Understand the when, why, and how! Here’s your guide to developing the skills you need to master the increasing complex challenges of documenting patient care. Step by step, a straightforward ‘how-to’ approach teaches you how to write SOAP notes, document patient care in office and hospital settings, and write prescriptions. You’ll find a wealth of examples, exercises, and instructions that make every point clear and easy to understand.

This volume, sponsored by the American College of Emergency Physicians, is a comprehensive, practical, ready-reference for the ED physician. Content focuses on how to effectively and accurately diagnose and treat this unique population. Each chapter is structured as follows: High Yield Facts: a bulleted list of 5 high yield facts Introduction: definition of problem and relevancy to older population Epidemiology (if applicable): scope, incidence/prevalence, mortality Pathophysiology: causative factors, predispositions, risk factors, mechanisms of disease process or injury, organ systems affected and disease course Clinical Features: chief complaint, presenting symptoms key historical information, physical examination including general appearance, vital signs, specific findings, and associated findings Diagnosis and Differential: laboratory findings and ancillary testing (including indications for same and also predictive value of such tests, differential diagnosis Emergency Department Care and Disposition: immediate management priorities (overview), initial ED management (to include both pharmacological and non-pharmacological care of the patient), subsequent care (if applicable). Can also include prognosis. Additional Aspects: complications, controversies, pitfalls, medical/legal issues, ethical issues, and costs

Health assessment is an ongoing process that evaluates the whole person as a physical, psychosocial and functional being, whether they are young or old, well or ill. This market-leading text presents health assessment, physical examination information and skills for health
professionals who undertake these types of assessments. Health Assessment and Physical Examination is scaffolded from foundation to more advanced health assessment, following a body-systems approach and a ‘head-to-toe’ approach. It uses the ENAP (Examine–Normal–Abnormal–Pathophysiology) approach as a tool for students to collect useful information. An applied case study at the end of each chapter walks students through an example of an assessment. This comprehensive yet student-friendly text is noted for its high-quality case studies, pedagogical elements, and excellent student resources. Unique to this text are the advanced topics and ‘Urgent findings’, which highlights serious or life-threatening signs or critical assessment findings that need immediate attention.

This concise book provides information on every vital area important to professionalism: documentation, law and ethics, and leadership all in the context of the five roles of the physical therapist as defined by the APTA’s Guide to Physical Therapist Practice, 2nd Edition. Readers will find information on the history of professionalism in physical therapy, the five roles of the physical therapist (Patient/Client Manager, Consultant, Critical Inquirer, Educator, and Administrator), the role of the physical therapist in today’s health care system, and professional leadership and development. Case studies, how to lists and tips from the field encourage critical thinking and provide strategies for various issues. (Midwest).

Publisher's Note: Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality, authenticity, or access to any online entitlements included with the product. Feeling unsure about the ins and outs of charting? Grasp the essential basics, with the irreplaceable Nursing Documentation Made Incredibly Easy!®, 5th Edition. Packed with colorful images and clear-as-day guidance, this friendly reference guides you through meeting documentation requirements, working with electronic medical records systems, complying with legal requirements, following care planning guidelines, and more. Whether you are a nursing student or a new or experienced nurse, this on-the-spot study and clinical guide is your ticket to ensuring your charting is timely, accurate, and watertight. Let the experts walk you through up-to-date best practices for nursing documentation, with: NEW and updated, fully illustrated content in quick-read, bulleted format NEW discussion of the necessary documentation process outside of charting—informing consent, advanced directives, medication reconciliation Easy-to-retain guidance on using the electronic medical records / electronic health records (EMR/EHR) documentation systems, and required charting and documentation practices Easy-to-read, easy-to-remember content that provides helpful charting examples demonstrating what to document in different patient situations, while addressing the different styles of charting Outlines the Do's and Don’ts of charting – a common sense approach that addresses a wide range of topics, including: Documentation and the nursing process—assessment, nursing diagnosis, planning care/outcomes, implementation, evaluation Documenting the patient’s health history and physical examination The Joint Commission standards for assessment Patient rights and safety Care plan guidelines Enhancing documentation Avoiding legal problems Documenting procedures Documentation practices in a variety of settings—acute care, home healthcare, and long-term care Documenting special situations—release of patient information after death, nonreleasable information, searching for contraband, documenting inappropriate behavior Special features include: Just the facts – a quick summary of each chapter’s content Advice from the experts – seasoned input on vital charting skills, such as interviewing the patient, writing outcome standards, creating top-notch care plans “Nurse Joy” and “Jake” – expert insights on the nursing process and problem-solving That’s a wrap! – a review of the topics covered in that chapter About the Clinical Editor Kate Stout, RN, MSN, is a Post Anesthesia Care Staff Nurse at Dosher Memorial Hospital in Southport, North Carolina.
Dynamic, interactive videos depict the most commonly performed physical exam procedures for each body system. With these DVDs, you'll learn to apply concepts and develop critical thinking skills. 185 video clips with a running time of 2-4 minutes each. For each body system, videos include: Overview (rationale and purpose) Preparation (including equipment and patient teaching) Procedure (printable step-by-step procedure checklists) Follow-up care (including health promotion and patient teaching) Documentation (tips and techniques) 25 detailed 3-D animations depict what's happening inside the body. Critical thinking case studies let you apply your knowledge to simulated patients. A documentation form library allows you to practice recording history and physical information. 80 NCLEX examination-style review questions let you reinforce your comprehension.

"Provides primary care providers with information specific to the medical management of acutely ill adult and elder patients with multiple comorbid health problems. It also contains material on advanced directives, end of life care and regulatory and compliance concerns that often affect treatment decisions in these settings. A section on staff education is also included for nurse practitioners who are directing patient care given by both skilled and unskilled staff in subacute and long term care." --Cover.

In this text "structure and function information is streamlined, health history is symptom and interview-focused, nursing documentation examples are included, data analysis is covered in end-of-chapter summary sections, health promotion is streamlined with a focus on follow-up and teaching at the end of the chapters." --Publisher.

This guide to successful practices in observation medicine covers both clinical and administrative aspects for a multinational audience.

Followed by a detailed treatment plan relevant to the specific types of abuse, each chapter in this book is structured to give a general overview of the topic area.

Written by leading experts in MR imaging, orthopaedic surgery, and sports medicine, this volume is a comprehensive state-of-the-art guide to the use of MR imaging and MR arthrography in evaluating shoulder disorders. Chapters cover normal anatomy, technical considerations, MR arthrography, shoulder biomechanics, clinical assessment of shoulder pain, rotator cuff conditions, glenohumeral instability, bicipital tendon disorders, SLAP lesions, the postoperative shoulder, arthritis, and miscellaneous disorders. Emphasis is placed on MRI findings with clinical and arthroscopic correlations. More than 650 illustrations, 73 in full color, complement the text.

The definitive reference source on the management of health records, this book provides the basic guidelines on content and structure, analysis, assessment, and improvement of information critical to every health care organization. The author has updated her well-received book beyond hospitals, incorporating the latest and most successful practices - most notably, the computerization of record operations and systems and of the record itself.

This complete worktext and practice software learning package highlights the concepts and procedures that medical assistants and medical claims specialists need to know to prepare and submit accurate health insurance claims. Features/Benefits: the most current and accurate learning package available; free Practice Software (3.5" Windows) packaged with the text - Completely Revised - permits completion of
computer-generated claim forms and reinforces learning; incorporates the latest regulations and practices for preparing and submitting health insurance claims; specific program templates ensure that all information necessary for claim processing is provided for each major insurance program discussed; and templates guide learners in preparing accurate claim forms: commercial carrier; Blue Cross/Blue Shield; Workers’ Compensation; basic Medicare; Medicare and Medigap, Medicare and Medicaid, Medicare as a secondary payor; Medicaid; and CHAMPUS.

