Nursing Note For Continuous Care

Patient Name:	Caregiver Signature: _____
Reason for Continuous Care:	**CC discharge plan:**

Vital Signs	B/P Lying Sitting Standing	Temp	Resp	Apical Pulse	Radial Pulse	Weight

Physical Assessment (Check those areas that pertain to patient)

Respiratory
□ No Problem □ Apnea □ Dyspnea/Extent _____
□ Resp Uneven □ Cough □ Sputum □ Rales
Breath Sounds: □ Clear □ Rhonchi □ Wheezing
□ O^2 _____
Glucometer Check: High_____Low_____
□ Scales Calibrated

Gastro Intestinal
□ No Problem □ Appetite Decreased □ Weight Loss/Gain:Amt_____
□ Constipation □ Incontinent □ Last BM_____
□ Nausea □ Vomiting □ Diarrhea □ Dysphagia
□ Abdomen: □ Soft □ Firm □ Distended
□ Diet Compliance:___Yes ___No □ Ostomy Care Taught/Performed

Neuro
□ No Problem □ Alert □ Lethargic □ Forgetful □ Agitated
□ Disoriented □ Dizziness □ Tremors
□ Grasps: ___R ___L □ Pupils equal/reactive to light
□ Oriented to: ___Time ___Place ___Person Other_____

Ears/Eyes/Nose/Throat
□ No Problem □ Impaired Vision □ Blind □ Cataract/Glaucoma
□ Deaf □ Impaired Hearing □ Impaired Speech
□ Tinnitus □ Epistaxis □ Congestion

Musculoskeletal
□ No Problem □ Bedbound □ Chairbound □ Ambulatory Aid
□ Unsteady Balance/Gait □ Amputations □ Joint Pain/Stiffness
□ Contracture □ Paralysis □ Arthritis □ Falls

Circulatory
□ No Problem □ Heart Irregular
□ Gallop □ Murmur □ Edema
□ Peripheral Pulses: ___LR ___RR ___LP ___RP
□ Chest Pain -Describe:

Skin Condition
□ No Problem □ Warm □ Cool □ Cold □ Dry
□ Clammy □ Turgor □ Diaphoretic □ Skin Broken
□ Pale □ Jaundice □ Cyanotic

GU Status
□ Incontinent □ Retention □ Dysuria - Freq _____
□ Catheter □ Hematuria □ Bladder Program
□ Foley Insertion □ Teaching Catheter care Output _____
□ Urine Clear Cloudy Odor Sediment Other

Pain Assessment: Controlled: ❑ Yes ❑ No Assessed by □ Pt. □Nurse □ CG □ Other

Intensity: 0 No Pain 1 2 3 4 5 Distressing 6 7 8 9 10 Intolerable Goal Pain Level:_____

Progress toward CC POC goals:_____

Physician Oversight/Contact: _____

Describe Pain: □ Dull □Sharp □ Aching □ Burning □ Other Location:_____

Current Medication Regimen: _____

Amount of Pain Medication taken in the last 24 hours (total mg):_____

Current Sleep Pattern: ❑ Restful ❑ Insomnia ❑ Restlessness ❑ Difficulty Arousing ❑ Increased need for sleep ❑ Sleep disturbance related to pain/anxiety

Sedative used _____

Effect:_____

SUMMARY: (DATE, TIME AND SIGNATURE AFTER EACH ENTRY)

Patient Name:_____ (INCLUDE DATE, TIME AND SIGNATURE AFTER EACH ENTRY)