ElderServeHealth
Live Well

NURSING REVISIT NOTE

Member Name:
ID#:
Visit Date:
Member Signature:_____

Vital Signs:

Temperature: O - _____ R - _____ A - _____
Pulse: A _____ R _____ (I/R) R _____
Glucose: FBS/PP _____ mgl/dl time:_____
BP: Lying Standing Sitting
LT - _____ RT - _____
Pain Scale: 1 2 3 4 5 6 7 8 9 10

Respiratory:

SOB: _____ DOE: _____ PND: _____ Endurance:_____
Orthopnea: _____ O_2: _____
Cough:____ Lungs Sounds: LT_____ RT_____
Comment:_____

Cardiovascular:

Chest Pain: Y N _____
Lower Extremities: LT / RT

Pedal Pulse:	WNL	Weak	Absent	____/____
Temperature:	WNL	ABN		____/____
Color:	WNL	ABN		____/____
Sensation:	WNL	ABN		____/____

Edema:
LT Instep_____ Ankle_____ Calf_____
RT Instep_____ Ankle_____ Calf_____
Other: _____
Comment: _____

Cognitive Function:

Orientation:
Alert:_____ Anxious:_____
Person:_____ Drowsy:_____
Place:_____ Lethargic:_____
Time:_____ Confused:_____
Forgetful: Past_____ Present_____
Neuro Paresis/Paralysis:_____ Location:_____
Swallowing/Speech Difficulties:_____
Comment:_____
_____

Functional Status:

Pain: Y N _____ Location:_____
ROM: Limited_____ Full_____
Ability to Participate in ADL: Bathing:_____
Dressing: Upper Body_____ Lower Body_____
Toileting:_____
Transferring: Indep_____ Asst_____ Device _____
Ambulation/Locomotion:
Steady_____ Unsteady_____ Device_____
Mobility: W/C_____ Bedbound_____
Safety Issues:_____
Comment:_____

Gastrointestinal:

Appetite:_____
Feeding/Eating: Indep_____ Asst _____
Diet: _____ Compliant: Y N _____
Last Bowel Movement: _____
Bowel Pattern: _____
Bowel Sounds: _____
Comment:_____

Genitourinary:

Continent / Incontinence _____
Frequency: _____ Odor:_____
Color:_____ Pain:_____
Catheter_____ Size_____ Balloon_____
Urinary Output:_____
Date Changed:_____
Comment:_____

Skin:

Lesion:_____ Skin Changes: _____
Location:_____
Describe:_____
Comment:_____

Medication Change:

Y N _____Comment:_____
_____
_____
Compliant: Y N _____

Clinical Observation Care:_____
_____
_____
_____
Management:_____
_____

Mediset Prefilled: _____ days	Medication Administered: _____	Treatment Administered: _____	Insulin Prefilled: _____Days

Teaching Response:_____
Problem / Goal / Timeframe:_____
_____

Plan for Next Visit:_____ MD Appt:_____ Visit Frequency:_____ Revisit Date:_____
Signature/Title:_____