

FCN Patient/Client Visit Record (Use new form for each visit)

Patient/Client Record		Name:					Date:		Time:					
	Home	Hospital	Office	Phone	Other									
Check location of visit											List other interventions below			
Nursing Interventions			Listening	Presence	Education	Advocacy	Resource referral	Prayer	Spiritual Care	Reduce risk	Care Coord			
For each Dx below, check the intervention(s) you used.														
NURSING DIAGNOSES														
Check Nursing Dx (s) below:														
Need for Self-health management														
Need for health education														
Impaired comfort (physical)														
Impaired comfort (emotional)														
Spiritual Distress														
Anxiety														
Impaired physical mobility														
Grieving														
Risk for loneliness														
Caregiver Stress														
Transitional Care/Care Coordin.														
Pre/Post surgery teaching														
Medication issues														
Need for Advance Care Planning														
Other Nsg Diagnosis?														
other?														
other?														
BP_____P_____0/2%_____														
Nursing Notes:														
Total time (minutes) for visit/call		3	Next visit date: (If needed)											
Plan:														
FCN Signature														