This text features all aspects of administration and management of emergency medicine departments. The approach is multi-variant to address all factors that impact the issues. It is definitive, yet practical, in the depth of coverage necessary for effective application by emergency physicians.

History and Physical Exam Documentation Manual: A Guide for Medical Students Entering Core Clinical Rotations:

"This handbook serves the needs of undergraduate medical students, nursing students and is good refresher for Pediatric post graduates." Neel Kamal, Aug14 This portable, photo-rich guide to physical examination for Nurse Practitioners and other primary care providers will help you develop the unique range of skills required to assess children of all ages. System chapters begin with embryological development and review the key developmental stages of childhood. For infants and young children, this step-by-step guide uses the "quiet-to-active" approach favored by pediatric experts and considered more effective for this age-group than the traditional head-to-toe approach used for adults. Other key topics include pediatric mental health assessment and growth and development screening and surveillance. Uses the quiet-to-active approach to the examination of infants and young children, starting with listening and moving on to touching, the pediatric assessment approach that yields the best results in this age group. More than 300 photos and line drawings facilitate learning and familiarize you with common assessment findings. Information Gathering tables highlight questions and data needed from the patient/guardian, with questions conveniently separated by age group, to help you take an accurate history. Charting examples show you how to record physical examination findings in the health record and acquaint you with documentation language and format. Pediatric Pearls highlight effective physical examination findings and techniques gleaned from actual practice. Coverage of assessment of the preterm infant equips you with practical tools for assessing this unique pediatric population. Full-color format facilitates readability and learning. An easy-access two-column format provides quick access to concise information. Spiral binding lets you lay the book flat or fold it back for easy visualization and quick reference in the clinical setting. NEW! Expanded coverage of growth and development screening and surveillance reviews the methods and tools used for screening children for developmental delays and emotional and behavioral problems - one of the most challenging aspects of well-child care. NEW! Expanded coverage of history-taking and charting, with special emphasis on electronic charting, dermatologic assessment of more darkly pigmented skin, and adolescent assessment, provides valuable, need-to-know information. NEW! Expanded coverage of pediatric mental health assessment, including depression and anxiety, better equips you to assess for the 70% of adolescent mental health disorders that are thought to be unrecognized and untreated. NEW! Family, Cultural, and Racial Considerations sections address the increasingly important areas of family and cultural assessment to prepare you for differences to anticipate when assessing children of different cultural or racial groups. NEW! Enhanced illustration program featuring more than 50 new photos and illustrations better prepares you for clinical practice. NEW Summary of Examination lists at the end of each examination chapter highlight key assessment points associated with each body system and serve as a convenient quick reference and learning aid. NEW! Evidence-Based Practice Tips highlight useful research findings that guide you in your clinical practice. NEW! New and updated content on congenital and acquired heart disease, disorders of sexual...
differentiation, and sports-related concussions, as well as updated autism screening guidelines and World Health Organization (WHO) growth charts, highlights important trends in pediatric primary care practice. NEW! Improved Environmental Health History chapter, with new information on exposure to lead and endocrine-disrupting chemicals, culture-specific exposures, and diagnostic testing, addresses key toxicants and guides you in performing an environmental health screening history and establishing a risk profile for exposure to environmental pollutants. NEW! Attractive new design improves readability and usability, as well as learning and reference value.

THE CLINICAL PICTURE by Drs. Conwell & LehmanTick tick tick how many patients are waiting?As a health-care student or new practitioner, you work hard to refine your clinical skills, including the all-important history and physical (H&P) examination. You document your findings to help you diagnose your patient's problem and develop a treatment plan, and those records assist other health-care providers treating the patient. When care is holistic, integrated, and evidence-based, best-case practice requires careful documentation to increase good outcomes for patients. Meanwhile, the clock is ticking and more patients are waiting. THE CLINICAL PICTURE by Drs. Conwell & Lehman will help you improve your skill and efficiency in performing and documenting the initial H&P for patients presenting with neuromusculoskeletal conditions. Mastering the information in this concise and practical guide will: - Prepare you for board examinations that require knowledge in evaluating patients with neuromusculoskeletal conditions.- Improve your acumen and efficiency in acquiring and documenting complete information in a neuromusculoskeletal workup- Improve your ability to diagnose the majority of neurologic and musculoskeletal complaints of the neck, back, and extremities- Improve quality of care and patient outcomes in a patient-centered environment. The book includes illustrations to help you easily comprehend the material. Its three sections are History and Physical Examination, Narrative Report Writing, and Daily Record-Keeping. This comprehensive guide covers the following information: SECTION I thoroughly, yet succinctly, covers how to pull a comprehensive Medical History and perform a detailed Physical Examination of the neuromusculoskeletal system.- Medical HistoryThis section includes an extensive Outline Guide for quick reference and a comprehensive Confidential Patient History Questionnaire form. You will learn how to obtain and use the valuable historical information by incorporating the following acronyms: HPI, PMH, OPQRST, PSFH, ADL, ROS, and much more. The history section covers all the steps required to collect a detailed history from the patient.- Physical ExaminationThe emphasis is placed on the individual parts of the medical exam including general appearance, vital signs, neurologic evaluation (screening for lesions of the Central and Peripheral Nervous System), and orthopedic evaluation (inspection, palpation, ROM, provocative tests, peripheral vascular screen, non-organic physical signs). Chapters cover in detail Impression/Diagnosis, Treatment Plan, Outcome Assessment Tools, indications for Diagnostic Tests, descriptions and significance of the most common orthopedic and neurologic tests, and the commonly used medical abbreviations. SECTION II, Narrative Report Writing, includes a complete Narrative Report Outline Guide for quick reference. You will learn how to: - Use the key components of the medical narrative- Integrate information from the physical exam into the narrative report- Use appropriate medical phrasing and a precise writing style for the narrative report.- Detailed sample narrative reports from different medical specialties will help you apply the information in this section. SECTION III, Daily Record Keeping, thoroughly discusses: - The S.O.A.P. Note method for documenting daily office visit findings- Documentation required for medical necessity of the treatment provided- Communications with other health care providers- The problem-oriented medical information system PROMIS- The definition of Evaluation & Management (E&M) service codes- This section includes numerous detailed Daily Office Note (SOAP note) examples with accompanying appropriate E&M codes.

A basic guide to hospital billing and reimbursement, Understanding Hospital Billing and Coding, 3rd Edition helps you understand, complete, and submit the UB-04 claim form that is used for all Medicare and privately insured patients. It describes how hospitals are reimbursed for patient care and services, showing how the UB-04 claim form reflects the flow of patient data from the time of admission to the time of discharge. Written by coding expert Debra P. Ferenc, this book also ensures that you understand the essentials of ICD-10-CM and develop
skills in both inpatient coding and outpatient/ambulatory surgery coding. UB-04 Claim Simulation on the companion Evolve website lets you practice entering information from source documents into the claim form. Over 300 illustrations and graphics bring important concepts to life. Detailed chapter objectives highlight what you are expected to learn. Key terms, acronyms, and abbreviations with definitions are included in each chapter. Concept Review boxes reinforce key concepts. Test Your Knowledge exercises reinforce lessons as you progress through the material. Chapter summaries review key concepts. Practice hospital cases let you apply concepts to real-life scenarios. UPDATED content reflects the most current industry changes in ICD-10, MR-DRGs, PPS Systems, and the Electronic Health Record. NEW Hospital Introduction chapter includes a department-by-department overview showing how today's hospitals really work NEW Health Care Payers and Reimbursement section follows the workflow of the hospital claim by including successive chapters on payers, prospect payment systems, and accounts receivable management.

