MSDP

Nursing Progress Note (Long Version)
Revision Date: *3-7-09*

Person's Name (First / MI / Last):	**Record #:**	**DOB:**
Organization Name:		
Present at Session	☐ Person Present ☐ No Show ☐ Person Cancelled ☐ Provider Cancelled Explanation: ☐ Others Present (please identify name(s) and relationship(s) to person):	

Interim History (Include the person's and collateral's report on his/her status, the effectiveness of medications, progress related to symptoms, substance use, any significant new issues and overall functioning since last encounter):

New Issue(s) Presented Today: ☐ None Reported ☐ New Issue resolved, no CA required ☐ CA Update Required

Person's Condition	**No Significant Changes Reported or Observed**	**Notable**	**Changes in Person's Condition**
Mood/Affect:	☐	☐	
Thought Process /Orientation:	☐	☐	
Behavior/Functioning:	☐	☐	
Medical Condition:	☐	☐	
Substance Use: ☐ NA	☐	☐	

Risk Assessment
Danger To: ☐ None **OR** Check all that apply below and record action taken in Therapeutic Interventions section below
☐ **Self**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt - Comments:
☐ **Others**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt / ☐ **Property**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt

Measurements: If appropriate, please complete the following pertinent information: ☐ Not Pertinent

Blood Pressure/Vital Signs:	**Weight/Height or BMI:**	**AIMS findings**:

Goal(s)/Objective(s) Addressed from IAP:

Therapeutic Interventions Provided:

Person's Response to Intervention/Progress Towards Goals:

Plan/Additional Information:

Issues to be Referred to Physician/APRN:

Provider (Print name):		**Supervisor - Print Name** (if needed):	
Provider Signature/Credentials:	Date:	**Supervisor Signature/Credentials** (if needed):	Date:

☐ **Medicare "Incident To" Services Only** *(If Applicable)*: **Name and Credentials of Supervising Professional on Site:**

Date of Service	Provider Number	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code