Route Sheet & Nursing Note

Florence Home Health Care

PATIENT VISIT RECORD

Contract ☐ Yes ☐ No

PATIENT NAME	PT #	CLINICIAN NAME AND SIGNATURE	TITLE	EMPLOYEE #

1. I CERTIFY THAT THE HOURS AND VISITS WORKED ARE CORRECT FOR THE DATE LISTED BELOW.
2. I UNDERSTAND THAT COMPLETED TIMESLIPS AND VISIT NOTES MUST BE TURNED INTO THE OFFICE WITHIN 72 HOURS FOR MY WORK TO BE CONSIDERED FINISHED.

DATE	TIME		VISITS				OFFICE HOURS	MILEAGE			PATIENT SIGNATURE
	AM	PM	OPEN EVAL	REGULAR	DIABETIC	RECERT/RESUME/HIGH-TECH		ODOMETER BEGIN	ODOMETER END	TOTAL MILEAGE	
TOTAL											

Florence Home Health Care

SKILLED NURSING NOTE

PURPOSE OF VISIT: _____ **PULSE:** ____ R A R/I **RESPIRATIONS** ____ R/I
TEMP: ____ F O/R/A **BP: Sitting** ____ / ____ **L/R Standing** ____ / ____ **L/R Lying** ____ / ____ **L/R** WEIGHT ____ lb Stated/Actual

MENTAL: ☐ Alert ☐ Oriented X ___ ☐ Restless ☐ Forgetful ☐ Confused ☐ Anxious ☐ Depressed
☐ Agitated ☐ Comatose ☐ Semi-Comatose Comment:

NEUROLOGICAL: ☐ No problem assessed at this time ☐ Aphasia ☐ Slurred Speech ☐ Seizures ☐ Headache ☐ Tremors ☐ Vertigo
☐ Change in LOC ☐ Grips Unequal ☐ Pupils Unequal ☐ Numbness ☐ Visual Deficit ☐ Hearing Deficit ☐ Speech Deficit
Comments:

CARDIOVASCULAR: ☐ No problem assessed at this time **Pedal Pulses:** ☐ Present ☐ Absent **Edema:** ☐ None ☐ Pitting ☐ Non-Pitting
Location/Amount: _____ ☐ Chest pain ☐ Palpitations ☐ Dizziness ☐ Orthopnea
Comment:

RESPIRATORY: ☐ No problem assessed at this time **Lung Sounds:** _____
☐ Cough: ☐ Prod ☐ Non-Prod ☐ O2____LPM/NC/Mask SOB: ☐ Rest ☐ Min Exertion Sputum: Color _____ Amt _____
Oxygen Saturation: ____ % Comment:

GASTROINTESTINAL: ☐ No problem assessed at this time **Appetite:** ☐ Good ☐ Fair ☐ Poor **Bowel Sounds:** ☐ Present ☐ Absent ☐
Hypo ☐ Hyper ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Incontinent ☐ Last BM _____ ☐ Feeding Tube ___
Diet: Comment:

GENITOURINARY: ☐ No problem assessed at this time ☐ Incontinent ☐ Frequency ☐ Urgency ☐ Pain on urination
☐ Nocturia ☐ Burning ☐ Retention ☐ FC ☐ Suprapubic Catheter/Size ___ F _____cc balloon ☐ Condom Catheter (S/M/L)
Urine: Color ☐ Odor ☐ Cloudy Amount: ____ ml Comments:

ENDOCRINE: ☐ No problem assessed at this time Blood Glucose ____MG/dl random/fasting ☐ Per patient/PCG ☐ Diaphoretic ☐ Polyuria
☐ Blurred Vision ☐ Polydipsia ☐ Polyphagia ☐ S/S of Hypoglycemia ☐ S/S of Hyperglycemia ☐ Tachycardia
Comment:

SKIN: ☐ No problem assessed at this time **Turgor:** ☐ Good ☐ Fair ☐ Poor **Skin Temp:** ☐ Warm ☐ Hot ☐ Cold
☐ Rash ☐ Diaphoretic ☐ Bruises ☐ Dry ☐ Excoriation ☐ Pallor ☐ Jaundice ☐ Pruritis ☐ Blister(s) ☐ Surgical wound ☐ Skin tear
☐ Stasis ulcer ☐ Pressure ulcer ☐ Diabetic Ulcer Site: _____ ☐ Drainage/Description/Amount:
_____ ☐ Odor ☐ Skin on Feet Intact ☐ Perineal Area Intact ☐ Wound Sheet Q week completed
Comment:

MUSCULOSKELETAL: ☐ No problem assessed at this time ☐ Stiff joints ☐ Painful joints ☐ Weakness _____ ☐ Contractures
☐ Unsteady Balance/Gait Comment:

PAIN: ☐ No ☐ Yes Location _____ Origin _____ Frequency _____
Intensity 1 2 3 4 5 6 7 8 9 10 (circle) ☐ Sharp ☐ Dull ☐ Burning ☐ Radiating Controlled?: ☐ Yes ☐ No Pain med last given: _____
Current Pain Management: _____ Comment: _____

MEDICATIONS: ☐ No meds currently ☐ No problem assessed at this time ☐ Pt/PCG compliant with med regime ☐ Pt/PCG lacks knowledge regarding med regime ☐ Medications are effective ☐ No drug interaction noted ☐ Started on new med _____ ☐ Med profile updated Comment:

Abnormal Findings/Skilled Care Provided: ☐ Standard Precautions observed ☐ Infection Control Measures observed including hand washing

☐ Two Identifiers used to verify Patient ☐ Safety Precautions Observed ☐ Medical Equipment in good working order

Requires SN since: ☐ No willing and able CG to administer Insulin ☐ No willing and able CG to provide wound care/administer IM/IV medication

Pt/PCG response: ☐ Pt/PCG verbalizes understanding of teaching ____ % ☐ Pt/PCG needs further instruction ☐ Pt/PCG demonstrated procedure properly w/o cues ☐ Pt/PCG demonstrated procedure w/ cues _____

Communication with (name and title) _____ Re: _____

☐ No new orders at this time ☐ Medication change ☐ Treatment change ☐ Physician appointment ☐ Lab specimen obtained

Plans for next Visit: _____

Homebound Status: ☐ Needs assistance with all activities ☐ Residual Weakness ☐ Requires assistance to ambulate ☐ Medical restrictions
☐ Confusion, unable to go out of home alone ☐ Unable to safely leave home unassisted ☐ Dependent upon adaptive device (s)
☐ Severe SOB, SOB on exertion ☐ other (specify) _____

AIDE SUPERVISION: Name of Aide _____ Aide present ☐ Yes ☐ No Follows task/care plan? ☐ Yes ☐ No
Patient satisfied with services? ☐ Yes ☐ No Cleans up work areas ☐ Yes ☐ No Uses good safety practice ☐ Yes ☐ No
Aide Task Sheet updated? ☐ Yes ☐ No Care Observed Instructed in

Patient's Name		Patient Number		
Nurse' Name	Nurse's signature	Date of Visit	Time In	Time Out

Florence Home Health Care

PHYSICIAN'S ORDERS

Time: _____

Date: _____

Patient Name: _____ Patient Number: _____

Physician's Name: _____ Phone #: _____

Orders: _____

_____

_____

_____

_____

_____

_____

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_____

_____

Communication Note: _____

_____

New Diagnosis: _____

_____

New /Changed Goals: _____

_____

_____

Medical Supplies Ordered: _____

_____

Patient Informed? ☐ Yes ☐ No ☐ Read back orders to MD and verified

Clinician Name/Signature _____ RN/LVN/RPT/OT/ST/MSW

Physician's Signature _____ Date: _____