HCBS/FE Nursing Evaluation Visit

Provider Name: _____

Customer Name: _____

Customer Name: _____ Date of Visit (MM/DD/YY): _____

Date Sent to TCM: _____

Diagnosis: _____

OBSERVATIONS/COMMENTS

Instructions regarding service delivery/attendant needs – specifications
Interventions/ Concerns/Goals

_____

_____

_____

_____

_____

_____

_____

_____

_____

CLINICAL MEASUREMENTS

Blood Pressure	_____	Pulse	_____
Respirations	_____	Temperature	_____
Weight	_____	Orientation	_____
Edema	_____	Nutrition Screen	_____
Pain	_____	Nutritional Risk	_____

HEALTH SYSTEMS REVIEW

Skin Integrity	_____	GU	_____
Eyes	_____	Reflexes	_____
Ears	_____	Upper Extremities	_____
Nose	_____	Lower Extremities	_____
Throat	_____	Psychosocial	_____
Respiratory	_____	Labs	_____
Cardiovascular	_____	Medications	_____
GI	_____	Safety	_____

Last Hospitalization: _____ Next Physician Visit: _____

Licensed RN Name: _____

Licensed RN Signature, with credentials: _____ Date: _____

Customer Signature: _____