Mankato Clinic
Extended Care

Physician Rounding Form

Family Member Present? Yes_____
Time_____ No _____
Initial Visit Only:
Admit Date _____
Prev. PCP_____

Internal Use Only:

PHQ9?
Completed _____
Patient Unable _____

Name: _____ **DOB:** _____ **ROOM#:** _____

Date Vitals Taken _____

WT: _____ **BP:** _____/_____
LOCATION: LLE / LUE / RLE / RUE
(Please Circle One)

POSITION: Sitting / Standing / Supine
(Please Circle One)

CUFF SIZE: Large / Peds / Reg / Thigh
(Please Circle One)

TEMP: _____

TEMP METHOD: (Please Circle One)

Axillary / Oral / Temporal / Tympanic

P: _____**R:** _____

LOCATION: (Please Circle One)

Apical / Brachial / L. Carotid / R. Carotid /
L. Radial / R. Radial

BLOOD GLUCOSE LEVEL: _____
(IF APPLICABLE)

Confirm Smoking Status: (please check one)

- ○ **Current some day smoker**
- ○ **Current, every day smoker**
- ○ **Former smoker**
- ○ **Never smoked**

Current Alcohol Usage: (please check one)

- ○ **Yes**
- ○ **No**

Primary Ambulation Status: (please check one)

- ○ **Independent**
- ○ **Cane**
- ○ **Walker**
- ○ **Wheelchair w/Limited Ambulation**
- ○ **Unable to Ambulate (wheelchair only/bedridden)**

Dates of Last Two Falls:

_____ _____

Did fall(s) result in injury?

Y / N (Please Circle One)

Nursing Staff Concerns:

_____

_____

_____

_____

Orders/Nurse Communications:

_____

_____

_____

_____

Provider Signature: _____ **Date:** _____

Nurse Signature: _____ **Date:** _____