**Progress Note**

# Patient:

***The use of this document is entirely voluntary/ optional.***

**First Name**: **Last Name**: **Date of Birth**: \_\_\_ /\_\_/

# Name of physician/Medicare allowed non-physician practitioner (NPP)\* who performed the encounter:

**Date of encounter**: \_\_/\_\_/ \_\_

**Is this encounter with the patient related to the primary reason the patient requires Home Health Services? Yes**  **No**  *(Please check one :)*

# Subjective:

Patient’s Chief Complaint:

 Check if not completing a history and physical during the encounter.

[In the e-clinical template, the “History of Present Illness” and “Review of Systems” will not appear if

Checked.]

History of Present Illness: Pain Assessment:

Location:

Quality:  aching  burning  radiating  other:

Severity:  1  2  3  4  5  6  7  8  9  10

Duration:  1day  2days  3days  other:

Timing:  constant  intermittent  time of day?

Context: better/worse  at work  rest  sleep  other:

Moderating Factors: better/worse with  heat  ice  other: Associated Signs/Symptoms:

Medical History:

Surgical Procedure(s) History:

Allergies: \_ Current Medications: \_

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Review of Systems:

Eyes:  visual changes  other ENT:  sore throat  rhinitis  other CV:  chest pain  other Resp:  SOB  cough  hemoptysis  other Gastro:  nausea  vomiting  diarrhea  abd pain  other

GenitoUr:  dysuria  frequency  urgency  other

Musk/Skel:  back pain  joint pain  other

Skin/Breast:  rash  itching  other

Neurologic:  numbness  dizziness  other \_ Psych:  anxiety  depression  other

Endocrine:  hypoglycemia  thirsty  other

Hem/Lymph:  anemia  bleeding  other

Allergy/Immune:  deficiency  other

Other:

# Objective:

Vital Signs: T=

P=

R=

BP= / Height= Weight=

General Appearance Objective Findings:

# Assessment:

**Plan/Orders:**

Plan for Home Health Services:

* This patient requires **Skilled Nursing Services**: *(specify services needed.)*

This patient needs to be evaluated and treated for one or more of the following services: *(Check all that apply.)*

* Physical Therapy (*specify services needed*)
* Occupational Therapy: (specify services needed)
* Speech Language Pathology: (specify services needed)

## To receive home health services, the patient must be homebound and meet Medicare’s criteria for “Confined to the Home.”

* Check here and continue if choosing to document homebound status as part of this Progress Note.

[In the e-clinical template, the “Homebound Status” section will not appear if not checked.]

# Homebound Status:

Medicare considers the patient homebound if the **ONE** of criteria A and **BOTH** of criteria B are met:

***Criteria A: Select and describe at least one.***

* Because of illness or injury, the patient needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence. Specify: \_

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* The patient has a condition such that leaving his or her home is medically contraindicated.

Specify: \_

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***Criteria B: (****To meet Medicare’s confined to home requirement, patient must meet at least one Criteria A* ***AND*** *both Criteria B.)*

* There must exist a normal inability to leave the home.

Specify: \_

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* Leaving home requires a considerable and taxing effort.

Specify: \_

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***Note: If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment (examples: outpatient dialysis, or chemotherapy/radiation therapy, attendance at adult day centers to receive medical care)***

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PHYSICIAN OR MEDICARE ALLOWED NPP**\*** SIGNATURE PRINTED NAME DATE