Caring Touch Nursing, Inc.

Category: CLIN **Client Name: _____ Date: _____**

Form 4: Monthly Summary

VITALS				
T:	P:	R:	BP:	PAIN:

MENTAL STATUS AND BEHAVIOR	
ORIENTATION	☐ Alert ☐ Orientated to Person ☐ Orientated to Place ☐ Orientated to Time ☐ Disorientated to Person ☐ Disorientated to Place ☐ Disorientated to Time
MEMORY	☐ Good ☐ Fair ☐ Poor ☐ Other_____
MOOD	☐ No Problems at this time ☐ Anxious ☐ Agitated ☐ Depressed ☐ Semi-comatose ☐ Comatose ☐ Intermittent Confusion ☐ Confused ☐ Other:_____
SLEEP	☐ Adequate Sleep: _____ hrs/night ☐ Naps during Day ☐ Difficulty falling asleep ☐ Intermittent awakening ☐ Early morning awakening ☐ Restless Sleep ☐ Sleeps with medication only

SENSORY SYSTEMS	
VISION	☐ Adequate ☐ Adequate with glasses ☐ Poor: Rt/ Lt/ Bilat (circle one) ☐ Blind ☐ Unable to assess ☐ Other_____
HEARING	☐ Adequate ☐ Adequate with Hearing Aid ☐ Hard of Hearing: Rt/ Lt/ Bilat (circle one) ☐ Deaf ☐ Unable to assess ☐ Other_____
SPEECH	☐Coherent & Relevant ☐Incoherent ☐ Clear & Understood ☐ Slurred Speech ☐Aphasic ☐ Non-English Speaking ☐Other_____

ACTIVITIES OF DAILY LIVING				
Specify: *INDEPENDENT, ASSIST/SUPERVISE, PARTIAL ASSIST, or TOTAL CARE*				
Bathing	Grooming	Oral Hygiene	Dressing	Feeding

LIVING ENVIRONMENT SAFETY ASSESSMENT
☐ Floor surfaces/stairs ☐ Electrical/lighting ☐ Water temp ☐ Entryways ☐ Bathroom ☐ Other:
Note:

NUTRITION & HYDRATION	
DIET	☐ Tube Feeding: _____ ☐ Normal Diet ☐ Special Diet _____ ☐ Supplement _____☐ Restrict Fluids _____☐ Force Fluids _____☐ NPO
APPETITE	Consumes: ☐100-75% ☐74-50% ☐49-25% ☐<25% ☐Eats in Room ☐Eats in Dining room ☐N/A
WEIGHT	Current weight:_____ Previous weight:_____ Weight Frequency: _____ Weight gain:_____ Weight loss _____

RESPIRATORY	
TRACH/VENT/INHALER NEB. TX/CPAP/O2	
BREATH SOUNDS/ PATTERNS	

ALLERGIES			
TO MEDS		Reaction Type	
TO ENVIRONMENT/ PRODUCTS/LATEX			

SKIN CARE
☐ Skin Intact • Bruises_____ ☐ Redness/Rash_____ ☐ Abrasions_____ ☐ Pressure Sore_____ Stage:____ ☐ Add'l sites; See CLIN 7: Body Outline ☐ Wound/Preventative Skin Care:

CONTINENCE	
BLADDER	☐ Continent all day and night ☐ Continent in day & wears briefs @ night ☐ Partial incontinent (less than 3X per week) ☐ Incontinent (more than 3X per week) ☐ Total Incontinent ☐ Wears briefs/uses under pads ☐ Toileting schedule ☐ Catheter; Date Last Changed_____ ☐ Ostomy
BOWELS	☐ Continent ☐ Continent in day & wears briefs @ night ☐ Toilet upon desire ☐ Partial incontinent (less than 3X per week) ☐ Incontinent (more than 3X per week) ☐ Total Incontinent ☐ Wears briefs /uses under pads ☐ Bowel Program _____ ☐Colostomy
ACTIVITY/ MOBILITY	
AMBULATORY	☐ Independent ☐ 1 person Assist ☐ Use of Walker ☐ Other Assistive Devices_____ ☐ Ambulates distance of _____ Strength: LUE _____ RUE _____ LLE _____ RLE _____ Balance: ☐ Good ☐ Fair ☐ Poor Gait:_____ ☐ N/A _____
WHEELCHAIR	☐ Rolls self ☐ Electric w/c ☐ Requires assistance ☐ N/A ☐ Up in w/c most of day ☐ Up in w/c short periods
RECLINER/CHAIR	☐ Up most of day ☐ Bed rest ☐ Up for short periods ☐ N/A
SAFETY PRECAUTIONS	☐ Fall ☐ Skin ☐ Home ☐ Emotional ☐ Infection ☐ Equipment Use ☐ Meds ☐ Airway/Respiratory ☐ Other:_____

RECENT MEDICAL HISTORY
Doctor Visits:
Hospital Admit:
Infections/ Injury:
New DME:
New Diagnoses:
New Physician Orders (Meds, Treatments, Etc.):

PROGRESS NOTES TOWARD GOALS AND EXPECTIONS

NOTES

POC up-to-date?	Satisfied with care?	Satisfied with staff?
Change in needs or service requests?		
Client/Family wishes to continue care:		
HHA / LPN Supervisory Visit? ☐ Yes ☐ No	Type: ☐ Direct (HHA/LPN on duty)	☐ Indirect (HHA/LPN not on duty)
NURSE SIGNATURE:		**DATE:**