Consumer Directed Services Option
skilled nurse assessment and narrative

DATE; Time In: Time Out:	DATE: Time In: Time Out:	
Client Name:	**Medicaid #**	**DX:**
T: P: R:		BP: RA LA Position:
Notify MD IF:	Last BM:	Notify MD IF:

NEUROLOGICAL	**GASTROINTESTINAL**	**HOMEBOUND STATUS**
A&O X3 Yes ( ) No ( )	Bowel Sounds Active X ( ) Quads	Bedbound/Contractures Yes ( ) No ( )
Confused Yes ( ) No ( )	Diarrhea Yes ( ) No ( )	Open/Complex Wounds Yes ( ) No ( )
Flat Affect Yes ( ) No ( )	Constipation Yes ( ) No ( )	Complex IV Therapy Yes ( ) No ( )
Hand Grasp Str ( ) Wk( )	Distended Yes ( ) No ( )	Taxing effort to leave home Yes ( ) No ( )
PERLA: Yes No Pupil Size: Sym Asym	G-Tube: Rotated 360 degrees ( ) Yes ( ) No	Requires Assistive Devices Yes ( ) No ( )
MAE's Yes ( ) No ( )	GT Care:	Medically Contra-Indicated Yes ( ) No ( )
Seizures: No( ) Yes ( ) see seizure log		Other Yes ( ) No ( )
SENSORY DEFICIT	**URINARY**	**DIET _____Compliant Yes ( ) No ( )**
Speech Yes ( ) No ( )	Voids Yes ( ) No ( )	Appetite Good ( ) Fair ( ) Poor ( )
Vision: Pupils:	Incontinent Yes ( ) No ( )	Supplement Type: _____
Hearing Yes ( ) No ( )	Cath _____ Yes ( ) No ( )	Fluid Intake: _____
CARDIOVASCULAR	_____FR _____Freq	Fluid Restriction Yes ( ) No ( )
Rate Reg ( ) Irreg ( )	Date Changed? _____	**PAIN ASSESSMENT [ ] No pain at this time**
Rhythm Reg ( ) Irreg ( )	Color Sediment	Locations _____
Pulse Str ( ) Wk ( )	**MUSCULOSKELETAL**	Type: Scale Rating:
Neck Veins Flat ( ) Dist ( )	Joint Pain Yes ( ) No ( )	Time of Day _____
Edema Yes ( ) No ( )	Joint Swelling Yes ( ) No ( )	Medication taken and response:
Pitting Non-pitting cm	Specify Area:	Pain Scale: 1-3 Chronic tolerable pain 4-6 Requires Nsg Intervention
LUNGS	**SKIN**	7-9 Requires medical intervention 10-requires acute care intervention
Clear Yes ( ) No ( )	[ ] Skin Intact [ ] Skin Not Intact (see narrative)	**LABORATORY DATA**
Coarse Yes ( ) No ( )	Warm Yes ( ) No ( )	Test Ordered: _____
Diminished Yes ( ) No ( )	Cold Yes ( ) No ( )	Site: _____ Stick X: _____
Wheezes Yes ( ) No ( )	Dry Yes ( ) No ( )	Pt Tolerated Well Yes ( ) No ( )
Crackles Yes ( ) No ( )	Clammy Yes ( ) No ( )	Lab Delivered To:
Symmetrical Yes ( ) No ( )	Pink Yes ( ) No ( )	**MEDICATIONS CHANGES**
Unlabored Yes ( ) No ( )	Pale Yes ( ) No ( )	
Labored Yes ( ) No ( )	Cyanotic Yes ( ) No ( )	
Cough Yes ( ) No ( )	Turgor: ( )WNL ( ) Decreased	
Sputum: Color _____ Const	**INFECTION [ ] None [ ] Ongoing Infection**	
( )O2 sats. Continuously while asleep & ( ) PRN WA	( ) NEW INFECTION	( ) See Post Hosp. Addendum
PULSE OXIMETER SITE:	Type of Infection: [ ]Skin [ ]Respiratory [ ]Wound	( ) See Recert Addendum
	[ ]UTI [ ] Influenza [ ]Yeast [ ] Other_____	

NURSING NARRATIVE

TIME:	SUBJECTIVE/OBJECTIVE FINDINGS / OBSERVATION / ASSESSMENT / TREATMENTS PERFORMED

COMMUNICATION / NOTIFICATION PROCESS ( ) None Required

Notified MD of:_____ Spoke to _____D ate/Time _____Orders: Yes ( ) No ( )

Notified Pt/Cg of: Changes in POC Spoke to _____

Notified Nurse of : Specific findings describe _____

_____ Spoke To: Date/Time:

PRINT Name: Title: [ ] RN [ ] LVN

NURSE'S SIGNATURE & TITLE:

CONSUMER DIRECTED SERVICES OPTION
NURSING NARRATIVE –CONTINUATION
PATIENT NAME:
DATE _____ NURSE"S NAME TITLE _

TIME	

CONSUMER DIRECTED SERVICES

SEIZURE LOG

PATIENT NAME: **DATE:**

Time	Type of Seizure	Body Part Affected	Duration	Intervention	MD Notified Date/ Time	Orders Received	PRN Given	Caregiver Notified	Initials

Narrative Notes:

TRACH TYPE	SIZE	LAST CHANGED:
COLLAR CHANGED:	PATENT:	OTHER
VENT TYPE	BATTERY:	CIRCUIT CHANGED:
SETTINGS		
OTHER		

NURSE'S SIGNATURE/TITLE	INITIALS	NURSE'S PRINTED NAME/TITLE

04/2014