	Patient Name: Date: MD/DO: Reason for Visit: SOC, ROC, Recert, F/U, DC
S	**Recent hospitalization date (if any):** **Primary Dx:** Therapies pt receives at home: (IV, parenteral, NG, GT, O2, etc) Advanced directive – yes, no, DNR Pt Living Situation: (alone, w others,) **Medications (MED LIST)**: **Allergies:** **Vaccines:** Flu, Pneumonia, Shingles, TB **PCG** name & contact:
O	*VITALS/PAIN – bp, hr, temp, rr, O2sat, *pain* Ht: Wt: BS: **SYSTEMS ASSESSMENT:** *eyes, ears, nose* *skin, pressure ulcer, wounds* ***lung sounds**, SOB, O2* *DM?, thyroid?* ***Heart sound**, rhythm, pulse, edema, pacemaker* *Last BM, GI probs, foley, ostomy, dials* *Diet, weight loss, eating well?* *LOC, depression screen, sleeping well?* *Mobility, DME needs, recent falls?*
A	Significant finding(s) to report:
P	**Nursing Intervention:** **Consents/RS Signed:** Y/N **HHA contact info given:** Y/N **Disciplines Needed:** PT/OT/ST/SN/MSW, Aide **Next Physician Visit:** **Pharmacy name and phone:**