Arkansas Methodist Medical Center

Pt. Label

PROGRESS NOTE

Circled terms are positive/affirmed, backslash terms are negative

Date: / /

Schumachergroup Hospital Medicine

Time: : AM / PM

Code Status: Full DNR

Hospice Patient: Y / N

Hospice Dx :

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS

Interval History:

Patient Statement or Reason Unable to Obtain:

New Complaint:

Severity:

Duration:

Location:

Quality:

Associated Signs/Symptoms:

REVIEW OF SYSTEMS

Const: malaise weakness fatigue insomnia *other:*

Resp: cough sputum short-of-breath pleurisy wheeze *other:*

GU: incontinence bleeding discharge burning *other:*

Neuro: dizzy paralysis parasthesia headache *other:*

Heme/lymph/allergy/imuno/eyes/ENMT/skin:

CVS: chest-pain dyspnea orthopnea edema *other:*

GI: nausea vomiting diarrhea constipation heartburn abdominal-pain other:

Psych: anxious depressed suicidal *other:*

All systems negative except as marked

EXAM

Vitals: *Temp_____ HR_____ RR_____ BP_____/_____ Pulse-Ox:_____ (O2:_____) I/O____*

Const: awake/alert no-distress nml-body-habitus **I** *lethargic mild/mod/severe-distress frail obese*

Eyes: nml-conjunctiva/lids symmetric-pupils **I** *pale-conjunctiva icteric-sclera EOM-palsy*

ENMT: nml-hearing nml-lips/teeth/gums **I** *decreased-hearing dry-lips dental-carries*

CVS: reg-rate/rhythm no-edema no-JVD **I** *irr/irr murmur_____ edema_____ JVD*

Lungs: nml-breath-sounds no-accessory-muscle-use **I** *accessory-muscle-use* wheezes/rales/ronchi/crackles

Abd: non-tender nml-liver/spleen nml-sounds **I** *tender_____ rebound/guarding distended*

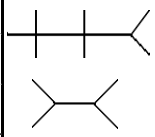
Psych: A&Ox3 Intact-judgment/insight calm **I** *poor-judgment/insight anxious agitated depressed*

Other: Neck, GU, Lymph, Musculoskeletal, Breasts, Neuro, Skin:

PAST, FAMILY, SOCIAL HISTORY

□Reviewed initial H&P PFSH □No changes □changes/additions noted below:

Data reviewed:



U/A:

Radiology:

Ca^{++}:
Mg^{+}:
$PO4^{---}$:
AST:
ALT:
T.bili:
Alk-Phos:
Albumin:
PT:
INR:
PTT:
UCX:
BLCX:
Sput CX:
EKG:

MEDICAL DECISION MAKING

ACUTE DXS/ACTIVE ISSUES

CHRONIC DXS

PLAN OF CARE

OVERALL PATIENT STATUS

☐ **Patient responding consistently with treatment. See Plan of Care for elements.**

☐ **Patient NOT responding as expected to treatment. See Plan of Care for elements.**

☐ **Other:**_____

DOCUMENTATION OF TIMED SERVICES

Crit. Care: < 30 min 30-74 mins >74 mins_____

Total Subsqnt Visit Time: _____

Total Prolonged Services Time: _____

Discharge Time: _____**mins**

D/C in aprox. days: 1 2 3 4+ awaiting-placement

Special D/C needs:

Anticipated D/C to: Home Home w/HHC Rehab LTAC NH MHU

Prophylaxis: Ambulating TED/SCD Anticoag

NP/PA Signature:_____

Physician Attestation - To be used when care is provided by the physician in conjunction w/ the NP or PA

For this patient encounter, I reviewed the NP or PA documentation, treatment plan, and medical decision making; and I had face-to-face time with this patient.

History:_____Exam:_____

Treatment Plan:_____

All procedures were done by me except:_____

Physician Signature:_____

Arkansas Methodist Medical Center