Now for the first time, a new diagnosis and treatment guide with even more focus on the most commonly encountered disorders than ever before. All major internal medicine diseases and disorders are covered in this new succinct evidence-based guide to treatment and diagnosis in internal medicine. Organized by body system, and focused on critical cor

In recent years, there has been a growing appreciation that the health problems of women require increased attention. Research has demonstrated important differences in the natural history, prevention, evaluation, & treatment of diseases in men & women. More & more, the primary care physician-ob/gyn, family practitioner, & internist needs to be skilled at delivering cost-effective treatment of non-ob/gyn problems in the office setting. This text helps the reader develop the necessary skills for the management of the full spectrum of disorders & conditions presented by the female patient.

Dynamic, interactive videos depict the most commonly performed physical exam procedures for each body system. With these DVDs, you'll learn to apply concepts and develop critical thinking skills. 185 video clips with a running time of 2-4 minutes each. For each body system, videos include: Overview (rationale and purpose) Preparation (including equipment and patient teaching) Procedure (printable step-by-step procedure checklists) Follow-up care (including health promotion and patient teaching) Documentation (tips and techniques) 25 detailed 3-D animations depict what's happening inside the body. Critical thinking case studies let you apply your knowledge to simulated patients. A documentation form library allows you to practice recording history and physical information. 80 NCLEX® examination-style review questions let you reinforce your comprehension


The leading single-source book in women's health care, reproductive medicine, and pelvic surgery Thorough review of all of obstetrics & gynecology Covers more than 1,000 diseases and disorders The latest screening and management guidelines More than 450 clear clinical
photos and illustrations in two colors Formatted to facilitate quick retrieval of information Concise, current coverage of treatments for common gynecologic infections Extensively revised throughout Covers underlying pathophysiology when relevant to diagnosis and treatment Helpful references to classic and important new sources

Many texts address the physical examination component of health assessment, but do not cover the diagnostic reasoning process that a health care provider must go through when assessing an actual case. In the Second Edition of Advanced Health Assessment and Diagnostic Reasoning, authors Rhoads and Petersen do just that. By including each step of health assessment, they demonstrate the links between health history and physical examination, and offer the healthcare provider with the essential data needed to formulate a diagnosis and treatment plan. Furthermore, the content in Advanced Health Assessment and Diagnostic Reasoning, Second Edition is accessible and presented in a way that is easy to follow and retain. Key Features & Benefits • Three introductory chapters cover general strategies for health history taking, physical examination, and documentation, and the remaining chapters cover clinical aspects of assessment, and focus on various systemic disorders (e.g., gastrointestinal, cardiovascular, musculoskeletal). • Aspects of the health history are presented in two columns. The first column gives the type of information that the provider should obtain, and the second column provides specific questions or information to note and gives examples of what conditions the findings may indicate. • Aspects of the physical examination are presented in two columns. The first column gives the action, and the second column lists normal and abnormal findings, and possible diagnoses associated with those findings. • Every clinical chapter contains a “Differential Diagnosis of Common Disorders” table. This table summarizes significant findings in the history and physical exam and gives pertinent diagnostic tests for common disorders. • Every clinical chapter also includes “Assessment of Special Populations.” This section highlights important information on assessing pregnant, neonatal, pediatric, and geriatric patients. • Case studies are integrated into each chapter. These case studies recount a patient’s history and provide sample documentation of the history and physical examination. The sample documentation familiarizes students with proper and complete documentation and use of forms, and is complete with a final assessment finding or diagnosis.

This notebook includes 40 templates to record a complete history and physical, assessment and plan. - Easily check boxes for review of systems and physical exam normals with room to write in additional findings. - Also includes sections for a differential diagnosis, assessment/plan, notes, and a checklist to record topics to look up later. - Great for medical students, PA students, and nursing students. - Your well organized notes will lead to perfect patient presentations. - Easily transfer your notes to the EMR after seeing the patient. Can also be used to record data for school patient logging. - The notebook is 5x8 inches and will fit in your white coat pocket.

Sabbath Diagnosis is a fascinating exploration of the seventh day from a unique clinical perspective. After covering an exhaustive medical history, this chart presents the findings of a comprehensive physical examination. The patient's chief complaint, family, social and surgical history are all there. Also, presented is a full discussion of the differential diagnosis, pathophysiology, etiology and epidemiology of the Sabbath. All consultations, doctor's orders and progress notes included. Within the covers of this extensive medical record you will discover compelling documentation to support your final diagnosis. Additional Topics: --Exposure and spread of Sabbath-keeping --Excision and Biopsy of the Ten Commandments --Classical Symptoms and Vital Signs

Addresses administrative aspects of medical practice such as: CPT coding, billing guidelines, establishing/monitoring fees, dealing with managed care plans and utilization review, improving collections, compliance efforts, and identifying future trends impacting these key areas.
History and Physical Examination: A Common Sense Approach provides a comprehensive, accessible foundation to the crucial patient care skill of clinical history taking and ‘head-to-toe’ clinical examination. Through full color illustrations, patient photographs, and video examples, this valuable resource highlights a logical, step-by-step approach to gain clinical competency. The authoritative content is divided into three sections to build and develop students’ practical skills: History Flows, which provide context and practice through clinical scenario work, to logically develop differential diagnoses; Physical Examination Flows, which focus on comprehensive and consistent exams by using the human body as a map; and finally, Comprehensive Flows, which enable the student to apply their history taking and examination tools together to develop a differential diagnosis and a treatment plan—all under the real-world pressure of a time-sensitive office visit. Each section features “Clinical Case Practice” for students to interact and apply the clinical concepts and to prepare for actual practice. By moving beyond discrete symptoms, History and Physical Examination: A Common Sense Approach prepares students not only for practical boards, but for delivering humanistic care in real-world patient encounters.

With an easy-to-follow approach and unmatched learning support, Jarvis' Physical Examination and Health Assessment, 8th Edition is the most authoritative, complete, and easily-implemented solution for health assessment courses in nursing. This tightly integrated learning package continues to center on Carolyn Jarvis's trademark clear, logical, and holistic approach to physical examination and health assessment across the patient lifespan. It's packed with vivid illustrations, step-by-step guidance and evidence-based content to provide a complete approach of health assessment skills and physical examination. With a fresh focus on today's need-to-know information, the 8th edition integrates QSEN and interprofessional collaboration, enhanced inclusion of LGBTQ issues, a new standalone Vital Signs chapter, and enhanced EHR and documentation content. The most trusted name in health assessment for nurses, now in its 8th edition! A clear, conversational, step-by-step, evidence-based approach to physical examination and health assessment of patients throughout the lifespan. A consistent format from chapter to chapter features sections on Structure and Function, Subjective Data, Objective Data, Documentation and Critical Thinking, and Abnormal Findings to help you learn to assess systematically. UPDATED! An unsurpassed collection of more than 1,100 full-color illustrations has been updated to vividly showcase anatomy and physiology, examination techniques, and abnormal findings. Enhanced content on the electronic health record, charting, and narrative recording exemplify how to document assessment findings using state-of-the-art systems with time-tested thoroughness. Engaging learning resources include assessment video clips; NCLEX® Exam review questions; case studies with critical thinking activities; audio clips of heart, lung, and abdominal sounds; assessment checklists, and much more. Promoting a Healthy Lifestyle boxes present opportunities for patient teaching and health promotion while performing the health assessment. Developmental Competence sections highlight content specific to infants, children, adolescents, pregnant women, and older adults. Culture and Genetics sections include information on biocultural and transcultural variations in an increasingly diverse patient population. NEW! Standalone Vital Signs chapter and refocused nutrition content includes an expanded emphasis on the national epidemic of obesity. NEW! Enhanced integration of QSEN and interprofessional collaboration emphasize how to ensure patient safety during the physical exam and how to collaborate with other health professionals to promote optimal health. NEW! Enhanced inclusion of LGBTQ issues and revamped and refocused Cultural Assessment chapter equip you with the skills to practice with greater sensitivity and inclusivity. NEW! Health Promotion and Patient Teaching sections underscore the unique role of nurses (especially advanced practice nurses) in health promotion.