Harbor Home HealthCare LLC
Tel: 703-734-6683 Fax: 703-879-7594

Nurse Notes: Medication Management

administrator@harborhc.com

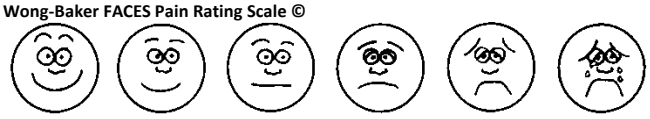
Patient Name	Date	Time in	Time Out	Total Hours

VITAL SIGNS

Time	Temperature ☐ Oral ☐ Axillary ☐Other	Pulse ☐ Apical ☐Radial	Respiration	Blood Pressure ☐ Left ☐ Right ☐ Sitting ☐ Lying	

PAIN ASSESSMENT

Wong-Baker FACES Pain Rating Scale ©



0	2	4	6	8	10
No Hurt	Hurts A Little	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Most

Location:_____ **Current Pain Regime**:_____
Is pain regime effective: ☐ Yes ☐ NO
Comment:_____

NUTRITION ASSESSMENT

Diet: ☐ NPO ☐ Regular ☐ Restricted/Type:_____
☐ Breast ☐ Formula-Type:_____ Other:_____
Amount:_____ **Frequency:**_____
Nutritional Risk Screening: ☐ LOW ☐ MED ☐ HIGH
Appetite: ☐ Good ☐ Fair ☐ Poor
Food Allergy:_____
Blood Sugar:_____ ☐ N/A
☐ Patient/Caregiver independent in diabetes management
Comment:_____

PATIENT/CAREGIVER EDUCATION

☐ Night shift/ teaching not appropriate ☐ PCG not available (or not living with patient) ☐ Paid Caregiver on duty Caregiver Name:_____

Topics Discussed and Individual
_____
_____
_____
_____

Taught to: ☐ Patient ☐ Family ☐ PCG ☐ Other:_____
Method: ☐ Discussion ☐ Demo ☐ Handout Other:_____
Level of Understanding: ☐ Good ☐ Fair ☐ Poor ☐ Needs reinforcement
Evaluation Method: ☐ Verbal ☐ Return Demo
Further Education needed: ☐ Equipment ☐ Therapies ☐ Medications

Medication Administration Management Nurse Notes:

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Patient left in care of: _____

_____ (RN/LPN/LVN) _____

Nurse name, Signature and Credentials / date **Patient/Family Signature Date**