

CHW PROGRESS NOTE:

Participant ID: _____

<u>DATE:</u>		<u>VISIT TYPE:</u> <input type="checkbox"/> In-Person <input type="checkbox"/> Phone
<u>LOCATION:</u>		
<u>TIME START:</u>		<u>VISIT TYPE:</u> <input type="checkbox"/> Educational <input type="checkbox"/> Instrumental
<u>TIME END:</u>		

SHORT-TERM GOAL CHECK-IN:

Short-term Goal #1: (describe goal set by client)

Short-term Goal Progress:

- Success
- Partial Success
- No Success
- Did not try

Description of progress w/ Short-Term Goal #1:

Short-term action plan for future:

Continue same plan

New Plan:

No Plan

Short-term Goal #2: (describe goal set by client)

Short-term Goal Progress:

- Success
- Partial Success
- No Success
- Did not try

Description of progress w/ Short-Term Goal #1:

Short-term action plan for future:

Continue same plan

New Plan:

No Plan

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LONG-TERM GOAL CHECK-IN:

Long-term Goal: (describe goal set by client)

Client was reminded about long-term goal and stated confidence in achieving goal as:

0 1 2 3 4 5 6 7 8 9 10
(no confidence at all) (Completely Confident)

VISIT CONTENT DISCUSSED:

<input type="checkbox"/> N/A – Instrumental Visit	<input type="checkbox"/> HTN 101
<input type="checkbox"/> Nutrition	<input type="checkbox"/> HTN 201
<input type="checkbox"/> Physical Activity	<input type="checkbox"/> Asthma 101
<input type="checkbox"/> Stress Management & Family Support	<input type="checkbox"/> Asthma 201
<input type="checkbox"/> Smoking Cessation	<input type="checkbox"/> Diabetes 101
	<input type="checkbox"/> Diabetes Complications

REQUEST FOR REFERRALS / RESOURCES:

REQUEST:	INFO PROVIDED / TO BE PROVIDED:
1.	
2.	
3.	
4.	
5.	

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CHW DESCRIPTION / ASSESSMENT / PLAN

DESCRIPTION:

ASSESSMENT:

PLAN: