

Nursing Progress Note

Date of Exam: 5/9/2013
Time of Exam: 2:02:45 PM

Patient Name: Smart, Julie
Patient Number: 1000010649803

HISTORY:

Status of patient:
Julie is worse today.

Target Symptoms:
Julie reports that depressive symptoms continue. Her symptoms, she reports, are more frequent or more intense. Anergia is present. Increased symptoms of anhedonia are present. Julie's difficulty with concentrating has not changed. Julie reports that she continues to feel sad. Guilty feelings are described by Julie. "I should have been with my sister, I had no idea she was suicidal." Sleep has improved with the use of PRN Ambien CR at HS. Julie convincingly denies suicidal ideas or intentions.

Basic Behaviors:
Medication has been taken regularly. She needs help with ADLs. When she attends activities participation is minimal. Ppn's are used occasionally and are described as effective for her headaches. Impulsive behaviors are occurring, but less frequently. Julie has diminished food and fluid intake. Julie has not been confused. A good night's sleep is described.

Additional Signs or Possible Side Effects:
Sedative effects of the medication are described.
Patient reports a dry mouth.
No other side effects are reported or in evidence.

MENTAL STATUS:
Julie presents as glum, downcast, inattentive, minimally communicative, and looks unhappy. She appears listless and anergic. She appears downcast. Thought content is depressed. Slowness of physical movement helps reveal depressed mood. Facial expression and general demeanor reveal depressed mood. She denies having suicidal ideas. There are no apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process. Associations are intact, thinking is logical, and thought content appears appropriate. There are signs of anxiety. Patient is fidgety in a way that is suggestive of anxiety.

Special Circumstances:
Julie continues to have an unsteady gait, especially after midnight. Call light is within her reach. She has been instructed to ring for the nurse to assist her when ambulating to bathroom.

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The OTA's Guide to Writing SOAP Notes Sherry Borcharding, Marie J. Morreale, 2007 Written specifically for occupational therapy assistants The OTA's Guide to Writing SOAP Notes Second Edition is updated to include new features and information This valuable text contains the step by step instruction needed to learn the documentation required for reimbursement in occupational therapy With the current changes in healthcare proper documentation of client care is essential to meeting legal and ethical standards for reimbursement of services Written in an easy to read format this new edition by Sherry Borcharding and Marie J Morreale will continue to aid occupational therapy assistants in learning to write SOAP notes that will be reimbursable under Medicare Part B and managed care for different areas of clinical practice New Features in the Second Edition Incorporated throughout the text is the Occupational Therapy Practice Framework along with updated AOTA documents More examples of pediatrics hand therapy and mental health Updated and additional worksheets Review of grammar documentation mistakes Worksheets for deciphering physician orders as well as expanded worksheets for medical abbreviations Updated information on billing codes HIPAA management of health information medical records and electronic documentation Expanded information on the OT process for the OTA to fully understand documentation and the OTA's role in all stages of treatment including referral evaluation intervention plan and discharge Documentation of physical agent modalities With reorganized and shorter chapters The OTA's Guide to Writing SOAP Notes Second Edition is the essential text to providing instruction in writing SOAP notes specifically aimed at the OTA practitioner and student This exceptional edition offers both the necessary instruction and multiple opportunities to practice as skills are built on each other in a logical manner Templates are provided for beginning students to use in formatting SOAP notes and the task of documentation is broken down into small units to make learning easier A detachable summary sheet is included that can be pulled out and carried to clinical sites as a reminder of the necessary contents for a SOAP note Updated information expanded discussions and reorganized learning tools make The OTA's Guide to Writing SOAP Notes Second Edition a must have for all occupational therapy assistant students This text is the essential resource needed to master professional documentation skills in today's healthcare environment

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