

SOAP NOTE EXAMPLE – NURSE PRACTITIONER

SECTION	DETAILS
Subjective:	Chief Complaint (CC): Brief statement of the patient's main concern or reason for the visit. Example: "I have been experiencing a persistent cough for the last two weeks." History of Present Illness (HPI): A detailed description of the patient's symptoms, onset, duration, severity, context, modifying factors, and associated signs and symptoms. Example: Patient reports a dry, non-productive cough that started gradually two weeks ago. The cough is worse at night, and there is no relief with over-the-counter cough suppressants. The patient denies fever, chills, chest pain, or shortness of breath. Past Medical History (PMH): Summary of the patient's relevant medical history, including chronic conditions, surgeries, allergies, and medications. Example: Asthma, seasonal allergies; Appendectomy (2018); Allergic to penicillin; Currently taking montelukast 10 mg daily and fluticasone/salmeterol inhaler. Social History (SH): Information about the patient's lifestyle, occupation, and living situation. Example: Non-smoker, occasional alcohol use, works as a teacher, lives with spouse and two children. Family History (FH): Relevant health information about the patient's immediate family. Example: Mother with asthma, father with hypertension, sibling with type 2 diabetes.
Objective:	Vital Signs: Blood pressure, heart rate, respiratory rate, temperature, and oxygen saturation. Example: BP 120/80 mmHg, HR 75 bpm, RR 18 breaths/min, Temp 98.6°F (37°C), SpO2 98% on room air. Physical Exam: Documentation of the physical examination, focusing on the relevant body systems. Example: General appearance: Patient is alert and oriented, in no apparent distress. HEENT: Pupils equal, round, and reactive to light. Nasal mucosa is erythematous and swollen. No discharge. Throat is clear without exudate. Lungs: Clear to auscultation bilaterally, no wheezing or

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Karen J. Tietze



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COMLEX Level 2-PE Review Guide Mark Kauffman, 2010-02-26 COMLEX Level 2 PE Review Guide is a comprehensive overview for osteopathic medical students preparing for the COMLEX Level 2 PE Performance Evaluation examination COMLEX Level 2 PE Review Guide covers the components of History and Physical Examination found on the COMLEX Level 2 PE The components of history taking expected problem specific physical exam based on the chief complaint incorporation of osteopathic manipulation instruction on how to develop a differential diagnosis components of the therapeutic plan components of the expected humanistic evaluation and documentation guidelines The final chapter includes case examples providing practice scenarios that allow the students to practice the cases typically encountered on the COMLEX Level 2 PE These practice cases reduce the stress of the student by allowing them to experience the time constraints encountered during the COMLEX Level 2 PE This text is a one of a kind resource as the leading COMLEX Level 2 PE board review book Offers practical suggestions and mnemonics to trigger student memory allowing for completeness of historical data collection Provides a method of approach that reduces memorization but allows fluidity of the interview and exam process Organizes the approach to patient interview and examination and provides structure to plan development Describes the humanistic domain for student understanding of the areas being evaluated Features Guidelines to help you prepare for successful completion of the COMLEX LEVEL 2 PE Mnemonic tools for detailed complete history taking and plan development Humanistic domain checklist to guide you through the patient encounter Test taking strategies and commonly made mistakes 50 practice case encounters 2011 290 pages [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 *Documentation for Physical Therapist Assistants* Wendy D Bircher, 2017-10-01 Build your documentation skills and your confidence Step by step this text workbook introduces you to the importance of documentation shows you how to develop and write a proper and defensible note and prepares you to meet the technological challenges you'll encounter in practice You'll learn how to provide the proper documentation to assure all forms of reimbursement including third party for your services You'll also explore issues of patient confidentiality HIPAA requirements and the ever increasing demands of legal and ethical practice in a litigious society **Writing Patient/Client Notes** Ginge Kettenbach, Sarah Lynn Schlomer, Jill Fitzgerald, 2016-05-11 Develop all of the skills you need to write clear concise and defensible patient client care notes using a variety of tools including SOAP notes This is the ideal resource for any health care professional needing to learn or improve their skills with simple straightforward explanations of the hows and whys of documentation It also keeps pace with the changes in Physical Therapy

practice today emphasizing the Patient Client Management and WHO s ICF model E&M Coding Clear & Simple Terri Ann Brame,2013-09-16 This easy to read text breaks these complex codes into manageable bite sized pieces Practice questions and real world case studies help you apply your knowledge and approach any coding situation with confidence *The History and Physical Examination Workbook: A Common Sense Approach* Mark Kauffman,Michele Roth-Kauffman,2006-07-06 During a typical office visit a provider has approximately fifteen minutes to interview examine diagnose and appropriately treat each patient The History and Physical Examination Workbook A Common Sense Approach is a must have resource for developing these skills Providing clinical practice in the art of performing H and Ps through the use of flow models this workbook encourages students to avoid memorization and develop a logical approach to patients chief complaints by allowing them to partner up as patient and **The OTA's Guide to Writing SOAP Notes** Sherry Borcharding,Marie J. Morreale,2007 Written specifically for occupational therapy assistants The OTA s Guide to Writing SOAP Notes Second Edition is updated to include new features and information This valuable text contains the step by step instruction needed to learn the documentation required for reimbursement in occupational therapy With the current changes in healthcare proper documentation of client care is essential to meeting legal and ethical standards for reimbursement of services Written in an easy to read format this new edition by Sherry Borcharding and Marie J Morreale will continue to aid occupational therapy assistants in learning to write SOAP notes that will be reimbursable under Medicare Part B and managed care for different areas of clinical practice New Features in the Second Edition Incorporated throughout the text is the Occupational Therapy Practice Framework along with updated AOTA documents More examples of pediatrics hand therapy and mental health Updated and additional worksheets Review of grammar documentation mistakes Worksheets for deciphering physician orders as well as expanded worksheets for medical abbreviations Updated information on billing codes HIPAA management of health information medical records and electronic documentation Expanded information on the OT process for the OTA to fully understand documentation and the OTA s role in all stages of treatment including referral evaluation intervention plan and discharge Documentation of physical agent modalities With reorganized and shorter chapters The OTA s Guide to Writing SOAP Notes Second Edition is the essential text to providing instruction in writing SOAP notes specifically aimed at the OTA practitioner and student This exceptional edition offers both the necessary instruction and multiple opportunities to practice as skills are built on each other in a logical manner Templates are provided for beginning students to use in formatting SOAP notes and the task of documentation is broken down into small units to make learning easier A detachable summary sheet is included that can be pulled out and carried to clinical sites as a reminder of the necessary contents for a SOAP note Updated information expanded discussions and reorganized learning tools make The OTA s Guide to Writing SOAP Notes Second Edition a must have for all occupational therapy assistant students This text is the essential resource needed to master professional documentation skills in today s healthcare environment Clinical Skills for Pharmacists

Karen J. Tietze, 2011-03-17 Covering the skills needed for pharmaceutical care in a patient centered pharmacy setting Clinical Skills for Pharmacists A Patient Focused Approach 3rd Edition describes fundamental skills such as communication physical assessment and laboratory and diagnostic information as well as patient case presentation therapeutic planning and monitoring of drug intake Numerous case examples show how skills are applied in clinical situations Now in full color this edition adds more illustrations and new coverage on taking a medication history physical assessment biomarkers and drug information Expert author Karen J Tietze provides unique pharmacy specific coverage that helps you prepare for the NAPLEX and feel confident during patient encounters Coverage of clinical skills prepares you to be more involved with patients and for greater physical assessment and counselling responsibilities with discussions of communication taking a medical history physical assessment reviewing lab and diagnostic tests and monitoring drug therapies A logical organization promotes skill building with the development of each new skill building upon prior skills Learning objectives at the beginning of each chapter highlight important topics Self assessment questions at the end of each chapter help in measuring your comprehension of learning objectives Professional codes of ethics are described in the Ethics in Pharmacy and Health Care chapter including confidentiality HIPAA research ethics ethics and the promotion of drugs and the use of advance directives in end of life decisions Numerous tables summarize key and routinely needed information Downloadable customizable forms on the companion Evolve website make it easier to perform tasks such as monitoring drug intake and for power of attorney

Writing Skills for Veterinarians Ryane E. Englar, 2019-02-05 Communicating ideas in veterinary medicine is a fundamental part of continuing veterinary research and building a career as a clinician The purpose of this book is to help increasing efficiency and effectiveness in writing professional documents e g writing a concise yet thorough discharge statement to avoid repeated client call backs to clarify medical recommendations The book also aims at improving the reader's confidence in writing skills through guided and well thought out homework or practice exercises Useful for both veterinary students and practising vets Writing Skills for Veterinarians addresses how to develop and hone veterinary medical and scientific writing techniques The basics of veterinary writing and why it matters are covered before concentrating on specific written models expected of vets creating medical documents client and colleague communications report writing journal articles and research papers and presentations At the end of the book is a resource bank of additional exercises relating to each type of document 5m Books

Oski's Essential Pediatrics Michael Crocetti, Michael A. Barone, Frank A. Oski, 2004 This concise text presents the essential information that medical students residents and other clinicians need to diagnose and treat patients Chapters focus on specific clinical problems and follow a user friendly format with numerous illustrations algorithms tables and graphs A new section on presenting signs and symptoms has been added and the chapter organization has been revised for easier reference

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