

**Nursing Clinical Progress Note**

Paloma Home Health Agency, Inc

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Date: \_\_\_\_\_ Arrival Time: \_\_\_\_\_ Departure Time: \_\_\_\_\_

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

# Home Health Progress Notes

**G Orfield**

A red circular graphic with a gradient, appearing as a stylized arrow or a partial circle, located to the right of the name 'G Orfield'.

## **Home Health Progress Notes:**

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**england germany new zealand headline day two at the world lacrosse** - Dec 15 2022

jun 30 2022 day two of the 2022 world lacrosse women s championship featured 20 teams in 10 games of action three headlines england made a statement in the lone pool a game of the day with a 12 4 win over australia in a rematch of the 2017 bronze medal game megan whittle scored five goals and added four draw controls

**gallery england takes the bronze on olivia hompe s world lacrosse** - Apr 19 2023

jul 9 2022 women s gallery england takes the bronze on olivia hompe s triple overtime game winner england captured the bronze medal after defeating australia 8 7 in triple overtime in one of the best games of the 2022 world lacrosse women s



championship

*100 years of women s international lacrosse* - May 20 2023

mar 24 2013 united kingdom england wales and scotland plan to celebrate a century of women s international lacrosse special events are planned to honor the trail blazers for and special contributors to international women s lacrosse the first ever international match for women was held on the richmond athletic ground just outside london in april

*women s field england lacrosse* - Sep 24 2023

jun 23 2023 the england senior women s field lacrosse team are ranked third in the world after winning the bronze medal at the 2022 women s world championship they are also reigning european champions winning the women s european lacrosse championship 2019 featured news british lacrosse announce hong kong super sixes squads 17 oct 2023

**women s world championship spotlight world lacrosse** - Aug 23 2023

may 25 2022 this year s event the 11th edition of the women s world championship features a record 30 teams vying for the sport s biggest prize with five countries making their debut in the competition the united states will host the event for the third time after previously hosting in

2019 women s european lacrosse championship wikipedia - Mar 18 2023

2019 women s european lacrosse championship the 2019 women s lacrosse european championship was the 11th edition of this tournament it was held in netanya israel from 15 to 25 july 2019 16 teams joined the tournament england is the defending champion

england women s world cup training squad announced - Feb 17 2023

oct 7 2021 england lacrosse is pleased to announce the england women s senior training squad selected for the forthcoming world lacrosse women s world championships 2022 following a series of trial weekends a 32 player training squad has been put together by head coach phil collier and his team of backroom

full download women s lacrosse a guide for advanced - May 08 2022

apr 26 2022 this classic book on women s lacrosse has been updated with recent rule changes and the state of the game today women s lacrosse is one of the fastest growing sports in the united states as stick technology advances athleticism increases and rules and regulations adapt even the most experienced players and coaches need to keep current

**england women s national lacrosse team wikipedia** - Nov 14 2022

the england women s national lacrosse team represents england at women s lacrosse it is governed by the english lacrosse association they were runners up in the women s lacrosse world cup twice and have also hosted the tournament twice the team came 3rd in the 2017 women s lacrosse world cup which has held in oshawa canada 1

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girls club lacrosse girls lacrosse clubs have junior sections offering girls lacrosse from a young age with the junior girls game operating u11 u13 u15 u18 age groups junior sections will compete against other local community lacrosse clubs in leagues and competitions our regional and national academies also provide girls with an  
*2020 2022 women's international official playing* - Jul 10 2022

as adopted by world lacrosse and ratified by all world lacrosse members the world lacrosse women s rule book is compiled and published by world lacrosse wl in addition to the rules guidance sections in italics are provided to give clarity and rule interpretations for umpires coaches and players  
playing rules world lacrosse - Apr 07 2022

women s field english spanish reglamento de lacrosse femenino men s box sixes spanish las reglas oficiales de sixes lacrosse additional rules wheelchair mixed field equipment legal stick list rule changes

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women s lacrosse wikipedia - Oct 13 2022

please help update this article to reflect recent events or newly available information april 2021 women s lacrosse or girls lacrosse sometimes shortened to lax is a field sport played at the international level with two opposing teams of ten players each 12 players per team at the u s domestic level

**england lacrosse to use 2021 22 world lacrosse women s rules** - Aug 11 2022

jun 10 2022 nlc has made this decision because of timescales related to world lacrosse s publishing of their latest rule book including the new rules instead these latest january 2022 rules will be implemented for the 2023 24 season to view the latest england lacrosse approved women s rules [click here](#)

*new women s rules england lacrosse* - Jan 16 2023

national lacrosse committee has voted in favour of implementing the world lacrosse women s field rule changes within the domestic game for the upcoming 2020 21 season the domestic game includes england lacrosse leagues regional school and university pending approval from bucs rules regulations meeting competitions

march 2021 st edition world lacrosse - Jun 21 2023

in general the official rules of sixes lacrosse apply equally to both the women s and men s game where the official english language version march 2020 1st edition page 6 the game sixes lacrosse is played by two teams of six players each the

purpose of each team is to score by causing

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usa lacrosse acknowledgement the ncaa acknowledges usa lacrosse the national governing body of men s and women s lacrosse and the former united states women s lacrosse association for their respective roles in developing and publishing the rules of women s lacrosse since 1932 the ncaa rules book was developed based on

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web driver and team obligations 2 01 during the term of this agreement and any renewals or extensions thereof the race team represents and warrants to the sponsor that a it will at its own expense hire furnish and maintain at all times an experienced first class complete race team the race team consisting of mechanics

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web whether you re the owner from a motorsports organization or even a driver seeking sponsorship i put together this tour for via car racing team firstname car racing team firstname are describe your team consisting of number ardently driver s from area all over the world and number crew member

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