

Nursing Clinical Progress Note

Paloma Home Health Agency, Inc

Visit ☐ Billable ☐ Non-Billable ☐ SN ☐ SN& Sup ☐ Sup Only ☐ PRN

Date: _____ Arrival Time: _____ Departure Time: _____

Patient Name: _____			
Vital	Temp: _____	Respirations: _____	Apical Pulse: _____ Radial Pulse: _____
Signs	B/P: _____	<input type="checkbox"/> Lying <input type="checkbox"/> Sitting <input type="checkbox"/> Standing	Weight: _____
Physical Assessment (Check those areas that pertain to patient)			
Respiratory <input type="checkbox"/> No Problem <input type="checkbox"/> Apnea <input type="checkbox"/> Dyspnea/Extent Respiration Uneven Cough Sputum Rales Breath Sounds: Clear Rhonchi Wheezing Oxygen		Gastro Intestinal <input type="checkbox"/> No Problem <input type="checkbox"/> Appetite Decreased Weight Loss/Gain: Amount: Constipation <input type="checkbox"/> Incontinent Date of Last BM: Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Dysphagia Abdomen: <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Distended Diet Compliance: <input type="checkbox"/> Yes <input type="checkbox"/> No Ostomy Care Taught/Performed	
Neurological <input type="checkbox"/> No Problem <input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Forgetful <input type="checkbox"/> Disoriented <input type="checkbox"/> Dizziness <input type="checkbox"/> Tremors <input type="checkbox"/> Agitated Grasps: <input type="checkbox"/> R <input type="checkbox"/> L : Pupils equal/reactive to light Oriented to: <input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person Other:		Ears/Eyes/Nose/Throat <input type="checkbox"/> No Problem <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Cataract/Glaucoma <input type="checkbox"/> Deaf <input type="checkbox"/> Impaired Speech <input type="checkbox"/> Blind <input type="checkbox"/> Tinnitus <input type="checkbox"/> Epistaxis <input type="checkbox"/> Congestion <input type="checkbox"/> Impaired Hearing	
Musculoskeletal <input type="checkbox"/> No Problem <input type="checkbox"/> Bedbound <input type="checkbox"/> Chair bound <input type="checkbox"/> Ambulatory Aid <input type="checkbox"/> Unsteady Balance/Gait <input type="checkbox"/> Amputations <input type="checkbox"/> Joint Pain/Stiffness <input type="checkbox"/> Contracture <input type="checkbox"/> Paralysis <input type="checkbox"/> Arthritis <input type="checkbox"/> Falls Date of last fall:		Circulatory <input type="checkbox"/> No Problem <input type="checkbox"/> Heart Irregular <input type="checkbox"/> Gallop <input type="checkbox"/> Murmur <input type="checkbox"/> Edema Peripheral Pulses: LR: 0 RR: 0 LP: 0 RP: 0 <input type="checkbox"/> Chest Pain -Describe:	
Skin Condition <input type="checkbox"/> No Problem <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Cold <input type="checkbox"/> Clammy Turgor: <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Skin Broken <input type="checkbox"/> Pale <input type="checkbox"/> Jaundice <input type="checkbox"/> Cyanotic <input type="checkbox"/> Dry		GU Status <input type="checkbox"/> No Problem <input type="checkbox"/> Incontinent <input type="checkbox"/> Retention Dysuria - Frequency: <input type="checkbox"/> Catheter <input type="checkbox"/> Hematuria <input type="checkbox"/> Bladder Program <input type="checkbox"/> Foley Insertion <input type="checkbox"/> Teaching Catheter care Output: <input type="checkbox"/> Urine <input type="checkbox"/> Clear <input type="checkbox"/> Cloudy <input type="checkbox"/> Odor <input type="checkbox"/> Sediment <input type="checkbox"/> Other:	
Pain Assessment: <input type="checkbox"/> No pain		Location: _____	
Intensity: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10		Duration: _____	
Current pain medication/s: _____			
Glucometer: Control <input type="checkbox"/> Results: FSBS obtained from: _____ Finger using aseptic technique.			
Results: <input type="checkbox"/> FBS <input type="checkbox"/> RBS			
Skilled Nursing Care Performed: _____			
Additional clinical findings: _____			
Progress Toward Goals on POC: _____			
New Identified Problems/Goals: _____			
Universal Precautions followed: <input type="checkbox"/> Hand washing <input type="checkbox"/> Gloves Worn <input type="checkbox"/> Sharps Disposal <input type="checkbox"/> Alcohol gel/hand cleanser			
<input type="checkbox"/> Other: _____			
Homebound Status: _____			
Coordination of Care: <input type="checkbox"/> RN, <input type="checkbox"/> LVN <input type="checkbox"/> Therapist <input type="checkbox"/> HHA <input type="checkbox"/> MSW Discussion: _____			
Physician contact: <input type="checkbox"/> N/A <input type="checkbox"/> Yes Discussion: _____			
Discharge Planning: _____			

Home Health Care Progress Notes

Marcel A. Müller

A red circular graphic with a gradient, appearing as a partial circle or a stylized 'C' shape, located to the right of the author's name.

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