

Clinical Documentation Cheat Sheet

Documentation element	Description	Key points
Patient identification	Patient's personal information	Include name, date of birth, medical record number, and contact details
Medical history	Comprehensive medical background	Document past and current medical conditions, surgeries, and family history.
Medication list	Current and past medications	Include dosages, frequency, and any adverse reactions
Allergies	Documented allergies or reactions	Note specific allergens and type of reactions experienced.
Chief complaint	Primary reason for the visit	Record the patient's main concern or symptom.
History of present illness	Detailed account of the chief complaint	Describe the onset, duration, intensity, and associated symptoms
Physical examination	Findings from the physical assessment	Document vital signs, general appearance, and system-specific findings.
Assessment and plan	Clinical judgment and care plan	Summarize diagnoses and outline the treatment plan, including medications, therapies, and follow-up.
Progress notes	Ongoing documentation of care	Record changes in condition, response to treatment, and any modifications in the plan.
Discharge summary	Overview of the hospitalization or visit	Summarize the reason for admission, course of treatment, final diagnoses, and follow-up instructions.
Additional notes		

Hospice Clinical Documentation

Judith A. Stein,Jr. Chiplin Alfred J.



Hospice Clinical Documentation:

Guide to Clinical Documentation Debra D Sullivan, 2018-07-25 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

Hospice and Palliative Care Handbook T. M. Marrelli, 1999 This handbook assists the home care hospice nurse with documentation and reimbursement for conditions commonly treated in the hospice setting identifies skilled interventions and outcomes for patients with a wide variety of problems and aids in assessments and nursing diagnosis discharge planning and psychosocial and spiritual considerations Also included are the relevant sections of the HCFA HIM 11 manual which delineates HCFAs documentation requirements for Medicare patients

Hospice and Palliative Care Handbook, Fourth Edition: Quality, Compliance, and Reimbursement Tina M. Marrelli, 2023-06-23 This book is a perfect blend of compassion and competence that addresses the core values of care the interdisciplinary team self care of staff and the needs of an aging society Betty Ferrell PhD FAAN FPCN CHPN Professor and Director Nursing Research City of Hope Medical Center Principal Investigator End of Life Nursing Education Consortium A must read for all hospice providers It is a comprehensive overview of the core elements required to practice effectively compliantly safely and compassionately An indispensable addition to all hospice libraries Kim Corral MA Ed BSN RN COS C Director of Corporate Compliance Quality and Education Bridge Home Health and Hospice I have utilized Tina Marrelli s home health and hospice handbooks to support training new clinical staff and students for decades and consider these resources to be the gold standard Kimberly Skehan MSN RN HCS D COS C Vice President of Accreditation Community Health Accreditation Partner Hospice Palliative Care Handbook Fourth Edition offers updated coverage of all aspects of hospice and palliative care for the entire healthcare team who provide important care while meeting difficult multilevel regulations This edition includes examples and strategies covering key topics related to standards guidelines goals and effective care planning

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Resources

ABOUT THE AUTHORS TINA M MARRELLI MSN MA RN FAAN is the author of over 10 award winning books She is an international consultant specializing in home care and hospice and is the President of Marrelli Associates Inc a publishing and consulting firm working in healthcare and technology for over 25 years JENNIFER KENNEDY EdD BSN RN

CHC is the Vice President for Quality Standards and Compliance at Community Health Accreditation Partner CHAP and is a nationally recognized hospice expert She has more than 35 years of experience as a leader and nurse in diverse healthcare settings and has worked in hospice and palliative care for more than 25 years **Hospice and Palliative Care Handbook** T. M. Marrelli, 2005 This easy to use handbook is the only one of its kind to offer concise focused coverage of all hospice related conditions Key topics include professional standards and guidelines bereavement services considerations outcomes and goals quality control and tips for obtaining reimbursement Couverture What Do You See? Michelle Crowell, 2016-09-17 Oftentimes documentation to prove hospice eligibility can be tricky Generalization and lack of specific details can result in non payment or repayment of claims My purpose in creating this pocket guide is to help nurses physicians and other disciplines be able to accurately and thoroughly document hospice decline Everything you need is at the drop of the hand in a small convenient size guide that can easily be carried with you anywhere The Clinical Documentation Improvement Specialist's Handbook, Second Edition Heather Taillon, 2011-01-21 The Clinical Documentation Improvement Specialist s Handbook Second Edition Marion Kruse MBA RN Heather Taillon RHIA CCDS Get the guidance you need to make your CDI program the best there is The Clinical Documentation Improvement Specialist s Handbook Second Edition is an all inclusive reference to help readers implement a comprehensive clinical documentation improvement CDI program with in depth information on all the essential responsibilities of the CDI specialist This edition helps CDI professionals incorporate the latest industry guidance and professional best practices to enhance their programs Co authors Heather Taillon RHIA and Marion Kruse MBA RN combine their CDI and coding expertise to explain the intricacies of CDI program development and outline the structure of a comprehensive multi disciplinary program In this edition you will learn how to Adhere to the latest government and regulatory initiatives as they relate to documentation integrity Prepare for successful ICD 10 transition by analyzing your CDI program Step up physician buy in with the improved education techniques Incorporate the latest physician query guidance from the American Health Information Management Association AHIMA Table of Contents Chapter 1 Building the CDI Program Chapter 2 CDI and the healthcare system Chapter 3 Application of coding guidelines Chapter 4 Compliant physician queries Chapter 5 Providing physician education Chapter 6 Monitoring the CDI program What s new in the Second Edition Analysis of new industry guidance including AHIMA s Managing an Effective Query Process and Guidance for Clinical Documentation Improvement Programs CMS guidance from new IPPS regulations MLN Matters articles Quality Improvement Organizations and the Recovery Audit Contractor RAC program among others Strategies to help you incorporate the guidance into your CDI program Tools to help you interpret MAC initiatives and RAC focus areas to enhance your CDI program and help prevent audit takebacks New sample queries forms tools and industry survey data BONUS TOOLS This book also includes bonus online tools you can put to use immediately Sample query forms Sample job descriptions for CDI managers and CDI specialists Sample evaluation form for

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