CAS Home Health Care, Inc.
7308 Castor Avenue
Phone: (215) 831-8008 Philadelphia, PA 19152 Fax: (215) 831-1011

NURSE'S CLINICAL NOTE

Patient Name: _____ Medical Record Number: _____

NURSING ASSESSMENT: PROBLEM (+) NO PROBLEM (-)

Mental Status		Cardiovascular		Neurological	
Skin		Gastrointestinal		Musculoskeletal	
EENT		Genito-Urinary		Metabolic	
Respiratory		Psycho/Social		Other Health Related Factors	

	Lying	Sitting	Standing
(R)			
B / P - (L)			

	Instep	Ankle	Calf
Edema (R)			
Edema (L)			

Measure in centimeters (cm) where required

Temp _____

Apical Pulse _____ Radial Pulse _____

Breath Sounds (R): _____ Blood Sugar _____ Abdominal Girth _____ Resp. _____

Breath Sounds (L): _____ LBM _____ I/O _____ Wt. _____

SKILLED SERVICE PROVIDED

___ Skilled Observation	___ Teach/Adm. Tube Feeding	___ Teach/Adm. Port A Cath Care
___ Foley Care Insertion ___ Size ___ Bal ___	___ Adm. IM/SQ Injection	___ Teach/Adm. IVs/Chemotherapy
___ Teach/Adm. Care of Trach	___ Teach/Adm. Injection	___ Teach Care Bedbound Patient
___ Wound Care/Dressing	___ Teach Meds/Action/Side Effect/Regima	___ Teach S/S Complications
___ Decubitus Prevention/Care	___ Teach Disease Process	___ Teach Diet/Fluid Intake
___ Bowel/Bladder Training	___ Assess/Teach Safety Measures	___ Teach Activity Restrictions
___ Digital with Manual Removal/Enema	___ Teach/Adm. Ostomy/Ileo Conduit Care	___ Other (Specify)

SPECIFIC SKILLED INTERVENTION / CARE PROVIDED / RESPONSE TO TEACHING

Case Conference: ❑ YES ❑ NO With: _____

Discussed Plan of Care: ❑ YES ❑ NO

_____

_____

_____

_____

_____

Plan: _____

_____

Home Bound Due To _____ Client Signature _____

HHA ACTIVITY

HHA Name _____

❑ Introduction Pt/Fam Satisfied with Care ❑ Yes ❑ No

❑ Supervision Care Plan ❑ Reviewed ❑ Updated

HHA Following Care Plan ❑ Yes ❑ No

HHA Needed _____ Times/Week

Next HHA Supervision _____

Nurse's Signature _____ Date _____ Time _____