

NURSING PROGRESS NOTES EXAMPLE

PATIENT'S INFORMATION:

Patient's Name: [Full Name]
Age: [55]
Gender: [Male]
Admission Date: [03/03/2040]
Room Number: [123]

VITAL SIGNS:

Date and Time	Temperature	Blood Pressure	Respiratory Rate	Heart Rate
[03/01/2040] [8:00 AM]	[98.6°F]	[120/70 mmHg]	[18 breaths/min]	[80 beats/min]
[03/01/2045] [4:00 PM]	[99.2°F]	[130/80 mmHg]	[20 breaths/min]	[84 beats/min]
[03/02/2040] [8:00 AM]	[98.8°F]	[140/90 mmHg]	[22 breaths/min]	[88 beats/min]

ASSESSMENT:

Date and Time	Assessment	Findings	Interventions
[03/01/2040] [8:00 AM]	Initial assessment	Patient is alert and oriented to person, place, and time. No complaints of pain. Lungs clear to auscultation. Abdomen soft and nontender.	None
[03/01/2045] [4:00 PM]	Follow-up assessment	Patient reports a pain level of [05] out of [10]. Administered [02] tablets of acetaminophen as ordered. Lungs clear to auscultation. Abdomen soft and nontender.	Administered medication as ordered
[03/02/2040] [8:00 AM]	Morning assessment	Patient reports a pain level of [03] out of [10]. Lungs clear to auscultation. Abdomen soft and nontender.	None

Documenting Progress Notes

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Documenting Progress Notes:

The Clinical Documentation Sourcebook Donald E. Wiger, 2010-02-02 All the forms handouts and records mental health professionals need to meet documentation requirements fully revised and updated The paperwork required when providing mental health services continues to mount Keeping records for managed care reimbursement accreditation agencies protection in the event of lawsuits and to help streamline patient care in solo and group practices inpatient facilities and hospitals has become increasingly important Now fully updated and revised the Fourth Edition of *The Clinical Documentation Sourcebook* provides you with a full range of forms checklists and clinical records essential for effectively and efficiently managing and protecting your practice The Fourth Edition offers Seventy two ready to copy forms appropriate for use with a broad range of clients including children couples and families Updated coverage for HIPAA compliance reflecting the latest The Joint Commission TJC and CARF regulations A new chapter covering the most current format on screening information for referral sources Increased coverage of clinical outcomes to support the latest advancements in evidence based treatment A CD ROM with all the ready to copy forms in Microsoft Word format allowing for customization to suit a variety of practices From intake to diagnosis and treatment through discharge and outcome assessment *The Clinical Documentation Sourcebook Fourth Edition* offers sample forms for every stage of the treatment process Greatly expanded from the Third Edition the book now includes twenty six fully completed forms illustrating the proper way to fill them out Note CD ROM DVD and other supplementary materials are not included as part of eBook file

The OTA's Guide to Writing SOAP Notes Sherry Borcharding, Marie J. Morreale, 2007 Written specifically for occupational therapy assistants *The OTA's Guide to Writing SOAP Notes Second Edition* is updated to include new features and information This valuable text contains the step by step instruction needed to learn the documentation required for reimbursement in occupational therapy With the current changes in healthcare proper documentation of client care is essential to meeting legal and ethical standards for reimbursement of services Written in an easy to read format this new edition by Sherry Borcharding and Marie J Morreale will continue to aid occupational therapy assistants in learning to write SOAP notes that will be reimbursable under Medicare Part B and managed care for different areas of clinical practice New Features in the Second Edition Incorporated throughout the text is the Occupational Therapy Practice Framework along with updated AOTA documents More examples of pediatrics hand therapy and mental health Updated and additional worksheets Review of grammar documentation mistakes Worksheets for deciphering physician orders as well as expanded worksheets for medical abbreviations Updated information on billing codes HIPAA management of health information medical records and electronic documentation Expanded information on the OT process for the OTA to fully understand documentation and the OTA's role in all stages of treatment including referral evaluation intervention plan and discharge Documentation of physical agent modalities With reorganized and shorter chapters *The OTA's Guide to Writing SOAP Notes Second Edition* is the essential text to providing instruction in writing

SOAP notes specifically aimed at the OTA practitioner and student This exceptional edition offers both the necessary instruction and multiple opportunities to practice as skills are built on each other in a logical manner Templates are provided for beginning students to use in formatting SOAP notes and the task of documentation is broken down into small units to make learning easier A detachable summary sheet is included that can be pulled out and carried to clinical sites as a reminder of the necessary contents for a SOAP note Updated information expanded discussions and reorganized learning tools make The OTA s Guide to Writing SOAP Notes Second Edition a must have for all occupational therapy assistant students This text is the essential resource needed to master professional documentation skills in today s healthcare environment

