Nursing Visit Progress Notes

Client Name:				Primary Physician:			
Date:		Time Allocated: Mileage:		Reason for Visit:			
CONDITION:							
Condition Stable? ☐ Yes ☐ No							
New Concerns or Change in Status:							
VITAL SIGNS							
B/P:	Pulse:		Respirations:		Temp:		Weight:
GENERAL:							
Bowel / Bladder Problems? ☐ Yes ☐ No							
If yes, explain:							
Appetite: □ Good □ Fair □ Poor							
Explain:							
MEDICATIONS:							
\square Pill Box Setup \square Refills Ordered				☐ Medication Changes ☐ Me		□ Mor	nthly Mar
Additional Comments:							
MEDICAL / PAIN MANAGEMENT							
Recent Physician Appointments:				Upcoming Physician Appointments:			
Pain and Discomfort: ☐ Yes ☐ No				If yes, is the pain ☐ Acute ☐ Chronic			
Location and Comments:							
Physicians Notification Required: \square Yes \square No				Method of Contact: ☐ Fax ☐ Telephone ☐ MD Visit			
NURSING NOTES:							
NURSES SIGNATURE:							