



Daily Nurse Progress Note

Date: «Current_Date»
Room #: «Room_»

PATIENT_NAME
DOB: «DATE_OF_BIRTH» ADMIT:
«DATE_OF_ADMISSION»
MR#: «MR» A#: «ACCOUNT_»
PROGRAM: «PROGRAM» GENDER: «GENDER»

Medical Necessity/Reason For Admission: Psychiatric Problems
«Psychiatric_Treatment_Problems»
Active Medical Problems
«Medical_Problems»
2300-0700 Sleep / Behaviors Note
Hours of Sleep:
Ordered: CPAP/BIPAP Wedge Other: N/A
Used ordered intervention(s)
Refused ordered intervention(s) N/A

Comments:
Nurse Signature:
Date: 10/27/25 Time: 10:00AM

0700-1900 1900-0700
ADLs
Orientation
Behavior / Events
Affect
Mood
Speech
Thought Process
Thought Content
Hallucinations
Behaviors
Aggressive Behaviors
Interaction
Group Attendance
Insight
Judgement

Review of previous CSSRS screen nurse Initials:
0700-1900 CSSRS 1900-0700

1 In the time since your last assessment: Have you wished you were dead or wished you could go to sleep and not wake up?
2 In the time since your last assessment: Have you actually had any thoughts of killing yourself?
3 In the time since your last assessment: Have you been thinking about how you might do this?
4 In the time since your last assessment: Have you had these thoughts and had some intention of acting on them?
5 In the time since your last assessment: Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
6 In the time since your last assessment: Have you done anything, started to do anything, or prepared to do anything to end your life?

CSSRS: If screens YES, initiate suicide precautions, contact physician, & perform CSSRS Assessment. If screen is positive and/or higher than previous screen, call physician.
Physician Name:
Time:

