

NURSING HOME PROGRESS NOTE

Initial

Date: ☐ Initial Visit ☐ Acute Care ☐ Recertification ☐ Annual Exam

ADDRESSOGRAPH

Advance Directives ☐ Yes ☐ No

HPI: CC: Recent problems

ROS: Constitutional ☐ neg

Allergies

Eyes ☐ neg

Problem List: ☐ Reviewed ☐ Updated

ENT, Mouth ☐ neg

HISTORY:

History obtained from: ☐ Patient ☐ Family

☐ Nursing Staff ☐ Chart ☐ Therapy Staff

Respiratory ☐ neg

PMHx:

Cardiovascular ☐ neg

Social/Family Hx:

GI ☐ neg

GU ☐ neg

Neuro ☐ neg

MS ☐ neg

Psych ☐ neg

Other

FUNCTIONAL STATUS

Basic ADLs	Indep.	Needs Asst.	Dep.	Ambulation		
Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Nonambulatory	<input type="checkbox"/> With Cane	<input type="checkbox"/> Unassisted
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> With Assistance	<input type="checkbox"/> With walker	
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Continence	Continent	Incontinent
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urine	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATIONS: ☐ Reviewed

Recent Changes

PHYSICAL EXAM / CLINICAL DATA T _____ P _____ BP _____ / _____ Wt: _____ ☐ GT ☐ Urinary Catheter ☐ Trach ☐ O2

Other

GENERAL APPEARANCE

HEENT ☐ EOM intact ☐ Eyes Clear ☐ No erythema, exudate or lesion ☐ TM intact ☐ Good dentition Other

NECK ☐ Neck symmetrical, no masses, trachea midline ☐ Thyroid not enlarged, non-tender Other

CARDIOVASCULAR ☐ RRR ☐ Normal S₁ & S₂ ☐ S₁ ☐ S₂ ☐ No murmur

RESPIRATORY ☐ Bilaterally clear to auscultation

GI ☐ Soft, non-tender ☐ Bowel sounds present ☐ No Mass ☐ No Organomegaly

EXTREMITIES ☐ No cyanosis, clubbing or edema

NEURO ☐ A&O x 3 ☐ CN intact ☐ Motor SFS ☐ Sensations intact ☐ Reflexes normal/symmetric Gait

SKIN

OTHER

LAB

☐ Total Care Plan/Pharmacy/Medication Orders Reviewed ☐ Labs Reviewed ☐ Radiology Reviewed

ASSESSMENT & PLAN

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Documentation for Physical Therapist Practice Jacqueline A. Osborne, 2015-07-31 Documentation for Physical Therapist Practice A Clinical Decision Making Approach provides the framework for successful documentation It is synchronous with Medicare standards as well as the American Physical Therapy Association s recommendations for defensible documentation It identifies documentation basics which can be readily applied to a broad spectrum of documentation formats including paper based and electronic systems This key resource utilizes a practical clinical decision making approach and applies this framework to all aspects of documentation This text emphasizes how the common and standard language of the Guide to Physical Therapist Practice and the International Classification of Functioning Disability and Health ICF model can be integrated with a physical therapist s clinical reasoning process and a physical therapist assistant s skill set to produce successful documentation Includes content on documentation formations Initial Evaluations Re examination Notes Daily Notes Conclusion of the Episode of Care Summaries Home Exercise Program Reviews all the important issues related to style types of documentation and utilization of documentation Covers documentation relevant in different settings inpatient home health skilled nursing facility outpatient Helps students learn how to report findings and demonstrate an appropriate interpretation of results Includes up to date information in line with APTA Guidelines for Defensible Documentation World Health Organization International Classification of Functioning Disability and Health Mode and Medicare Reviews electronic documentation ICD 9 ICD 10 and CPT codes Includes important chapters on Interprofessional Communication Legal Aspects Principles of Measurement *Community/Public Health Nursing - E-Book* Mary A. Nies, Melanie McEwen, 2018-08-31 Give your students a complete guide to community health nursing Community Public Health Nursing 7th Edition provides a unique upstream preventive focus and a strong social justice approach all in a concise easy to read text Covering the nurses role in promoting community health it shows how students can take an active role in social action and health policy emphasizing society s responsibility to protect all human life and ensuring that diverse and vulnerable populations have their basic health needs met Clinical examples and photo novellas show how nursing concepts apply to the real world Written by community health nursing experts Mary A Nies and Melanie McEwen this book describes the issues and responsibilities of today s community and public health nurse UNIQUE A social justice approach

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The OTA's Guide to Documentation Marie Morreale,2024-06-01 The bestselling newly updated occupational therapy assistant OTA textbook The OTA s Guide to Documentation Writing SOAP Notes Fifth Edition explains the critical skill of documentation while offering multiple opportunities for OTA students to practice documentation through learning activities worksheets and bonus videos The Fifth Edition contains step by step instruction on occupational therapy documentation and the legal ethical and professional documentation standards required for clinical practice and reimbursement of services Students and professors alike can expect the same easy to read format from previous editions to aid OTAs in learning the purpose and standards of documentation throughout all stages of the occupational therapy process and different areas of clinical practice Essentials of documentation reimbursement and best practice are reflected in the many examples presented throughout the text Worksheets and learning activities provide the reader with multiple opportunities to practice observation skills and clinical reasoning learn documentation methods create occupation based goals and develop a repertoire of professional language Templates are provided to assist beginning OTA students in formatting occupation based SOAP notes and the task of documentation is broken down into smaller units to make learning easier Other formats and methods of recording client care are also explained such as the use of electronic health records and narrative notes This text also presents an overview of the

initial evaluation process delineating the roles of the OT and OTA and guidelines for implementing appropriate interventions New in the Fifth Edition Incorporation of the Occupational Therapy Practice Framework Domain and Process Fourth Edition and other updated American Occupational Therapy Association documents Updated information to meet Medicare Part B and other third party payer requirements Revised clinical terminology on par with current trends Added examples from emerging practice areas Expanded tables along with new worksheets and learning activities Included with the text are online supplemental materials for faculty use in the classroom this includes access to supplemental website worksheets learning activities and scenario based videos to practice the documentation process *Medicare Hospital Manual* ,1983

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