Jewish Tradition Home Care

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NURSING SUPERVISORY VISIT AND PLAN OF TREATMENT

Patient Name: _____ DOB: _____
Patient Address: _____
Patient Phone: _____ Sex: Male _____ Female _____
SOC Date: _____ Certification Period From: _____ To: _____
Visit Schedule: Routine: ___ 60 Day: ___180 Day: ___Special Reason: _____
Diagnosis: #1: _____ #2: _____
Allergies: _____

PHYSICAL ASSESSMENT

Vital Signs: Temp: ____ Pulse: ____ Respirations: ____ BP: ____ Weight: ____
Neurological: Gait: _____ Balance: _____ Tremors: _____
Seizures: _____
Mental Status: Oriented: _____Forgetful: _____Disoriented: _____Confused: _____
Agitated: _____ Lethargic: ____ Comatose: _____
E.N. T.: _____
Respiratory: _____
Cardiovascular: _____
G.I.: _____
Diet: _____ Appetite: _____
G.U.: _____
Musculoskeletal: _____ Skin: _____

FUNCTIONAL LIMITATIONS

Ambulation: _____Amputation: _____Contracture: _____
Paralysis: _____ Endurance: _____ Feeding: _____
Sight: _____ Speech: _____ Hearing: _____
Incontinence: Bladder: _____ Bowel: _____

ACTIVITY A=with assistance I=independent

Bed rest: _____ Transfer: _____ Up as tolerated: _____ Walk: _____
Bath/Shower: _____ Dressing: _____ Feeding: _____ Toileting: _____

SAFETY MEASURES AND EQUIPMENT NEEDS

_____
_____
_____

Patient Name: _____

MEDICATIONS **ASSISTANCE REQUIRED WITH SELF ADMINISTRATION OF MEDICATIONS: YES: _____ NO: _____**

Name	Dose	Frequency	Route	New/Changed

ORDERS FOR DISCIPLINE AND TREATMENT

_____
_____
_____
_____
_____

Last M.D. Visit: _____ Next M.D. Visit: _____

PROGNOSIS

Poor: _____ Fair: _____ Guarded: _____ Good: _____ Excellent: _____

GOALS

_____
_____
_____
_____

_____ _____

Primary Physician Signature/Date **Registered Nurse Signature/Date**

Name: (printed) _____ **Name: (printed) _____**
Address: _____
_____
Phone: _____
Fax: _____