**Teach PROGRESS NOTE**

**Date/time of service:**

**Interpreter (if used):**

**Chief complaint:**

**Subjective:**

**Review of Systems**

**Constitutional**: No fever, No chills.

**Respiratory**: No shortness of breath, No cough.

**Cardiovascular**: No chest pain, No palpitations, No tachycardia, No peripheral edema.

**Gastrointestinal**: No nausea, No vomiting, No diarrhea, No constipation, No abdominal pain.

**Objective**

Allergies

Meds

Vitals

**Physical Examination**

**General**: Alert, No acute distress.

**HENT**: Normocephalic, Normal hearing, Oral mucosa is moist.

**Respiratory**: Lungs are clear to auscultation, Respirations are non-labored, Breath sounds are equal, Symmetrical chest wall expansion.

**Cardiovascular**: Normal rate, Regular rhythm, No murmur, No edema.

**Gastrointestinal**: Soft, Non-tender, Non-distended, Normal bowel sounds.

**Integumentary**: Warm, Dry. No rashes.

**Neurologic**: Alert, Oriented, CNII-XII grossly intact. Strength and sensation normal and symmetrical.

**Psychiatric**: Cooperative, Appropriate mood & affect.

**Imaging**

Any pertinent imaging or EKG

**ASSESSMENT/PLAN**:

Assessment

#Problem

#Problem

#Problem

FEN:

Prophylaxis:

Code Status:

MPOA/Contact person and phone#:

DISCHARGE PLANNING:

Medical reason for continued hospitalization:

Location patient will be discharged to: (Home/SNF/ALF, etc)

Discharge needs: (Home Health, Outpatient PT, Home O2, etc)

The attending physician of record for this patient encounter is Dr.

Provider Name, PGY-#

Pager #