Nursing Contact Progress Note - Short
Revision Date: 11-1-12

Organization Name:	**Program Name:**	
Individual's Name (First / MI / Last):	**Record #:**	**DOB**:

List of Individuals Present	☐ Individual Present / **Contact Type:** ☐ Onsite ☐ Offsite ☐ Phone Conversation ☐ Others Present (please identify name(s) and relationship(s) to individual): ☐ No Show ☐ Person Canceled ☐ Provider Canceled Explanation:

New Issues / Stressors / Extraordinary Events Presented Today: ☐ New Issue Resolved, No Update Required
☐ New Issue, CA/IAP Update Required ☐ None Reported
Explanation:

Measurements: If appropriate, please complete the following pertinent information:
Vital Signs: TPR/BP **Height/Weight**:

Goal(s)/Objective(s) Addressed As Per Individualized Action Plan or ☐ Based on Initial Plan for Services:

Goal ___ Objective ___ Objective ___ Objective ___ Objective ___	Goal ___ Objective ___ Objective ___ Objective ___ Objective ___	Goal ___ Objective ___ Objective ___ Objective ___ Objective ___	Goal ___ Objective ___ Objective ___ Objective ___ Objective ___

Intervention(s) / Method(s) Provided:
Psychopharmacology: ☐ Medication Prescribed
☐ Injection Given – If Yes, Injection Site: Medication Tolerated ☐ No ☐ Yes –
If No, describe:

Other:

Response to Intervention / Progress Toward Goals and Objectives:

Plan / Additional information (referrals, labs to be ordered, Medical Strategies, other types of treatment, frequency/interval or next visit and duration, as indicated):

Completed By - Print Staff Name/Credentials:	**Staff Signature:**	**Date:**
Print Supervisor Name/Credentials (if applicable**):**	**Supervisor Signature:**	**Date:**
Individual's Signature (Optional**):**		**Date:**

☐ Medicare "Incident to" Services Only	**Name and Credentials of Medicare Supervising Professional on Site (if applicable)**

Date of Service	Staff Identifier	Loc. Code	Service Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Duration in Minutes