Atrium Home & Healthcare Services, Inc.

Skilled Nursing Note

PATIENT NAME_____ **PATIENT NUMBER**_____

Diagnosis_____ Time In_____ Time Out_____ Visit Time_____ Date_____

BP	LYING	SITTING	STANDING	Apical Pulse_____Reg/Irreg	Resp_____	Weight_____❑Actual ❑Approx	**LEGEND:**
RT	_____	_____	_____	(R)Radial Pulse ____Reg/Irreg	Temp_____	Pt last saw Physician_____	**N=See Narrative**
LT	_____	_____	_____	(L)Radial Pulse ____Reg/Irreg	Blood Sugar_____❑ Fasting	Next visit to Physician_____	**✔=Present**

NEUROLOGICAL/MENTAL STATUS

❑ Alert/Oriented x_____ ❑Comatose
❑ Confused ❑ Agitated ❑ Disoriented
❑ Lethargic ❑ Impaired decision making
❑ Memory Loss: ❑ Short ❑ Long
❑ PE RLA ❑ H/A ❑ Dizziness
❑ Hand Grip: (R)_____ (L)_____
❑ No problems

NERVOUS SYSTEM

Circle Syncope Vertigo
Tremors Seizures
Other_____

HEENT

❑ Dysphagia ❑ Chewing Problems
❑ Gum problems:_____
❑ Tinnitis ❑ Sore Throat ❑ Hoarse
❑ Lesion(s): Location/Type_____
❑ Epistaxis ❑ Sinus/Congestion
❑ Vision ▲ Since Last visit
❑ ↑ ❑ ↓
❑ Hearing ▲ Since Last visit
❑ ↑ ❑ ↓
❑ No Problems

MEDICATIONS

❑ No Problems
❑ New/Changed Med:_____
❑ See Medication Profile
❑ Side Effects
❑ Allergic Reaction:_____
❑ Compliant ❑Missed Dose
❑ Rph Notified/Consulted
❑Indep ❑Assist ❑ Unable

CARDIOVASCULAR

❑ Pale ❑ Cyanotic ❑ Palpitations
Pulses: Right Left
Pedal _____ _____
Cap Refill <3 sec >3sec.
❑ Edema ❑ Pedal R/L ❑ Dependent:_____
❑ Pitting +1/+2/+3/+4 ❑ Non-Pitting (site)
_____
Other_____

RESPIRATORY

❑ LSCTA ❑ Dyspnea/Sob
❑ Non-productive cough
❑ Productive cough
Amt: ❑ Sm ❑ Mod ❑ Lge
❑ Thick ❑ Foul Odor ❑ Color_____
❑ *Rales/Ronchi_____
❑ * Wheeze_____
* (Describe)
❑ Oxygen____Litres/min
❑ Trach ❑ No problems ❑ *S&S Infection
* Describe_____

NUTRITIONAL

❑ No Problems
❑ Diet Supplement_____
❑ Orals ❑ NG ❑ G-Tube
❑ Fluid Restriction ❑ Compliant
Appetite: ❑ Good ❑Fair ❑ Poor
Fluid Intake ❑ Good ❑Fair ❑Poor
Nutrition: ❑ Adequate ❑ Inadequate
❑Weight Loss/Gain ❑No Food Prep
❑Lack of Food Access
❑Other_____

GI/GU

Abdomen: ❑ Soft ❑ Firm ❑ Rigid
Bowel Sounds: ❑ Normal ❑ Hypo
❑ Hyper ❑ URQ ❑ ULQ ❑ LRQ ❑ LLQ
❑ Nausea ❑ Vomiting ❑ Heartburn
Last BM: _____(Date)
❑ Constipation ❑ Diarrhea_____**x/d**
❑ Incontinence: ❑ Bowel ❑ Bladder
❑ Frequency ❑ Burning ❑ Pain
❑ Hematuria ❑ Catheter: ___Fr ___CC
❑ Signs/Symptoms Infection:_____
❑ Urine Color/Odor_____
Other_____

Integumentary

Circle Warm Cool
Dry Clammy
Bruise Abrasion
Location_____
❑ Incision ❑ Wound/Decub
❑ See wound Assessment/Narrative
❑ Tears ❑ Rash
❑ No problems
❑ Other

MUSCULOSKELETAL SYSTEM

Limited ROM: RUE_____ LUE_____
RLE_____ LLE_____
Other_____
Joints: ❑ Swollen ❑ Painful
❑ Reddened ❑ Rigid
❑ No Problem

PAIN

Location_____
Intensity: 0 1 2 3 4 5 (O=No pain)
↑ W/_____
↓ W/_____
❑ Intermittent ❑ Constant ❑ Dull
❑ Sharp ❑ Burning ❑ Aching
Relieved with: ❑ Rest ❑ Activity
❑ Position change
Meds Effective ❑ Yes ❑ No*
* Explain_____
❑ No problems

HHA SUPERVISION

❑ Pt/CG Satisfied with care
❑ Care Plan Appropriate
❑ Aide following care plan
❑ HHA observed performing care
❑ Changes in Plan of Care
(See Narrative)
❑ HHA Present; HHA Signature:

RN/LPN Sig._____