

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

Clemens Wendtner



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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

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"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

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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 for Rehabilitation** Lori Quinn,James Gordon (Ed.D.),2010 In this textbook Quinn and Gordon provide a general approach to documentation that can be adapted to different settings for physical therapy students and professionals They emphasize the concept that clinical reasoning is reflected in documentation and vice versa and that documentation is a framework for clinical decision making They cover each documentation component and examples and exercises that relate to areas such as rehabilitation women s health health and wellness orthopedics and acute care This edition has been revised and expanded and includes new chapters on payment policy and coding legal aspects pediatrics and computerized documentation and incorporates the International Classification of Functioning Disability and Health model

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