HCBS/FE WELLNESS MONITORING

Agency Name: _____

Customer Name: _____

Date of Visit (MM/DD/YY): _____
Date Sent to TCM: _____

Diagnosis: _____

OBSERVATIONS/COMMENTS:
Interventions / Teaching Issues / Concerns / Goals / Plan

_____

_____

_____

_____

_____

CLINICAL MEASUREMENTS:

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

Customer's health concerns discussed / reviewed:

_____

_____

_____

_____

_____

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: _____ Next WM Visit: _____

Licensed Nurse Name: _____

Licensed Nurse Signature (with credentials): _____ Date: _____

RN Supervisor Signature (with credentials, as needed): _____ Date: _____

Customer Signature: _____