IndependenceFirst
The Resource For People With Disabilities

NURSING VISIT REPORT

PCW Sup. _____ NBV _____ Other _____

Consumer: _____ Date: _____

ID: _____ Current Payor Source: MA FC Milw. County CC
Circle One
ICARE MHS UHC ABRI

Address: _____

Satisfaction with Services: _____

Medically Stable YES _____ NO _____
Skilled Agency Active YES _____ NO _____

Agency: _____ Payor: _____

Other Services: _____
_____

Home environment safe? YES _____ NO _____

Supervision of PCW: _____
_____

Care plan reviewed with: _____

NO CHANGES _____

Revised: _____
_____
_____

PCW: _____ Follows Universal precautions.
_____ Uses safe body mechanics.
_____ Has satisfactory relationship with consumer/family.
_____ Follows care plan.

Recent Hospitalizations: Yes _____ Dates _____ No _____

Comments: _____
_____
_____
_____
_____

Consumer/Surrogate Signature: _____ RN Signature: _____

PCW Signature: _____