Skilled Nurse Visit Record

Client Name:	Client Signature:	Date:
Client Identifiers(2): verified name; stated name; caregiver stated name; correct address; known to me	Printed SN Name:	Start Time: _____ End Time: _____
Client Centered Goals/Tasks:	Education Given:	Tasks/Skills Preformed:

ASSESSMENT
Neurological:
Cardiovascular: BP_____ HR____ RR _____ T_____
Pulmonary: RR_____ Breath Sounds:
GI: Last BM:
GU:
Skeletal:
Skin:
Pain Scale _____ **Rating**___ **Location** _____ **Duration**_____ **Intervention** _____
Medication Intervention: ☐ **Education** ☐ **Set-up** ☐ **Administration** **(see MAR)** _____

CLINICAL NOTES

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Physician; RN communication

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Provider Signature/Title/Date:_____

By signing above the SN states that the documentation is complete and accurate; each box is documented in its entirety and completed by 1159pm on the date above. Goals and tasks were taken off care plan or verbal communication with RN or physician. All medication administration is documented on MAR in home. MAR is to be turned in to Med1Care, LLC once per month.