☐ Tinnitis ☐ Epistaxis ☐ Congestion ☐ Impaired Hearing
Musculoskeletal	**Circulatory**
☐ No Problem ☐ Bedbound ☐ Chairbound ☐ Ambulatory Aid ______________ ☐ Unsteady Balance/Gait ☐ Amputations ☐ Joint Pain/Stiffness ☐ Contracture ☐ Paralysis ☐ Arthritis ☐ Falls	☐ No Problem ☐ Heart Irregular ☐ Gallop ☐ Edema ______________ ☐ Chest Pain -Describe: ______________
Skin Condition	**GU Status**
☐ No Problem ☐ Warm ☐ Cool ☐ Cold ☐ Clammy ☐ Diaphoretic ☐ Dry ☐ Turgor__________ ☐ Pale ☐ Jaundice ☐ Cyanotic ☐ Skin Broken______________	☐ No Problem ☐ Incontinent ☐ Retention ☐ Dysuria - Freq___________ ☐ Catheter ☐ Hematuria ☐ Bladder Program ☐ Teaching Catheter care Output ______________ ☐ Urine ____ Clear ____ Cloudy ____ Odor ____ Sediment ______ Other ______________

Additional clinical findings: ______________________________

(See Plan of Care and/or verbal orders for parameters to identify normal test values for this patient.)

Glucose meter Control Results:______________________________
FSBS obtained from __________ finger using aseptic technique. Results:_____________ ☐ FBS ☐ RBS ______ Hours postprandial
☐ Pt ☐ Caregjver performs FSBS checks Frequency/Observations: ______________________________
Blood sugar log review- FBS range: ______________ RBS range: ______________ Period reviewed ______

New Identified Problems/Goals:______________________________

HCL / SN Progress Note
Rvd. 042820

HealthCare ConsultLink

Patient Name:

Skilled Nursing Care Performed :

☐ Medications reviewed ☐ Compliant ☐ Changes/problems identified:____________________

☐ See Wound Care Addendum

Patient/Caregiver response to skilled services provided this visit:____________________

Progress toward Goals on the Plan of Care (Measurement of physical outcomes of treatment and/or description of the changed behaviors due to education):

Continued Skilled Need (provide detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences, the complexity of the service to be performed, and any other pertinent characteristics of the beneficiary or home)____________________

Care planned for next visit (based on the rationale of prior results): ____________________

Coordination of Care: RN LVN Therapist Other____________ Discussion: ____________________

Last physician visit:____________ Next physician visit: ____________
Physician contact: N/A Yes Discussion:____________________

Discharge Planning: ____________________

Discharge notice given to patient/physician

Technology (application/device) used: ____________________
Who is onsite with the patient during the visit ____________________(names)
Assistance provided ❑Yes ❑ No Describe____________________

Nurse's Signature: ____________________ **Date: ____________________**

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