	NU	RSING	PROGRESS RE	EPORT"			
Temperature/Route	PULSES	WEIGH		BLOOD PRESS	URE		
	Radial	İ	☐ Actual	Standing	Sitti		Lying
			☐Stated	□ Left		.eft	☐ Left
Despiration	Aminat		□ Unable □ Client scale	-			
Respiration	Apical		☐ Agency scale	∏Right	ШH	Right	☐ Right
	SYSTEMS ASSE	SSMENT	- Check appropriate	e items & fill in bla	nks.		
CARDIOVASCULAR	RESPIRATORY	MUSC	ULOSKELETAL &	MENTAL & EMOT	TIONAL	NEURO	LOGICAL
☐ Pulse regular	☐ Lungs Clear	MOBIL	ITY	Oriented Labile		☐ Awake	€
☐ Pulse irregular	Rales	End	uranceft.	☐ Cooperative ☐ Disoriented	☐ Agitated		
Abnormal heart sounds	☐ Wheeze ☐ Labored	extrem	re ROM, all	Forgetful	Anxious	☐ Drows	iy
☐ Chest pain	☐ Cough/Sputum	Bed		□Withdrawn		Dizzin	
□ Chest pain		☐ Gait		Depressed		□Visual	deficit
☐ Edema/fluid retention			unsteady	☐ Lethargic ☐ Special needs			
	□ SOB / DOE	☐ Parti	al weight bearing	☐ Social isolation)	□Hearir	ng deficit
☐ Neck vein distention	☐ O2 ☐ Tracheostomy	☐ Mon	weight bearing - ambulatory	☐ Comatose		□ Spece	ch difficulty
☐ Pedal pulses	☐ Ventilator	☐ Pain	, weakness, injury	Paranoid		☐ Speed	owing difficulty
<u>L</u> R	Mode		·	☐ Delusional ☐ Hallucinations		☐ Pupils	s unequal
Numbness	T.V	☐ Pros	thesis	Dim. thought pro	cess	☐ Pupil	response
	Hate			☐ Poor coping skills		l L B	
□Other	IE Ratio + Pressure Limit	☐ DME		☐ Affect `		☐ Hand grasp L B	
 ☐ WNL for client	+Pressure Limit +Pressure Limit	Othe	F	Other		Other	_ N
E VVIVE IOI CREAT	Other Findings:	LIOINE	1	CI Onei			
		□ WNL	for client	☐WNL for client		□ WNL f	or client
HOMEBOUND STATUS	☐ WNL for client	CACTO	OINTECTION	GENITOURINAF)V	CIZINI	
	NUTRITIONAL &	1	OINTESTINAL	☐ No identified p		SKIN Norma	ПБ
☐ Immunosuppressed ☐ O2 dependent	HYDRATION		entified problems el sounds x 4	☐ Incontinence	robiems	□ Warm	
☐ Acute iliness	Appetite		BM	Retention		☐ Diaphoretic	
☐ Impaired mobility	☐ Good ☐ Fair ☐ Poor	Diarr		☐ Foley catheter		☐ Pallor	nenc
☐ Severe dyspnea	□TPN	☐ Cons		,		☐ Cyano	sis
☐ Severe pain		□Naus		Urine characte	eristics	□Turgor	
☐Incontinence	☐ Regular diet	☐ Vomit					
☐Wound	☐ Special diet	□Incor		☐ Burning			l 🗆 Lesions
Poor cardiac reserve	☐ G-tube feeding	☐ Abdor	ninal girth	Pain		□Rash	☐ Incision
☐ Other			<u></u>	Urgency		☐ WNL fo	or client
		☐ Ostor	ny	Frequency		. Dogum	ant waynad
	☐ Recent weight change	Other		☐ Ostomy		* Document wound appearance on pg 2	
	Other			Other		appearan	ce on pg z
	Li Ottlei	□Laxat	ive use				
	☐WNL for client		for client	☐WNL for client		l	
COMFORT	INJECTION & IV'S		S ACCESS	IV SITE CARE			ECIMENS
Absence of pain	☐ Not applicable		pplicable	☐ Not applicable		□ Not app	
☐ Complaint of pain	□IM □IV □SQ	Hickm	1	☐ Cap change		☐ CBC/P	
<u>Location</u> Severity:	Medication:	☐ Medip ☐ PICC	oort	Frequency Dressing change		☐ Chem I	
1 2 3 4 5 6 7 8 9 10		Grost	1000	Describe	je	☐ Protime	
MILD SEVERE	Dose:	☐ Porta		Describe		BUN	ıe
☐ Pain control measures	Site:	LI Orta	Jani			24 hou	r urino
Medication	Frequency:	Location		□Flush		Culture	
Frequency			nce	Describe		☐ FBS	
Response		, wpould		Describe		□RBS	İ
☐ Increased pain with	Response:	Single	Lumen	F-11-11-11-11-11-11-11-11-11-11-11-11-11		□UA	
activity			e Lumen	☐ Extension tubin	10	Other	
Other		☐ Triple	ì	change			:
				·- 3*			
	Administered By:						i
☐ WNL for client							1

Client Name			VISIT TYPE	Frequency	N	MD VISITS:	-
110.4			☐ Skilled Nursing	Visit Date	Visit Data		
HC #			□PRN	l Da		ate of Last	
Diognosis				Time In		Saka af Mai I	
Diagnosis	- Accessive contracts of contracts and contr			Time Out	L	rate of Next	
				1 113365 1111	4		1

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NURSE DIAGNOSIS

Bowel elimination, alteration Urinary elimination alteration Aftered Cardiac Function	10. Home main 11. Inconsisten follow- thre		15. Knowledge deficit RT: Client Caregiventon Careg	22.1 er 23.1	Sleep pattern dis Thought process Medication Comp Other:	alteration diance
4. Altered Cardiac Function 5. Comfort altered 6. Coping: □ Client □ Caregiver 7. Skin integrity impairment 8. Social isolation	☐ Clien 12. Infection: ☐	it □ Caregiver □ Potential □ Actual □ Potential □ Actual	17. Nutritional alteration18. Respiratory function, alter19. Self care deficit20. Sensory-perceptual altera	red	Julei.	
Intervention/Disease Specific	Assessment	Response	to Intervention		Outcome	
				The state of the s	1 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	
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	☐ Yes ☐ No	Patient remains at ris		scharge Plan:		□ No
	☐ Yes ☐ No	Patient remains at ris		scharge Plan:		
escribe		Patient remains at ris  Orders: □ New	Dis	scussed with:	☐ Client	☐Fami
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