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 ($\geq$ 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: Length of visit ________ min.   >50% spent in coord. of care &/or counseling

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