SAMPLE: PSYCHIATRIC NURSE PROGRESS NOTE

Generously Provided By Angel Home Care Services, Inc. – Miami, FL

PATIENT DETAILS			DATE			EMPLOYEE	
LAST NAME	FIRST NAME	NUMBER	MO.	DAY	YR.	NUMBER	INITIALS

HOMEBOUND DUE TO

_____

SKILLED NURSING SERVICES

NURSING VISIT CODE
RV – ROUTINE VISIT
EV – EMERGENCY VISIT

OBSERVATIONS / MONITORING

VITAL SIGNS: BP _____ AP _____ REG _____ IRREG _____
TEMP _____ RESPIRATIONS _____
LUNGS: CTA _____ RALES _____ BS _____

PATIENT / FAMILY TEACHINGS

- ☐ MEDICATION REGIME
- ☐ ACTION / SIDE EFFECTS OF: _____
- ☐ S/S DISEASE PROCESS OF: _____
- ☐ S/S OF COMPLICATIONS OF: _____
- ☐ EXTRAPYRAMIDAL SYMPTOMS
- ☐ SAFETY MEASURES
- ☐ RELAXATION TECHNIQUES

MENTAL STATUS: IMPROVED _____ SAME _____ REGRESSED _____
☐ ALERT ☐ CONFUSED ☐ DISORIENTED
☐ HALLUCINATIONS / DELUSIONS: PRESENT _____ ABSENT _____
☐ SUICIDAL TENDENCIES: PRESENT _____ ABSENT _____
☐ EXTRAPYRAMIDAL SX: PRESENT _____ ABSENT _____
☐ ORIENTED: TIME _____ PLACE _____ PERSON _____
☐ INSIGHT PT / FAMILY: GOOD _____ FAIR _____ POOR _____

NUTRITION

- ☐ DIET
- ☐ PROPER FLUID INTAKE

THERAPY PROVIDED

- ☐ SUPPORTIVE
- ☐ REALITY

MOOD / AFFECT: IMPROVED _____ SAME _____ REGRESSED _____
☐ FLAT ☐ AGITATED ☐ DEPRESSED
☐ ANXIOUS ☐ COMBATIVE ☐ NEGATIVE

AIDE SUPERVISORY VISIT

COMMUNICATION: IMPROVED _____ SAME _____ REGRESSED _____
SOCIALIZATION: _____
SOMATIZATION: _____
VENTILATES FEELINGS: GOOD _____ FAIR _____ POOR _____

PATIENT SATISFIED WITH CARE PLAN	☐ YES	☐ NO
AIDE FOLLOWING CARE PLAN	☐ YES	☐ NO
CARE PLAN UPDATED	☐ YES	☐ NO
AIDE NEEDED _____ TIMES PER WEEK		

RAPPORT: _____
PATIENT with FAMILY: IMPROVED _____ SAME _____ REGRESSED _____
FAMILY with PATIENT: IMPROVED _____ SAME _____ REGRESSED _____
PATIENT with RN: IMPROVED _____ SAME _____ REGRESSED _____
FAMILY with RN: IMPROVED _____ SAME _____ REGRESSED _____

SPECIFIC MEDICAL TREATMENTS / TEACHINGS

_____
_____

NUTRITION STATUS:
APPETITE: IMPROVED _____ SAME _____ DECREASED _____
FLUID INTAKE: IMPROVED _____ SAME _____ DECREASED _____

G.I. BOWEL FUNCTIONS: REGULATED _____ IRREGULAR _____
CATHARTIC REQUIRED: YES _____ NO _____

ADL LEVEL: IMPROVED _____ SAME _____ REGRESSED _____
DRESSING: IMPROVED _____ SAME _____ REGRESSED _____
MOTIVATION: IMPROVED _____ SAME _____ REGRESSED _____
PERSONAL HYGIENE: IMPROVED _____ SAME _____ REGRESSED _____
SLEEPING HABITS: IMPROVED _____ SAME _____ REGRESSED _____

ASSESSMENT OF PROBLEMS AND RESPONSES:

PLAN:

PHYSICIAN COMMUNICATION:

ADDITIONAL / CHANGE ORDERS:

DISCHARGE PLANNING:

SIGNATURE: