# Nurse Monitoring Visit Checklist

**CLIENT NAME: _____**

**NURSE MONITOR NAME: _____**

**DATE OF HOME VISIT: _____**

| ITEM | YES | NO | N/A |
|---|---|---|---|
| Copy of Client's Plan of Care in Home? Dated: | | | |
| Agency Nurse Visiting per regulations (every 45 day, if medication admin./Delegation; every 3 months with Med reminders; or every 4 months, if no medication assistance needed)?<br>Date of Last Nursing visit:_____ | | | |
| If Medication Administration – Is MAR in the home &being used by CMT | | | |
| If MAR being used, is it signed by RN at least every 45 days? | | | |
| Is Client satisfied with Agency and Care provider being sent? | | | |
| Is OTP device in the home and seen by you? (if applicable) | | | |

**Assessment Summary/Concerns**

**Vital Signs:**

Temp:_____BP:_____Pulse:_____Respiration:_____

**RN Signature:_____Date:_____**

_____ _____

**Client (or Representative) Signature** **Date:**