Nursing Visit Note for Remote Visit Using Telecommunication Technology

Patient Name: MR#

Date of Visit: Start Time: End Time:

Terminal Diagnosis:

Level of Care: RHC Continuous Care Inpatient Respite

Related Conditions:

Goal of Visit: ❑ **update comprehensive health assessment**

PHYSICAL/FUNCTIONAL DOMAIN

Temp = BP = R = P = Weight = Mid-Arm Circ = Change in measurement/wt =

STRUCTURE/FUNCTION	PARTICIPATION/LIMITATION
Cardiovascular: ❑ No Problem ❑ Symptoms managed ❑ Regular rhythm ❑ Irregular rhythm ❑ Bradycardia ❑ Tachycardia ❑ Dyspnea ❑ Heart murmur ❑ Chest Pain-Describe________“ ❑ Faint or absent Pulses: Explain. ________ ❑ Edema. Describe.	**Cardiovascular:** ❑ Fainting/dizziness ❑ Increased symptoms w/anxiety ❑ Symptoms present at rest ❑ Fatigue ❑ Weakness ❑ Exercise intolerance-Describe________ ❑ Ability to carry out tasks. Describe:________
Respiratory ❑ No Problem ❑ Symptoms managed ***HIS** Pt who screened positive for dyspnea on initial nursing assessment received treatment within 24 hours of screening ❑Yes ❑No ❑Does not apply to this assessment ❑ Dyspnea/Extent ________ ❑ Orthopnea ❑ Cough ❑ Sputum ❑ Shallow respirations ❑ Apnea ❑ Breath Sounds ❑ Clear ❑ Diminished ❑ Rhonchi ❑ Wheezing ❑ Rales	**Respiratory** ❑ Limited ability to carry out tasks ❑ Fatigue ❑ Weakness ❑ Exercise tolerance ❑ Oxygen dependent. Oxygen at ________L/min via n/c or mask
Neurosensory ❑ Oriented x ________ ❑ Alert ❑ Disoriented ❑ Confused ❑ Agitation ❑ Headaches ❑ Lethargic ❑ Comatose ❑ Seizures ❑ Syncope ❑ Visual tracking ❑ Grasps: ________R ________L ❑ Pupils ❑ PERLA ❑ Non-reactive ❑ Un-equal ❑ Impaired movement Speech ❑ < 6 words ❑ Intermittent ❑ Incoherent/repetitive ❑ Non-verbal Sleep Pattern: ❑ Restful ❑ Insomnia ❑ Restless ❑ Difficulty Arousing ❑ Increased need for sleep Sedative Used/Amt.	**Neurosensory** ❑ Restless ❑ Forgetful ❑ Memory Loss :❑ Short term ❑ Long term ❑ Rarely/Never makes eye contact ❑ Sensitive to heat or cold ❑ Sensitivity decreased/ increased ❑ Interferes with interpersonal relationship/socialization ❑ Self-care with tasks. Describe: ________ Sleep: ❑ Difficulty arousing Sleep Aids ❑ Sedatives ❑ HOB elevated ❑ Pillows ❑ Fan ❑ Other
Musculoskeletal ❑ No Problem ❑ Symptoms managed ❑ Bone or joint problems ❑ Stiffness ❑ Pain or cramps. Describe:________ ❑ Redness, Warmth, Swelling. Describe:________ ❑ Contractions. Describe:________ ❑ Unsteady gait, or ataxia. ❑ Impaired balance/coordination ❑ Paralysis ❑ Tremors ❑ Bedbound ❑ Chairbound ❑ Ambulatory Aid:	**Musculoskeletal** ❑ Decreased mobility/endurance. ◻ Weakness ❑ Falls: ________ ❑ Decreased ROM. Describe:________ ❑ Assistance w/ADLs: ❑ ambulation ❑ Transfer ❑ Positioning in bed ❑ Maintaining body posture with/without assistance. ❑ Hoyer lift ❑ Self-care with tasks. ❑Geri chair ❑ Bed rails up ❑ Cane ❑ Walker Describe:
Gastrointestinal ❑ No Problem ❑ Symptoms managed ❑ Dehydration/Dry mouth ❑ Stomatitis ❑ Difficulty Swallowing ❑ Gastric Distress ❑ N/V ❑ Reflux ❑ Hiccups ❑ Cachexia ❑ Anorexia ❑ Absent or minimal bowel sounds. Describe:________ ❑ Abdominal soft ❑ Abdominal distention/ascites or tenderness. ❑ Stool Incontinence. ❑ Abnormal stool characteristics. ❑ Diarrhea ❑ Constipation ❑ Impaction ❑ Bleeding	**Gastrointestinal** Meal intake: AM________% Lunch________% Dinner________% ❑ Appetite decreased ❑ Pockets Food ❑ Coughs with food/fluids ❑ Refusing food ❑ Refusing fluids ❑ Assist with feeding: ❑ independent ❑ min. assist ❑ mod. assist ❑ must be fed ❑ prompt to swallow ❑ Last BM ________ *No BM > 3 days requires next day follow-up by nursing until BM Self care: ❑ independent ❑ min. assist ❑ mod. assist ❑ total care
Endocrine ❑ No Problem ❑ Symptoms managed ❑ Increased thirst ❑ Increased urination ❑ Increased hunger ❑ Bruises, petechiae, bleeding:________ ❑ Urine/blood testing performed):________ Glucometer check: High Low	**Endocrine** ❑ Stasis ulcers. Describe. ________ ________ ❑ Non-compliance with diet/treatment. ❑ Foot care necessary.
Genitourinary ❑ No Problem ❑ Symptoms managed ❑ Urine output ________ ❑ Urinary incontinence ❑ Urgency/Frequency ❑ Burning or painful urination ❑ Retention ❑ Oliguria ❑ Hematuria ❑ Abnormal urine odor or appearance:________ ❑ Nocturia. # times per night: ________	**Genitourinary** ❑ External catheter (assess use) ❑ Indwelling catheter size:________ ❑ Last changed: ________. ❑ Self care ❑ independent ❑ min. assist ❑ mod. assist ❑ total care ❑ Ability to communicate needs:

HealthCareConsultLink

Nursing Visit Note Patient Name: Date of Visit:

STRUCTURE/FUNCTION

Pain Assessment: ❑ No Problem ❑ Pain managed with current regimen
***HIS** Pt who screened positive for pain on initial nursing assessment received a clinical assessment of pain within 24 hours of screening
❑Yes ❑No ❑ Does not apply to this visit
Intensity: 0 No Pain 1 2 3 4 5 Distressing 6 7 8 9 10
Type of pain scale used: ____________________
Goal Pain Level:____*Pain level > than goal level requires intervention
Location of Pain: ____________________
Quality: ❑Prick ❑Ache ❑Burn ❑Throb ❑Pull ❑Sharp ❑ Other__________
Routine pain medication:____________________
Total breakthrough med in last 24 hours: ____________________(amt.in mg)
❑ Compliant with med regimen ❑Non-compliant with med regimen

Nutrition/Skin Diet/Supplements/Tube Feed: ____________________
Meal consumption: Breakfast_______% Lunch_______% Dinner______%
Wound : Site: _______________Width: __________Length___________
Depth:____________________ Undermining____________________
Tunneling:____________________
Drainage: ❑Serous ❑Serosanguineous ❑Purulent
Amount: ❑Small ❑Moderate ❑Large
Wound Bed appearance: ❑Granulation ❑Slough ❑Eschar
Surrounding Tissue ❑Erythema ❑Induration ❑Maceration
Odor: ❑None ❑Mild ❑Foul
Infection: ❑Fever ❑Redness ❑Swelling ❑Warmth ❑Other

PARTICIPATION/LIMITATION

Pain: ❑ No Problem ❑ Non Compliant due to: ____________________
Effects of pain: ❑ Sleep interrupted ❑ Appetite decreased
❑ Physical activities decreased ❑Irritability
❑ Interfering with relationships ❑ Anger ❑ Suicidal
❑ Crying
Describe any of the above in detail: ____________________
____
____
MD Contact: ❑ Awaiting response ❑ Orders received

Nutrition/Skin
❑ Addition/change supplements: ____________________
Wound Care Treatment:____________________
____
____
Dressing Change:____________________
____
____
MD Contact: ❑Awaiting response ❑ Orders received

PSYCHOSOCIAL/SPIRITUAL DOMAIN

Patient: ❑ No reported problems
❑ Anxious ❑ Difficulty coping ❑ Loss of energy ❑ Appears sad
❑ Denial ❑ Flat affect ❑ Angry ❑ Tearful
❑ Expresses feelings of loss ❑ Expresses feelings of despair

Caregiver: ❑ No reported problems ❑ Signs of caregiver burnout
❑ Anxious ❑ Difficulty coping ❑ Loss of energy ❑ Appears sad
❑ Denial ❑ Flat affect ❑ Angry ❑ Tearful
❑ Expresses feelings of loss ❑ Expresses feelings of despair

Referral to: ❑ Social Worker ❑ Chaplain **Care Coordination with**: ❑ IDT member ❑ Nursing Home Staff member ❑ ____________________

TEACH ❑ Family/Caregiver ❑ Patient ❑ Facility as Caregiver:
❑ Medication:____________________❑ Disease Process ❑ Signs and symptoms of impending death
❑ Pain Management ❑ Symptom Management ❑ Standard Precautions ❑ Sharps Disposal ❑ DME:____________________
❑ Skin Care ❑ Positioning ❑ Hydration ❑ Nutrition ❑ Oxygen safety ❑ Coping Strategies ❑ Grief Process
❑ Other:____________________
❑ Environment assessed for Safety needs
Patient/CG response: ❑ verbalizes understanding ❑ needs more instruction ❑ other:

Professional Management in an ❑ Inpatient facility ❑ Nursing Facility ❑ Other Facility **Discussed POC with**: ____________________

LVN/HH Aide Supervision ❑ Patient/Caregiver satisfied with care ❑ Care provided according to assignment ❑ Request change in assignment.
❑ Employee courteous, respectful ❑ Continue frequency at ____________________
❑ Supervisory Visit Onsite ❑ LVN (name) ❑ HHA (name)

MD Contact: ❑Awaiting Response ❑ Orders Received**: Medication/Treatment/Procedure Orders** (new or changed) ❑No change

Summary of Care: ____________________
____
____
____
____
____

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

SN Signature: ____________________ Date: ____________________

***HIS** is Hospice Item Set

HealthCare ConsultLink