



# GERIATRIC ENCOUNTER FORM

Links: [CC](#) [HPI](#) [Prob 1](#) [Prob 2](#) [Prob 3](#) [Prob 4](#) [Risks](#) [ROS](#) [Vitals](#) [PE](#)

Billing Code

Initial	Subsequent	Assist - New	Assist - Establish	Discharge	Annual	Consultation
<input type="radio"/> 99304	<input type="radio"/> 99307	<input type="radio"/> 99324	<input type="radio"/> 99334	<input type="radio"/> 99315	<input checked="" type="radio"/> 99318	<input type="radio"/> 99251
<input type="radio"/> 99305	<input type="radio"/> 99308	<input type="radio"/> 99325	<input type="radio"/> 99335	<input type="radio"/> 99316		<input type="radio"/> 99252
<input type="radio"/> 99306	<input type="radio"/> 99309	<input type="radio"/> 99326	<input type="radio"/> 99336			<input type="radio"/> 99253
	<input type="radio"/> 99310	<input type="radio"/> 99327	<input type="radio"/> 99337			<input type="radio"/> 99254
		<input type="radio"/> 99328				<input type="radio"/> 99255

NO BILLING CODE SET

**Demographic Information:** Admit Status:  Note Title:

Resident Last Name:  Resident First Name:  MI:  DOB:  Chart:  Encounter:

Social Security Number:  Marital Status:  Gender:  Age:  Religious Affiliation:  Education:  Children:

Nursing Home Information:  Room #:  Family Member Phone #:

Previous Location:  Race:  Other Race:  Family:

Guarantor's Name: Last  First Name  MI

Guarantor's Address  Apt  Guarantor's City  ST  Zip Code

Home Phone  Cellular Phone  Lab

Method of Payment:  Cash  Check  Credit Card Driver's License Number  DL State

Primary Insurance Company:  Primary Insurance Phone Number

Family Health Center,

Primary Insurance Street Address  PI Suite  PI City  ST  PI Zip

Primary Insured Party  D.O.B.  Relationship to Insured (Primary)

Primary Policy Number  Primary Group Number  Effective Date  Co-Pay

Include primary policy number in footer

Secondary Insurance Company:  Secondary Insurance Phone#

Secondary Insurance Street Address  SI Suite  SI City  ST  SI Zip

Secondary Insured Party  D.O.B.  Relationship to Insured (Secondary)

Secondary Policy Number  Secondary Group Number  Effective Date  Co-Pay

**ADVANCED DIRECTIVES:**

Full Code  DNR  No Code  Comfort Only  Hospice  No Tubes  No IV  No Hospitalization  No Life Support

**PROGNOSIS:**

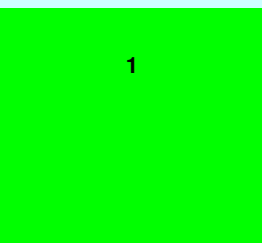
Good  Fair  Poor  Guarded

abigail@lefoy.net

**ALERTS**

**Chief Complaint:**

**History of Present Illness Notes:**



# Family Health Center

Patient Request:

Family Request:

Nursing Request:

Diagnostic results require physical eval of:

Follow-up visit needed for evaluation of:

Regulatory visit to evaluate D's listed: Regulatory rounds, chart review, med check, medical status, nursing report

Telephone Order:

Consultant/Pharmacist Request:

**HPI Score**

1

1

1

1

1

1

1

1

**History of Present Illness:**

**HPI Factors:**

Location: forehead

Duration: several hours

Timing: evenings

Quality:  Sharp  Dull  Steady  Ache  Tender  Warm

Notes:

Context: after work

Severity:  0  1  2  3  4  5  6  7  8  9  10

Associated Signs & Symptoms: blurred vision

Modifying Factors: resting helps

Date of Last Visit:

Expected Date of Next Visit:



**5**

Description: None

Problem Points: None

Data Points: None

Billing: 0

1	None
2	None
3	None
4	None
5	None
6	None

**RISK/MDM Problem 5:**

3-Two or more stable chronic illnesses

Phone Orders:

**6**

Description: None

Problem Points: None

Data Points: None

Billing: 0

1	None
2	None
3	None
4	None
5	None
6	None

**RISK/MDM Problem 6:**

3-Two or more stable chronic illnesses

Phone Orders:

**7**

Description: None

Problem Points: None

Data Points: None

Billing: 0

1	None
2	None
3	None
4	None
5	None
6	None

**RISK/MDM Problem 7:**

3-Two or more stable chronic illnesses

Phone Orders:

**8**

Description: None

Problem Points: None

Data Points: None

Billing: 0

1	None
2	None
3	None
4	None
5	None
6	None

**RISK/MDM Problem 8:**

3-Two or more stable chronic illnesses

Phone Orders:

**9**

Description: None

Problem Points: None

Data Points: None

Billing: 0

1	None
2	None
3	None
4	None
5	None
6	None

**RISK/MDM Problem 9:**

3-Two or more stable chronic illnesses

Phone Orders:

10

Description:

None

Problem Points

None

Data Points

None

Billing

0

- 1 None
- 2 None
- 3 None
- 4 None
- 5 None
- 6 None

**RISK/MDM Problem 10:**

3-Two or more stable chronic illnesses

Phone Orders:

11

Description:

None

Problem Points

None

Data Points

None

Billing

0

- 1 None
- 2 None
- 3 None
- 4 None
- 5 None
- 6 None

**RISK/MDM Problem 11:**

3-Two or more stable chronic illnesses

Phone Orders:

12

Description:

None

Problem Points

None

Data Points

None

Billing

0

- 1 None
- 2 None
- 3 None
- 4 None
- 5 None
- 6 None

**RISK/MDM Problem 12:**

3-Two or more stable chronic illnesses

Phone Orders:

13

Description:

None

Problem Points

None

Data Points

None

Billing

0

- 1 None
- 2 None
- 3 None
- 4 None
- 5 None
- 6 None

**RISK/MDM Problem 13:**

3-Two or more stable chronic illnesses

Phone Orders:

14

Description:

Problem Points:

Data Points:

1

2

3

4

5

6

Billing  
0

**RISK/MDM Problem 14:**

3-Two or more stable chronic illnesses

Phone Orders:

15

Description:

Problem Points:

Data Points:

1

2

3

4

5

6

Billing  
0

**RISK/MDM Problem 15:**

3-Two or more stable chronic illnesses

Phone Orders:

**Other Problems:**

**Overall Risk Levels:**

Problem Level:

Risk Management:

Diagnostic Procedures and Risk:

**Risk Level Note:**

Morbidity Risk Factors:

**Ambulation:**  Independent  Assist

Bed bound  Ambulation  Geri/chair  Cane  Walker  Rolling walker  Wheelchair

Lift transfer  Transfers independent  Transfers - one person  Transfers - two people

**DIET:**  Regular  Mechanical Soft  No Added Salt  Carb controlled  Pureed  Tube Feeding

Increase liquids  Thickened liquids  Liquid Diet

**ADLS**

**Eating**

Indepen.  Limited Assist.

Extensive Assist.  Total Dependence

**Dressing**

Indepen.  Limited Assist.

Extensive Assist.  Total Dependence

**Toileting**

Indepen.  Limited Assist.

Extensive Assist.  Total Dependence

**Hygiene**

Indepen.  Limited Assist.

Extensive Assist.  Total Dependence

**Bed Mobility**

Indepen.  Limited Assist.

Extensive Assist.  Total Dependence

**Review and Summation of Old Records:**

[Empty text box]

**Social History**

- APS Client
- Alcohol - abuse
- Alcohol - none
- Alcohol - social
- Substance Abuse
- PASSRr
- Non-smoker
- Active Smoker
- History of Smoking
- Glasses

Marital Status: Married ▼

Family: Unknown ▼

Religion: Unknown ▼

Education: None ▼

Occupation: [Empty text box]

Notes: [Empty text box]

3



**Family History**

Alzheimers [331.0]	▼ None	▼ None	▼
None	▼ None	▼ None	▼
None	▼ None	▼ None	▼
None	▼ None	▼ None	▼

Notes: [Empty text box]

**Pertinent Negative Family History**

Depression [311]	▼ None	▼ None	▼
None	▼ None	▼ None	▼
None	▼ None	▼ None	▼
None	▼ None	▼ None	▼

Notes: [Empty text box]

**Change in Family History**

None ▼    None ▼    None ▼

Notes: [Empty text box]

**Past Medical History:**

1	None	▼
2	None	▼
3	None	▼
4	None	▼
5	None	▼
6	None	▼
7	None	▼
8	None	▼
9	None	▼
10	None	▼
11	None	▼
12	None	▼

**Past Surgical History:**

1	Back Surgery	▼
2	None	▼
3	None	▼
4	None	▼
5	None	▼
6	None	▼
7	None	▼
8	None	▼
9	None	▼
10	None	▼
11	None	▼
12	None	▼

Other Significant Medical History:

[Empty text box]

Other Surgical History:

[Empty text box]

**Medicinal Allergies:**  NO KNOWN MEDICINAL ALLERGIES

1	▼	6	▼	11	▼
2	▼	7	▼	12	▼
3	▼	8	▼	13	▼
4	▼	9	▼	14	▼
5	▼	10	▼	15	▼

Other Medicinal Allergies:

[Empty box for Other Medicinal Allergies]

**Review of Systems through Patient/Staff/Doctor:**  
(Checks indicate Positive Conditions)

Patient is unable to answer ROS questions due to their diagnosis.

Checkboxes Reviewed	Systems Reviewed
---------------------	------------------

**Constitutional/Systemic**

Normal, healthy     Well-groomed     Oriented     Pleasantly confused     Unkempt  
 Pain     Fever     Anorexia     Malaise     Lethargy     Sweats  
 Weight Loss     Insomnia     Chills     Dizziness     Fatigue     Obese  
 Weight gain     Night sweats

Note: [Empty box]

TRUE	13
2	1

**Skin**

Good Turgor     Good color     Clear skin     Normal hair distribution/loss  
 Skin Rashes     Ulcer     Bruising     Discoloration     Vitiligo  
 Tumor     Nevus     Nodules     Non-healing lesion     Itch  
 Pale     Dry     Poor turgor

Note: [Empty box]

TRUE	
2	1

**Eyes**

No change/loss in vision     No double vision     No itching     No inflammation     No drainage  
 No spots     No flashes     No tenderness  
 Vision Change     Diplopia     Discharge     Tearing     Change in field of vision  
 Spots     Tenderness     Itching     Burning     Eye Inflammation  
 Flashes     Dry eyes     Blurring

Note: [Empty box]

TRUE	
2	1

**Ears, Nose, Mouth, Throat**

No drainage     No lesions     No swelling     No sneezing     No sore throat  
 Neck: Stiffness     Neck: Pain     Nodes/swelling     Difficulty swallowing     Tenderness  
 Ear Symptoms     Tinnitus     Discharge     Recurrent sinusitis     Drainage  
 Post Nasal Drip     Dry Nose     Nose Bleed     Mouth Lesions     Mouth Ulcers  
 Dry mouth     Rhinorrhea     Congestion     Bruxism     TMJ

Note: [Empty box]

TRUE	
2	1

**Cardiovascular**

No chest pain     No palpitations     No irregular beats     No orthopnea  
 No swelling     No dyspnea on effort     No Paroxysmal Nocturnal Dyspnea  
 Pain in chest     Irregular heart beat     Sudden changes in heart beat     High blood pressure  
 L.E. Edema     DOE     Palpitations     Paroxysmal Nocturnal Dyspnea  
 Orthopnea     Heart murmurs

Note: [Empty box]

TRUE	
2	1

**Pulmonary/Chest**

No SOB     No cough     No sputum     No dyspnea     No wheezing     No pain on breathing  
 No asthma  
 Dyspnea     Shortness of breath     SOB at rest     Dyspnea on effort  
 Choking     Cough: dry     Cough - productive     Cough - blood tinged  
 Productive sputum     Sputum: clear     Sputum: white     Sputum: yellow  
 Sputum: frothy     Sputum with odor     Sputum: green     Hemoptysis  
 Rattling     Wheezing     Pain with Breathing

TRUE	
------	--

<p>Note:</p>	2	1
<p>Gastrointestinal</p> <p> <input checked="" type="checkbox"/> No nausea    <input type="checkbox"/> No vomiting    <input type="checkbox"/> No dysphagia    <input type="checkbox"/> No pain    <input type="checkbox"/> No bleeding    <input type="checkbox"/> No melena  <input type="checkbox"/> No incontinence    <input type="checkbox"/> No BM changes    <input checked="" type="checkbox"/> No liver disease    <input type="checkbox"/> No dyspepsia </p> <p> <input type="checkbox"/> Nausea    <input type="checkbox"/> Vomiting    <input type="checkbox"/> Dysphagia    <input type="checkbox"/> Hematemesis    <input type="checkbox"/> Reflux    <input type="checkbox"/> Dyspepsia  <input type="checkbox"/> Cramping    <input type="checkbox"/> IBS    <input type="checkbox"/> Obstipation    <input type="checkbox"/> Diarrhea    <input type="checkbox"/> Loose Stools    <input type="checkbox"/> Rectal Bleeding  <input type="checkbox"/> Hemorrhoids    <input type="checkbox"/> Hernia    <input type="checkbox"/> Distention    <input type="checkbox"/> Melena    <input type="checkbox"/> Liver Disease    <input type="checkbox"/> Black Tarry stools  <input type="checkbox"/> GERD    <input type="checkbox"/> Constipation    <input type="checkbox"/> Pain    <input type="checkbox"/> BM Changes    <input type="checkbox"/> Incontinent    <input type="checkbox"/> Colostomy  <input type="checkbox"/> Obstruction    <input type="checkbox"/> Impaction </p> <p>Note:</p>	TRUE	1
<p>Genitourinary</p> <p> <input checked="" type="checkbox"/> No incontinence    <input type="checkbox"/> No bleeding    <input type="checkbox"/> No pain    <input type="checkbox"/> No lesions    <input type="checkbox"/> No nodes    <input type="checkbox"/> No rash  <input checked="" type="checkbox"/> No discharge </p> <p> <input type="checkbox"/> Dysuria    <input type="checkbox"/> Hesitancy    <input type="checkbox"/> Urine reten.    <input type="checkbox"/> Pain    <input type="checkbox"/> Hematuria  <input type="checkbox"/> Nodes    <input type="checkbox"/> Lesions    <input type="checkbox"/> Genital itch    <input type="checkbox"/> Genital rash    <input type="checkbox"/> Incontinent  <input type="checkbox"/> Foley    <input type="checkbox"/> Suprapubic cath    <input type="checkbox"/> Neuro. bladder    <input type="checkbox"/> Spasm  <input type="checkbox"/> No complaints of BPH    <input type="checkbox"/> Genital Discharge </p> <p>Note:</p>	TRUE	1
<p>Neurologic</p> <p>Oriented x4 <input type="text" value=""/></p> <p> <input type="checkbox"/> Alert    <input type="checkbox"/> NO Tardive dyskinesia    <input type="checkbox"/> No seizures  <input checked="" type="checkbox"/> No weakness    <input checked="" type="checkbox"/> No loss of function    <input type="checkbox"/> No memory loss    <input type="checkbox"/> No gait disturbance    <input type="checkbox"/> No syncope </p> <p> <input type="checkbox"/> Apraxia    <input type="checkbox"/> Ataxia    <input type="checkbox"/> Dysphasia    <input type="checkbox"/> Loss of function    <input type="checkbox"/> Lethargic  <input type="checkbox"/> Loss of smell    <input type="checkbox"/> Loss of taste    <input type="checkbox"/> Shakes    <input type="checkbox"/> Tremors    <input type="checkbox"/> Headaches  <input type="checkbox"/> Sciatica    <input type="checkbox"/> Trigeminal Neuralgia    <input type="checkbox"/> Temporal Neuralgia    <input type="checkbox"/> Sensory Changes  <input type="checkbox"/> Seizures    <input type="checkbox"/> Sleep disturbance    <input type="checkbox"/> Syncope    <input type="checkbox"/> Unsteadiness  <input type="checkbox"/> Numbness or tingling of hands    <input type="checkbox"/> Weakness  <input type="checkbox"/> Numbness or tingling of feet    <input type="checkbox"/> Migraine Headaches </p> <p>Note:</p>	TRUE	1
<p>Psychiatric</p> <p> <input checked="" type="checkbox"/> Pleasant    <input type="checkbox"/> Cooperative    <input type="checkbox"/> No confusion    <input type="checkbox"/> No agitation    <input type="checkbox"/> No hallucinations  <input type="checkbox"/> No delusions    <input type="checkbox"/> No psychosis    <input type="checkbox"/> No abnormal behaviors </p> <p> <input type="checkbox"/> Disoriented    <input checked="" type="checkbox"/> Confused    <input type="checkbox"/> Delusional    <input type="checkbox"/> Agitated    <input type="checkbox"/> Paranoid    <input type="checkbox"/> Anxiety  <input type="checkbox"/> Bipolar    <input type="checkbox"/> Manic    <input type="checkbox"/> Depression  <input type="checkbox"/> Good mood    <input type="checkbox"/> Good affect    <input type="checkbox"/> Appropriate affect    <input type="checkbox"/> Apathy    <input type="checkbox"/> Despondent    <input type="checkbox"/> Distant </p> <p>Note:</p>	TRUE	1
<p>Endocrine</p> <p> <input type="checkbox"/> No diabetes    <input checked="" type="checkbox"/> No thyroid disease    <input type="checkbox"/> No parathyroid disease    <input type="checkbox"/> Menopausal  <input type="checkbox"/> No unexplained weight loss/gain    <input type="checkbox"/> No excessive thirst    <input type="checkbox"/> Adrenopausal  <input checked="" type="checkbox"/> No history of heat/cold intolerance </p> <p> <input type="checkbox"/> Diabetes    <input type="checkbox"/> Hyperthyroidism    <input type="checkbox"/> Hypothyroidism    <input type="checkbox"/> Excessive thirst  <input type="checkbox"/> Heat/cold intolerance    <input type="checkbox"/> Unexplained weight loss/gain </p> <p>Note:</p>	TRUE	1

Hematologic/Lymphatic

- No easy bruising     No excessive bleeding     No swollen glands/nodes     No blood problems
- Anemia     Leukemia     Blood problems     Easy bruising     Excessive bleeding
- Swollen glands/nodes     Tender glands/nodes

Note:

TRUE

2

1

Allergic/Immunologic

- No hx of HIV exposure     No history of chronic infection
- Frequent sneezing     Increased susceptibility to infection     Seasonal allergies
- HIV exposure     Hives or rashes

Note:

TRUE

2

1

Other  
Notes on  
ROS:

0

0

# Physical Examination:

Admit Weight

Temp Pulse Respirations BP Previous Wgt Current Wgt % Chg Pain\_Scale

6 out of 10

Wt - Kilograms

Checkboxes Reviewed Systems Reviewed

12

## Constitutional/Systemic

- No Acute Distress
- Pleasantly confused
- Follows Commands
- Cooperative
- Good mood
- Well nourished
- Well Hydrated
- Spontaneous Movement
- Under nourished
- Obese
- Dyspnoeic
- Obtunded
- Diaphoretic
- Sarcopenic
- In distress
- Cachexia
- Dehydrated

TRUE

Note:

2

1

## Skin

- Good turgor
- Good skin color
- Skin intact
- No breakdown
- No jaundice
- Normal hair loss
- Not hyperemic
- No edema
- No warmth
- Rosacea
- Dermatitis
- Skin Tear
- Lymphedema
- Wounds
- Stasis edema
- Pigment changes
- Lesion
- Onychomycosis
- Bullae/blister
- Stasis dermatitis
- Herpetic Lesions
- Decubitus
- Sclerodactyly
- Breakdown
- Surgical wound
- Nail Changes
- Ecchymosis
- Telangiectasias
- Vitiligo
- Petechiae
- Bad turgor
- Hyperemic
- Edema
- Warmth

TRUE

Note:

2

1

## Eyes

- Pupils equal
- Pupils reactive
- EOM intact
- Sclera clear
- Decreased Vision Left
- Decreased Vision Right
- Pupils: Non-reactive
- Lesion
- Conjunctivitis
- Ectropion: Left
- Ectropion: Right
- Entropion: Left
- Entropion: Right
- Cataract: left
- Cataract: right
- Sclera jaundice
- Arcus Senilis
- Blind Left
- Blind Right
- Legally Blind
- Anisocoria

FALSE

Note:

0

0

## ENT

- Mucosal: pink, moist
- Mucosal: pink, dry
- Mucosal: pale, moist
- Mucosal: pale, dry
- No lesions
- No oral lesions/ulcers
- No nodes
- Edentulous - full
- Mucosal Dryness
- Edentulous - partial
- Own teeth
- Hearing Loss Right
- Submandibular nodes
- Tenderness
- Lesion
- Abnormal hair loss
- Hearing Loss Left
- Tooth Pain
- Gingivitis
- Tinnitus
- Cheilosis
- Thyroid Thrill
- Sinus Pain
- Dry mouth
- Drainage
- Inflammator
- Neck supple
- Neck: Stiffness
- Neck: Pain
- Sore Throat
- Thyroid bruit
- Multiple caries
- Epistaxis
- Nodes
- Dysphagia
- Thyromegaly
- Lymphadenopathy
- Rhinorrhea
- Supra clavicular fossa nodes
- Cervical nodes
- Posterior cervical nodes

TRUE

Note:

2

1

## Pulmonary/Chest

- Clear to auscultation and percussion
- Good excursion
- No Rhonchi
- No wheezing
- No Rales
- Good breath sounds
- No Rubs
- Absent BS
- Abnormal Breath Sounds
- Tubular sounds
- Dullness
- Rales: Coarse
- Rales: Fine
- Rubs
- Wheeze
- Diminished BS
- Cyanosis: Periph.
- Cyanosis: Circumoral
- Cough
- Rhonchi

TRUE

Note:	2	1
<b>Cardiology</b> <input checked="" type="checkbox"/> Regular rate <input type="checkbox"/> No JVP <input checked="" type="checkbox"/> No murmur <input type="checkbox"/> No bruit <input type="checkbox"/> No S3  <input type="checkbox"/> IRRG/IRRG Rate <input type="checkbox"/> Irregular Rate <input type="checkbox"/> Murmurs: None ▼ <input type="checkbox"/> S3 <input type="checkbox"/> Carotid Bruit Right <input type="checkbox"/> Carotid Bruit Left <input type="checkbox"/> Bruit: Left <input type="checkbox"/> Bruit: Right <input type="checkbox"/> Edema: left leg <input type="checkbox"/> Edema: right leg <input type="checkbox"/> Chronic LE edema <input type="checkbox"/> Dependent LE edema <input type="checkbox"/> JVP Elevated <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Ischemic changes	TRUE	
Note:	2	1
<b>Abdomen</b> <input type="checkbox"/> Abdomen soft <input type="checkbox"/> No Organomegaly <input type="checkbox"/> Bowel Sounds: Normal ▼ <input type="checkbox"/> Non-tender <input type="checkbox"/> No Pulsatile masses <input type="checkbox"/> PEG intact, clean, functional <input checked="" type="checkbox"/> Tenderness: Right <input type="checkbox"/> Tenderness: Left <input checked="" type="checkbox"/> Hepatomegaly <input type="checkbox"/> Ascites <input type="checkbox"/> Tenderness: UQ <input type="checkbox"/> Tenderness: LQ <input type="checkbox"/> Guarding <input type="checkbox"/> Masses <input type="checkbox"/> Distension <input type="checkbox"/> Organomegaly (hep/spl) <input type="checkbox"/> Pulsatile masses <input type="checkbox"/> Pulsations <input type="checkbox"/> Splenomegaly	TRUE	
Note:	2	1
<b>GU</b> <input type="checkbox"/> Male genitalia intact <input checked="" type="checkbox"/> Female genitalia intact <input checked="" type="checkbox"/> No discharge <input type="checkbox"/> No lesions <input type="checkbox"/> No bleeding  <input type="checkbox"/> Lesion <input type="checkbox"/> Cath <input type="checkbox"/> Prolapse <input type="checkbox"/> Bleeding <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia <input type="checkbox"/> Suprapubic: Distension <input type="checkbox"/> Suprapubic: Tenderness <input type="checkbox"/> Pruritus <input type="checkbox"/> Rash <input type="checkbox"/> Incontinence	TRUE	
Note:	2	1
<b>Breasts</b> <input checked="" type="checkbox"/> No asymmetry <input type="checkbox"/> No distortion <input checked="" type="checkbox"/> No nodes/nodules <input type="checkbox"/> No tenderness <input type="checkbox"/> No discharge <input type="checkbox"/> Mastectomy: None ▼  <input type="checkbox"/> Asymmetric <input type="checkbox"/> Tenderness <input type="checkbox"/> Nodules <input type="checkbox"/> Discharge <input type="checkbox"/> Auxiliary Nodes <input type="checkbox"/> Distortion <input type="checkbox"/> Mass	TRUE	
Note:	2	1
<b>Vascular</b> <input checked="" type="checkbox"/> No bruit/thrill <input checked="" type="checkbox"/> Bilaterally Equal <input type="checkbox"/> Bilaterally Unequal  <input type="checkbox"/> Carotid    4-Normal ▼ <input type="checkbox"/> Radial    4-Normal ▼ <input type="checkbox"/> Dorsalis Pedi    4-Normal ▼ <input type="checkbox"/> Posterior Tibial    4-Normal ▼ <input type="checkbox"/> Femoral    4-Normal ▼ <input type="checkbox"/> Varices: lower left <input type="checkbox"/> Varices: lower right	TRUE	
Note:	2	1

Neuro Exam/Psych

- Alert
- Afocal
- Oriented
- Good Affect
- Good mood
- Minimal Memory deficit
- DTRs present and equal
- Comatose
- Delirium
- Lethargic
- Hallucinations
- Obtunded
- Dementia
- Aphasic
- Hemiplegia
- Non-responsive
- Disoriented
- Cranial nerves III-XII intact to Inspection
- Confused
- AMS
- Babinski: Present Right
- Babinski: Present Left
- DTRs abnormal
- Panic attacks
- Psychosis
- Agitated

TRUE

Note:

2

1

Lymphatic

- No Nodes Were Palpated In:  Occipital
- Supraclavicular
- Subclavian
- Cervical
- Axillary
- Groin
- Inguinal
- Femoral
- Epitrochlear
- Nodes were found in the following:  Occipital
- Supraclavicular
- Subclavian
- Cervical
- Axillary
- Groin
- Inguinal
- Femoral
- Epitrochlear

TRUE

Note:

2

1

Extremities

- Full range movement - upper
- Full range movement - lower
- No ischemic changes
- No edema
- No amputations
- Left foot intact
- Right foot intact
- FROM x1
- FROM x2
- FROM x3
- FROM x4
- Left foot lesion
- Right foot lesion
- Rigidity
- ROM Changes
- Contracture
- Muscle waste
- Ulceration
- Tremor
- Lesion
- Blister
- Wound
- Cold feet
- Shiny skin
- No hair
- Dystrophic nails
- Edema left
- 1+
- 2+
- 3+
- 4+
- Edema right
- 1+
- 2+
- 3+
- 4+
- Myalgia
- Arthropathy

TRUE

Note:

3

1

Significant Changes in Physical Exam:

Skilled Therapy

None

Speech:

Physical:

Occupational:

Restorative:

Notes:

Abnormal Movements:

No Abnormal Movement

Signature

Dr. Melanie Cooper

Nursing Facility

Life Care Center of Lawrenceville (LCCL)

Visit Schedule

Week 1

Nurse

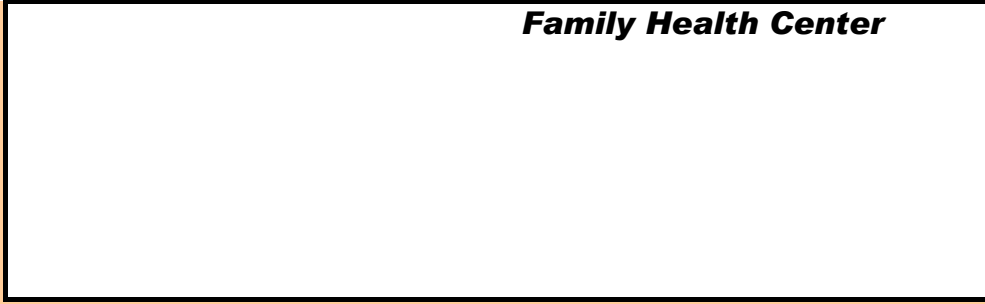
Hafiza Ukani

Place of Service

31 - Skilled Nursing Facility

General Assessment:

***Family Health Center***



**General Plan:**

