### Nursing Contact Progress Note - Short

**Revision Date:** 11-1-12

<table>
<thead>
<tr>
<th>Organization Name:</th>
<th>Program Name:</th>
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</thead>
<tbody>
<tr>
<td>Individual’s Name (First / MI / Last):</td>
<td>Record #:</td>
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<tr>
<td>DOB:</td>
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</tbody>
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#### 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

#### 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:**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objective</th>
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#### 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

<table>
<thead>
<tr>
<th>Name and Credentials of Medicare Supervising Professional on Site (if applicable)</th>
<th>Medicare “Incident to” Services Only</th>
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</thead>
<tbody>
<tr>
<td>Date of Service</td>
<td>Staff Identifier</td>
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</table>

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