Bluestone Vista™ ON-SITE PRIMARY CARE
PROVIDED BY Mankato Clinic

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:** _____