Nursing Progress Note – Short

This form is to be completed by a LPN, RN, BSN, or MSN when providing nursing services. There are two different versions of the Nursing Progress Note – a short and long version. The short version is to provide adequate documentation for short length services such as injections, etc. while the long version has additional data fields that support the focus of the Psychopharmacology Progress Note including an interim history and mini mental status section.

Data Field	Identifying Information Instructions
Organization Name	Enter your organization name
Program Name	Enter your program name
Individual's Name	Record the first name, last name, and middle initial of the Individual served. Order of name is at agency discretion.
Record #	Record your agency's established record number for the Individual served.
DOB	Record the Individual's date of birth. **Example: mm/dd/yyyy**
List of Individuals Present	Check the box that applies for the contact type. List location if offsite. Check appropriate box: "Individual Present"- If Individual is present "Others Present" – If others are present. Identify name(s) and relationship (s) to Individual. "No Show" – If Individual did not show. Follow-up as indicated by agency policy/ procedures "Individual Canceled" – If Individual canceled. "Provider Canceled" – If provider canceled. Document explanation(s) as relevant. Manual and Agency Policy should indicate need to address missed appointments (No Show and Cancellation) in subsequent progress notes.
Data Field	**Measurements**
Vital Signs	Indicate Individual's vital signs: temperature, pulse, respiration, and blood pressure.
Height/Weight	Indicate Individual's height/weight if appropriate. Leave blank if not performed during visit.

Data Field	New Issues, Stressors, Extraordinary Events Instruction
New Issue(s)/Stressors/ Extraordinary Events Presented Today	There are three options available for staff using this section of the progress note (New Issues refers to all **new** issues/stressors/extraordinary events). 1. If Individual reports a new issue that was resolved during the contact, check the "New Issue resolved, No Update Required" box. Briefly document the new issue in this section and then identify the interventions used in the Interventions/Methods section and indicate the resolution in the Response section of the progress note. If services are provided during the contact that have not been previously ordered in the Individualized Action Plan, then an explanation of the rationale for those services should be provided. **Example of new issue not requiring a CA/IAP Update:** **John reported harassment by neighbor, leading to increase in worry and anxiety symptoms. Referred Individual to Legal Services and left message for individual therapist to coordinate care around legal issues and work with individual on anxiety management skills.** 2. If individual presents any new issue(s) that represent a need that is not already being addressed in the IAP, check box indicating "New Issue, CA/IAP Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed issue(s) may require a new goal, objective, intervention or service that will require use of the IAP Review/Revision form. **Example of new issue that may require a CA/IAP Update:** **Jane reported that last week she was involved in a car accident and since that time she is having nightmares and memories of physical abuse when she was in elementary school.** 3. If no new issues presented mark "None Reported" and proceed to planned intervention/goals.
Data Field	**Goals, Interventions, Response to Intervention, Plan/Additional Information**
Goal(s)/Objective(s) Addressed as Per Individualized Action Plan	Identify the specific goal(s) and objectives in the Individualized Action Plan being addressed in this note. (Progress notes must be linked to specific goal/objectives in the IAP).
Intervention(s) / Method(s) provided	Summarize the interventions provided during this appointment, including medication and symptom monitoring, education, medication administration, recommendations, referrals, etc. List injections, site, dosage, and drug. Wellness, safety/safe housing, medication management, coping, social skills, assertiveness, community resources, relapse prevention, sleep hygiene, nutrition. Record linkage between therapeutic interventions and goals/objectives from the IAP. **Example: Provided education to Jane about potential side effects of new medication. Recommended that she continue to work on her goal of improving anxiety management skills with her individual therapist. Made referral to Legal Services for help with harassment by neighbor.**

Response to Intervention/ Progress Toward Goals and Objectives	This section should address **BOTH**: • *The Individual's response to the intervention* - Include evidence the Individual participated in the session and how, and information about how the Individual, family and /or collaterals were able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • *Progress toward goals and objectives* - Include an assessment of how the session has moved the Individual closer, further away, or had no discernable impact on meeting the Individual's identified goal(s) and objective(s). **Example: Angela was able to correctively identify medications and dosages. She has an understanding of potential side effects and agrees to report same to staff.**
Plan / Additional Information	The nurse should document future steps or actions planned with the individual such as homework, plans for the next session, etc. *Plan to overcome lack of progress* - If no progress is made over time, this section should also include how the counselor intends to change his/her strategy to help the individual work toward improvement. Document additional pertinent information that is not appropriate to document elsewhere. **Example: John was not able to correctly identify medications and dosages, so index cards were utilized to give more explicit instructions for each of the medications.**
Data Field	**Signature, Medicare Services and Billing Strip Instructions**
Print Staff Name Credentials/Title	Print staff name, credentials (degree/license), and title.
Staff Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Supervisor Name/ Credentials/Title (if needed)	Print the supervisor's name, credential (degree/license), and title of supervisor, if needed.
Supervisor Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Individual's signature (optional)	Legible signature. This is encouraged, especially if the note was written collaboratively.

Data Field	Medicare "Incident To" Instructions
Medicare "Incident to" Services Only (if applicable)	Check the box when service is to be billed using the "incident to" billing rules.
Name and Credentials of Medicare Supervising Professional on Site (if applicable)	Enter the name of the supervising professional who provided the on-site supervision of the "incident to" service. **Note:** The presence of an appropriately licensed supervising professional is one of the key requirements for an "*incident to"* service. For nursing services this must be an MD or an NPP. In some cases, the service is billed under the number of the supervising professional. In others, the attending professional's number should be used. Providers should consult with their Medicare Carrier's Local Medical Review Policies.