The Psychotherapy Documentation Primer Donald E. Wiger,2011-12-20 Everything you need to know to record client intake treatment and progress incorporating the latest managed care accrediting agency and government regulations Paperwork and record keeping are day to day realities in your mental health practice Records must be kept for managed care reimbursement for accreditation agencies for protection in the event of lawsuits to meet federal HIPAA regulations and to help streamline patient care in larger group practices inpatient facilities and hospitals The standard professionals and students have turned to for quick and easy yet comprehensive guidance to writing a wide range of mental health documents the Third Edition of The Psychotherapy Documentation Primer continues to reflect HIPAA and accreditation agency requirements as well as offer an abundance of examples The new edition features Revised examples of a wider range of psychological concerns New chapters on documentation ethics and the art and science of psychological assessment and psychotherapy Study questions and answers at the end of each chapter Greatly expanded The Psychotherapy Documentation Primer Third Edition continues to be the benchmark record keeping reference for working professionals reflecting the latest in documentation and reporting requirements

"Code of Massachusetts regulations, 2013" ,2013 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of January 2020

Effective Documentation for Occupational Therapy Jane D. Acquaviva,1998

"Code of Massachusetts regulations, 2016" ,2016 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of January 2020

"Code of Massachusetts regulations, 2012" ,2012 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of January 2020

"Code of Massachusetts regulations, 2005" ,2005 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of January 2020

New York Court of Appeals. Records and Briefs. New York (State)., **The Massachusetts Register** ,2017-01-13

The Adult Psychotherapy Progress Notes Planner Arthur E. Jongsma, Jr.,2001-03-09 The Adult Psychotherapy Progress Notes Planner contains complete prewritten session and patient presentation descriptions for each behavioral problem in The Complete Adult Psychotherapy Treatment Planner Second Edition The prewritten progress notes can be easily and quickly

adapted to fit a particular client need or treatment situation Saves you hours of time consuming paperwork yet offers the freedom to develop customized progress notes Organized around 39 main presenting problems that range from chemical dependence and low self esteem to anxiety impulse control grief loss and others Features over 1 000 prewritten progress notes summarizing patient presentation themes of session and treatment delivered Provides an array of treatment approaches that correspond with the behavioral problems and DSM IV diagnostic categories in The Complete Adult Psychotherapy Treatment Planner Second Edition Offers sample progress notes that conform to the requirements of most third party payers and accrediting agencies including the JCAHO and the NCQA "Code of Massachusetts regulations, 1992" ,1992 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of January 2020 **Effective Documentation for Physical Therapy Professionals** Eric Shamus,Debra Feingold Stern,2004 This is a comprehensive textbook for the documentation course required in all Physical Therapy programs The textbook incorporates current APTA terminology and covers every aspect of documentation including reimbursement and billing coding legal issues PT and PTA communication as well as utilization review and quality assurance Midwest Documentation Survival Handbook for Psychiatrists and Other Mental Health Professionals Stephen Michael Soreff,Mary Ann McDuffee,1993 **Annuaire de documentation coloniale comparée** ,1928 *The Severe and Persistent Mental Illness Progress Notes Planner* David J. Berghuis,Arthur E. Jongsma, Jr.,2002-12-09 This timesaving resource features Progress notes components for 25 behaviorally based presenting problems that correlate with The Severe and Persistent Mental Illness Treatment Planner Over 1 000 prewritten progress notes describing client presentation and interventions implemented Prewritten progress notes that can be quickly adapted to fit a particular client need or treatment situation The Severe and Persistent Mental Illness Progress Notes Planner contains complete prewritten session and patient presentation descriptions for each behavioral problem in The Severe and Persistent Mental Illness Treatment Planner The prewritten progress notes can be easily and quickly adapted to fit a particular client need or treatment situation Saves you hours of time consuming paperwork yet offers the freedom to develop customized progress notes Organized around 25 main presenting problems that range from antisocial behavior and eating disorders to anxiety substance abuse gambling and others Features over 1 000 prewritten progress notes summarizing patient presentation themes of session and treatment delivered Provides an array of treatment approaches that correspond with the behavioral problems and DSM IV diagnostic categories in The Severe and Persistent Mental Illness Treatment Planner Offers sample progress notes that conform to the requirements of most third party payers and accrediting agencies including the JCAHO and the NCQA **Functional Outcomes Documentation for Rehabilitation** Lori Quinn,James Gordon (Ed.D.),2003 This hands on textbook workbook teaches readers how to document functional outcomes in a clear logical progression Extensive examples and exercises in each chapter highlight the essential points of functional outcomes documentation designed to help improve client function

and reduce disability as well as provide evidence of functional progress for insurance payment and reimbursement Kevin
V. Thompson ,2000 **Medicare and Medicaid Guide** ,1969 *Documentation Skills for Quality Patient Care* Fay
Yocum,1999

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web back titration is used for 1 volatile substances e g nh₃ 2 insoluble or slightly soluble substances e g caco₃ 3 substances

for which the quantitative reaction proceeds rapidly only in the presence of excess of reagent e.g. lactic acid aspirin 4 substances which decompose on heating e.g.

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web Jun 10 2019 1 answer sorted by 3 I am afraid direct acid base titration is not the right way to analyze aspirin exactly because of the you stated hydrolysis the rule number no. of any titration is that there should be no side reaction and it

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web pubchemdatabase aspirin cid 2244 here back titration was done to obtain the concentration of aspirin from known aspirin tablets amount of product expected was 0.5g measured yield obtained was 0.335g which shows there was an error in the determination

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