

NURSE DELEGATION: NURSING VISIT

1. CLIENT NAME		2. DATE OF BIRTH	3. ID SETTING (OPTIONAL)		
4. CHECK ALL THAT APPLY <input type="checkbox"/> Initial Client Assessment (See attached) <input type="checkbox"/> Supervisory Visit <input type="checkbox"/> Initial Caregiver Delegation <input type="checkbox"/> Condition Change <input type="checkbox"/> Initial Insulin Delegation <input type="checkbox"/> Other					
5. CLIENT REQUIRES NURSE DELEGATION FOR THESE TASK(S): DUE TO:					
6. REVIEW OF SYSTEMS: Only check changes in condition from last assessment. <input type="checkbox"/> No Change <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Diet/Weight/Nutrition <input type="checkbox"/> Neurological <input type="checkbox"/> GU/Reproductive <input type="checkbox"/> GI <input type="checkbox"/> Respiratory <input type="checkbox"/> Endocrine <input type="checkbox"/> ADL <input type="checkbox"/> Sensory <input type="checkbox"/> Pain <input type="checkbox"/> Integumentary <input type="checkbox"/> Psych/Social <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Cognition					
7. NOTES					
8. Caregiver (CG) Training/Competency (Check or date all that apply)					
A. CG Evaluated	B. Observation or Demonstration	C. Verbal Description	D. Record Review	E. Training Needed Completed	F. Other (specify)
1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
9. <input type="checkbox"/> Check here if additional notes/caregiver name on page 2.					
10. <input type="checkbox"/> Client stable and predictable <input type="checkbox"/> Continue delegation <input type="checkbox"/> See rescind form					
11. <input type="checkbox"/> I am now delegating insulin injections for this client.					
Fax page 1 of this form to the ND Program Manager at (360) 438-8633 ONLY when documenting the first visit at which you delegate insulin injections.					
I have verified, informed, taught and instructed the caregiver(s) to perform the delegated task(s). The caregiver(s) has indicated that he/she accepts responsibility for performing the task as delegated. The caregiver(s) has been given the information on how to contact the RND if he/she is no longer able or willing to do these task(s) or resident health care orders change.					
12. RND SIGNATURE			13. DATE		14. RETURN VISIT ON OR BEFORE

To register concerns or complaints about Nurse Delegation, please call 1-800-562-6078

DISTRIBUTION: Copy in client chart and in RND file

NURSE DELEGATION: NURSING VISIT – PAGE 2

14. CLIENT NAME				15. DATE OF BIRTH		16. ID SETTING (OPTIONAL)	
17. NOTES							
18. Caregiver (CG) Training/Competency (Check or date all that apply)							
A. CG Evaluated	B. Observation or Demonstration	C. Verbal Description	D. Record Review	E. Training Needed Completed		F. Other (specify)	
6)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
8)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
9)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
10)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
11)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
12)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
13)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
14)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
15)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
16)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
18)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
19)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
20)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
I have verified, informed, taught and instructed the caregiver(s) to perform the delegated task(s). The caregiver(s) has indicated that he/she accepts responsibility for performing the task as delegated. The caregiver(s) has been given information on how to contact the RND if he/she is no longer able or willing to do these task(s) or resident health care orders change.							
19. RND SIGNATURE				20. DATE		21. RETURN VISIT ON OR BEFORE	

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INSTRUCTIONS – NURSE DELEGATION: NURSING VISIT

All fields are required unless marked “**OPTIONAL**”.

1. Client Name: Enter ND client’s name (last name, first name).
2. Date of Birth: Enter ND client’s date of birth (month, date, year).
3. ID Setting: **OPTIONAL** – Enter client’s ID number as assigned by your business OR enter settings “AFH”, BH, “DDD Program”, “In-home”.
4. Check the box or boxes that apply to how you are using this form.
5. Client Requires Nurse Delegation For These Delegated Task(s): List the task(s) you are delegating and the reason why the client needs to have the task(s) delegated.
6. Review Of Systems: Check the box for “No change” if client’s condition is unchanged from your last client assessment. If client’s condition is changed from your last assessment, check the appropriate category box. If a category box is checked, complete a note in Box 7 below.
7. Notes: Describe change in client’s condition in this box if a category box (other than “No change” is checked above).
8. Caregiver Training Competency:
 - A. List the name of each caregiver evaluated at this visit.
 - B. – D. Check the box.
 - E. Check box or insert the date for training needed or completed.
 - F. **OPTIONAL** – In this column, enter any other method of determining competency not already listed.
9. **OPTIONAL** – Check this box if a second page is used for additional notes/caregiver names.
10. Check all boxes that apply. If “Rescinding delegation” box is checked, you must complete “Rescinding Delegation form, DSHS 13-680.
11. Check the box and fax this page of the form to the Nurse Delegation Program Manager **ONLY** the first time insulin injections are delegated for this client.
12. RND Signature and Date: Sign and date your signature.
13. Return Visit On Or Before: Enter a date or the number of days within the 90 day time frame, that you will return for the next supervisory visit.
14. See number 1. above.
15. See number 2. above.
16. See number 3. above.
17. See number 7. above.
18. See number 8. above.
19. & 20. See number 11. & 12, above.
21. See number 13. above.

Be sure to sign and date both pages if a second page is used.