Company Name

PATIENT OUTCOMES FOR
MANAGEMENT & EVALUATION OF THE PLAN OF CARE

Patient Last Name	First Name	Pt. ID #	Date	Pay

ASSESSMENT OF SYMPTOMS CONDITIONS *Address Abnormalities Under Comments*

Temperature:	Edema: R L	Nutrition Adequate: Y / N
Blood Pressure R L	Measurements: R L	Hydration Adequate: Y / N
		GU Output Adequate: Y / N
Pulse: AP RP	GI:	Foley Change Due: _____
Rhythm:	Last BM:	Pain: Y / N
Respiration	Nausea: Y / N	Location:
Lung Sounds: R L	Vomiting: Y / N	Scale (1 - 10)
	Weight:	Homebound: Y / N

A. Cognitive
1. Memory Loss
2. Disease Related Learned Impairment
3. Lack of Basic Knowledge & Skills

B. Functional
1. Sensory Deficits
   a. Acute
   b. Chronic
2. Motor Deficits
   a. Acute
   b. Chronic

C. Psychosocial
1. Social Deficits
2. Behavioral Issues
3. Religious Beliefs
4. Cultural Influences

D. Environmental
1. Support System Deficit
2. Living Environment Prohibitive to Care
3. External Environment

E. All Other Barriers to Meeting Outcomes

RESPONSES OF PATIENT (PT) CAREGIVER (CG) TO CARE & HEALTH TEACHING BY NURSE

VERBALIZES	EDIT	OUTCOME	VARIANCE # (circle correct)	
Purpose / action of each med		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Dose / time of each med		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Common side effects of each med		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Adequate food / fluid intake		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Dietary restrictions		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Adequate activity / rest / sleep patterns		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Rationale for prescribed lab tests		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Emergency access 911 / other:		met not met n/a	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Correct treatment for exacerbation symptoms		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
How to use pain scale		met not met n/a	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
How to report pain / symptoms		met not met n/a	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E

DEMONSTRATES ABILITY	EDIT	OUTCOME	VARIANCE # (circle correct)	
Notice onset of exacerbation		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Perform ADLs / hygiene safely		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Comply with diet / food / fluid restrictions		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Reorder meds / supplies		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Schedule follow-up appointments		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Maintain absence of pain		met not met n/a	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Access community resources / support		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Maintain proper elimination patterns		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Treat _____ correctly		met not met n/a	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Cope with limitations / lifestyle		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
Disease status of _____		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
OTHER OUTCOMES:		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E
		met not met	A 1 2 3 4 B 1 a b 2 a b C 1 2 3 4 D 1 2 3 4	E

SKILL:

Refer to: ☐ PT ☐ OT ☐ ST ☐ RD ☐ HHA ☐ MSW   Care Coordination: ☐ MD ☐ RN ☐ PT ☐ OT ☐ ST ☐ HHA

Discharge Plan Discussed: ☐ Yes   ☐ No   ☐ MSW ☐ RE:

Nurse Signature: Date: Time In: Initials: _____   Time Out: Initials: _____

SERVICE	CHARGE	QUANTITY	SUPPLY DESCRIPTION
☐ RN	☐ Initial Visit	_____	_____
☐ LPN	☐ Regular Visit	_____	_____

Patient Name _____ Signature _____ Date _____

Employee Name _____ Signature _____ Date _____