☐ Acute Visit ☐ Regulatory Visit ☐ Skilled

Name: _____ DOB: _____/_____/_____ Date: _____/_____/_____

Facility: _____ ADV DIR: DNR Full Cor Comfort DNH Hospice _____

CC/Reason for visit: _____ Pneumo Vax: _____ (YEAR) Flu Vax: _____ (YEAR)

Diagnoses/Status:

1. _____

2. _____

3. _____

Social History: _____

ROS: ☐ Unable b/o dementia/language

Allergies: _____

Const: fatigue falls fever chills lightheaded wt loss

Eyes: blur dim blindness cataract glaucoma glasses

H/ENT: dryness sores dysphagia hearing loss wax congest

Resp: dyspnea wheeze cough sputum

CV: CP orthopnea edema palpitations claudication

GI: anorexia pain n/v diarrhea constip melena heartburn

GU: dysuria urge freq hesitancy hematuria incont cath

Reviewed: ☐ Meds; ☐ Nsg Notes; ☐ Interdisc Notes;

M/S: arthralgia back pain swelling stiffness myalgias limb pn

Skn/Brst: sores discoloration pruritus pain lumps discharge

Neuro: paralysis HA slurred speech tremor parasthes neuralgias

Psych: depress anxiety memory loss agitation insomnia

Endo: heat/cold intolerance polyuria polydipsia

Hemo: easy bruisability bleeding

ADLs: Needs help: trans toilet eat walk drsg bth

Amb: Independent w/cane w/walker w/assist w/c not at all

CON: ☐ Resting Comfortably _____ ☐ Vital Signs (3) _____ _____ _____

EYES: ☐ PERRLA, EOMI ☐ Nl Lids/Conjunctiva

NECK: ☐ Supple, No Masses, Sym ☐ No Thyromegaly

H/ENT: ☐ NC/AT ☐ Nl Hearing ☐ Nl Ext Ears/Nose ☐ Ext Aud Cnl clr, Nl TM's ☐ Nl Lip/Tongue/Gums ☐ Nl Pharynx

RESP: ☐ Nl Effort ☐ Lungs Clr to A ☐ Nl Palp ☐ Nl Perc

CV: ☐ Nl Palp ☐ Nl S1, S2, No M,G,R ☐ No Carotid Bruits: ☐ No AAA ☐ Nl DP/PT ☐ No Edema

BREASTS: ☐ Nl Appearance ☐ No Masses/NT

GI: ☐ Soft, Nl BS, NT/ND, No Mass ☐ No HSM ☐ No Herniation ☐ Nl An/Peri/Rect ☐ Neg FOBT

GU-F: ☐ Nl Ext Genitalia GU-M: ☐ Nl Penis ☐ Nl Scrotum ☐ Nl Prostate

LYMPH (≥ 2 areas): ☐ No Lymphadenopathy ○Nl Cervical ○Nl Axillary ○Nl Groin

M/S: ☐ Nl Gait _____ ☐ Nl Digits/Nails

Area(s) examined: _____

☐ Nl Inspection _____ ☐ Nl Stability _____

☐ Nl ROM _____ ☐ Nl Strength & Tone _____

SKIN: ☐ Nl Inspection ☐ Nl Palp

NEURO: ☐ Nl CN ☐ Nl DTR's ☐ Nl Sensation

PSYCH: ☐ Nl Memory ☐ O x 3 ☐ Nl Mood/Affect ☐ Nl Judgment & Insight

Lab/X-ray:

ASSESSMENT AND PLAN:

☐ SPOKE WITH FAMILY ☐ MESSAGE WITH FAMILY ☐ MD spoke w/ PA or w/NP, agrees w/ plan

☐ Time Spent _____ Total # Minutes ☐ > = 50% of total time spent C&C ☐ Time spent FF _____ Total # Minutes

Signature: _____ Date: _____

Revised: 8/9/11