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a clinical documentation cheat sheet is a succinct guide designed for healthcare professionals to streamline the documentation of patient encounters this tool condenses the essential elements of clinical documentation into a quick reference format enabling providers to record accurate and comprehensive patient information efficiently

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some examples of charting include documenting medications administered vital signs physical assessments and interventions provided nursing notes are a narrative written summary of a given nursing care encounter this might include a description of a nursing visit a specific care event or a summary of care

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documenting a patient assessment in the notes is something all medical students need to practice this guide discusses the soap framework subjective objective assessment plan which should help you structure your documentation in a clear and consistent manner you might also find our other documentation guides helpful subjective

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sample documentation of unexpected findings patient is alert and oriented to person place and time speech is clear affect and facial expressions are appropriate to situation patient cooperative with exam and exhibits pleasant and calm behavior

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physical therapy assessment documentation examples you ll find yourself writing a lot of assessments throughout your career most commonly you ll include an assessment when completing daily notes documenting progress notes or writing an evaluation

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these examples will give you an idea of how you might perform a patient s documentation although they are written for a sample patient in an outpatient setting you can use similar wording for the subjective objective and assessment goals in other settings such as neuro home health skilled nursing or acute rehab

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sample documentation of expected findings the patient denies abdominal pain nausea vomiting bloating constipation diarrhea urinary pain urgency or frequency change in appetite food intolerance dysphagia or personal or family history abdominal contour is flat and symmetric no visible lesions pulsations or peristalsis noted bowel

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project documentation is how leaders create a timeline for their projects a framework for measuring progress and a system that ensures accountability there are about a million ways for a project to go wrong from inadequate resource allocation to a lack of monitoring and communication and project managers must plan for every

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sample documentation of expected findings patient denies cough chest pain or shortness of breath denies past or current respiratory illnesses or diseases symmetrical anterior and posterior thorax anteroposterior transverse ratio is 1 2 respiratory rate is 16 breaths minute unlabored regular and inaudible through the nose

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