Top Choice Home Healthcare, Inc.

30 - Day Progress Report

Patient Name: MR#:

Certification Period From: To:

Financial Problems: ◉ Yes ○ No

Medical Treatment Change Within 30 Days: ○ Yes ○ No

Hospitalization Within Last 30 Days: ○ Yes ○ No

New Diagnosis: ○ Yes ○ No

Safety Hazards at Home: ○ Yes ○ No

Sanitation Hazards at Home: ○ Yes ○ No

Primary Diagnosis:

Other Pertinent Diagnosis:

POC Goals

Supportive Assistance: ☐ In Place ☐ Not Needed ☒ With Paid CG ☐ Lives Alone ☐ Referred MSW ☐ Lives With Family Who Provides Care ☐ Other:

Signs or Symptoms of Abuse: ○ Yes ◉ No Action Taken:

Frequency of Pain: ☐ No Pain ☐ Less Often Than Daily ☐ Daily, but Not Constantly ☒ All the Time

Pain Scale: Location: Medication: Effective: ☐ Yes ☐ No

Codes: *P=Problem | NP=No Problem*

Wound Healing Codes: *A=Fully Granulating | B=Early/Partial Granulation | C=Not Healing | D=Fully Healed*

Intergumentary Status: ☐ NP ☐ Skin Ulcers ☐ Other/Specify Problems: _____

Surgical Incision Healing Status Code: _____

Site: _____ Healing Code: _____

Site: _____ Healing Code: _____

Site: _____ Healing Code: _____

Site: _____ Healing Code: _____

Respiratory Status: ☐ NP ☐ P=

Diabetic Status: ☐ NP ☐ P=

Neurosensory Status: ☐ NP ☐ P=

Nutritional Status: ☐ NP ☐ P=

Musculo-sceletal Status: ☐ NP ☐ P=

Gastroenterology Status ☐ NP ☐ P=

Genitourinary Status ☐ NP ☐ P=

Cardiovascular Status: ☐ NP ☐ P=

Elimination Status: ☐ Continent ☐ Incontinent of ☐ Urine ☒ Feces

Emotional & Behavioral Status: ☐ NP ☐ P=

ADL Status: ☐ Independent ☐ Min. Assist. ☐ Mod. Assist. ☒ Max. Assist.

Falls: ☐ No ☐ Yes ☐ Specify Injuries:

BP Ranged At: To: BS Ranged At: To:

Compliance Status:					If Unable, specify reason:	Person Responsible
Injections	◉ N/A	○ Able	○ Unable			
Wound Care	◉ N/A	○ Able	○ Unable			
Blood Sugar Monitoring	◉ N/A	○ Able	○ Unable			
Foley Catheter Management	◉ N/A	○ Able	○ Unable			
Management of Oral Meds	◉ N/A	○ Able	○ Unable			
Management of nebulizers:	◉ N/A	○ Able	○ Unable			
G.T. Site Care	◉ N/A	○ Able	○ Unable			
Management of G.T. Meds/Feeding	◉ N/A	○ Able	○ Unable			
Colostomy Care	◉ N/A	○ Able	○ Unable			
Safety Compliance	◉ Poor	○ Fair	○ Good	○ Excellent		
Medication Compliance	◉ Poor	○ Fair	○ Good	○ Excellent		
Diet Compliance	◉ Poor	○ Fair	○ Good	○ Excellent		

Goal Achievement:				
Skilled Nursing	◉ Met	○ Partially Met	○ Not Met and Needs Ongoing Intervention	○ N/A
Therapy Service	◉ Met	○ Partially Met	○ Not Met and Needs Ongoing Intervention	○ N/A
MSW Service	◉ Met	○ Partially Met	○ Not Met and Needs Ongoing Intervention	○ N/A
CHHA Service	◉ Met	○ Partially Met	○ Not Met and Needs Ongoing Intervention	○ N/A

Staff Name: Staff Signature/Title: Date: