NURSING SOAP NOTE EXAMPLE

SUBJECTIVE:	
Chief Complaint (CC)	 Reason for visit
	 Duration of the problem.
	 Severity of the problem
History of Present - Illness (HPI)	Onset and course of the problem.
	 Associated symptoms
	 Aggravating/relieving factors
	 Prior occurrences/treatments
Past Medical History (PMH)	Chronic medical conditions
	 Surgeries
	Hospitalizations
Medications	Prescription medications
	 Over-the-counter medications
	 Supplements and herbal remedies
Allergies	Medication allergies
	 Food/environmental allergies
Social History (SH)	Tobacco, alcohol, and drug use
	Occupation
	 Living situation
Family History (FH)	 Significant medical conditions in the family
	 Hereditary diseases
Review of Systems (ROS)	 System-specific symptoms, organized by body syster

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Examples Soap Nursing Documentation

R Barnett

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Basic Concepts of Psychiatric-mental Health Nursing Louise Rebraca Shives, 2007 This seventh edition includes new chapters and maintains popular features from previous editions such as self awareness prompts while adding research boxes and student worksheets at the end of each chapter **Documentation Basics** Mia Erickson, Mia L. Erickson, 2012 Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively The new Second Edition of Documentation Basics A Guide for the Physical Therapist Assistant continues the path of teaching the student and clinician documentation from A to Z Mia Erickson and Rebecca McKnight have updated this Second Edition to reflect changes of the American Physical Therapy Association and the ever evolving profession Updated inside Documentation Basics A Guide for the Physical Therapist Assistant Second Edition The discussion on integrating disablement into documentation The discussion on how a PTA can show medical necessity and need for skilled care The discussion on using documentation to communicate with other providers Writing the assessment and plan to coincide with the initial documentation Sample notes completed on forms More examples and practice including physical agents school based services paediatrics traumatic brain injury spinal cord injury and interventions consistent with the Guide to Physical Therapist Practice Medicare reimbursement in different settings The importance of consistent reliable and valid measurements How to improve communication and consistency between documentation by the PT the PTA The discussion on disablement has also been updated shifting away from the Nagi Model toward the International Classification of Functioning Disability and Health ICF In addition the PTA Normative Model has been integrated throughout to include more information on clinical decision making New inside Documentation Basics A Guide for the Physical Therapist Assistant Second Edition Navigating the PT plan of care A step by step model for PTAs to use as they navigate the initial PT documentation and plan of care How the PTA uses the PT goals from the initial examination and evaluation Positive and negative aspects of using electronic documentation and a discussion on integrating SOAP notes and the problem oriented medical record into electronic documentation Sample notes and discussion of documentation in school based settings early intervention skilled nursing settings in patient rehabilitation and direct access Medicare Parts C and D Cash based services and pro bono services Instructors in educational settings can visit www efacultylounge com for additional material to be used for teaching in the classroom Documentation Basics A Guide for the Physical Therapist Assistant Second Edition is the perfect guide for all physical therapist assistant students and clinicians who want to update and refine their knowledge and skills in Modules for Basic Nursing Skills Janice Rider Ellis, Elizabeth Ann Nowlis, Patricia M. Bentz, 1992-01-01 documentation Fundamental Nursing Skills and Concepts Barbara Kuhn Timby, 2009 Now in its Ninth Edition this full color text

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