Documenting Physical Exam Findings

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Documenting Physical Exam Findings

Documenting your findings on a physical exam as well as the reasoning for your plan of care serves as a defense in the event another provider, patient etc. doesn't agree with your actions. Second,

documentation helps with continuity of care.

Cheat Sheet: Normal Physical Exam Template | ThriveAP

While you won’t use all of these abnormal elements in documenting a single heart exam, here are a few atypical findings you may note: Tachycardia, bradycardia Irregular rhythm Murmurs (systolic, diastolic)

Extra heart sounds (S3, S4) Displaced PMI External chest appearance (asymmetry, scars, signs ...

A Quick Guide to Documenting a Cardiovascular Exam | ThriveAP

Documenting a normal exam of the head, eyes, ears, nose and throat should look something along the lines of the following:

Head – The head is normocephalic and atraumatic without tenderness, visible or palpable masses, depressions, or scarring.

The 411 on Documenting a HEENT Exam | ThriveAP

Physical Exam Format 1: Subheadings in ALL CAPS and flush left to the margin. PHYSICAL EXAMINATION:

GENERAL APPEARANCE: The patient is a [x]-year-old well-developed, well-nourished male/female in no acute distress.

Normal Physical Exam Template Samples

Inspection – Evaluation of the external abdomen. Bruising, for example, may indicate trauma. Distention could be a sign... Auscultation –

Assessment of bowel sounds, can give you a clue as to the patient's pathology. Absence of bowel sounds,... Percussion – Evaluation of the liver. This one takes ...

The Skinny on Documenting an Abdominal Exam | ThriveAP

DATA BASE SAMPLE: PHYSICAL EXAMINATION WITH ALL NORMAL FINDINGS

GENERAL APPEARANCE: (include general mental status) 45 y/o female who is awake and alert and who appears healthy and looks her stated age VITALS Temperature: 37.5° C oral (list the site where the temperature was taken, i.e., oral, rectal, tympanic membrane, axillary) Blood

DATA BASE SAMPLE: PHYSICAL

EXAMINATION WITH ALL NORMAL ...

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History and Physical Examination (H&P) Examples | Medicine ...

Previously, the guidelines required

that such an exam include findings from eight or more of the 12 organ systems. The revised guidelines require documentation of at least two elements from each ...

Exam Documentation: Charting Within the Guidelines -- FPM

Sample Detailed Normal Exam Documentation. If you are documenting a

more in-depth neurological exam, your corresponding documentation for a normal exam should look something along the lines of the following: Mental Status: The patient is alert and oriented to person, place, and time with normal speech. Memory is normal and thought process is ...

Documenting a Neuro Exam,

Decoded | ThriveAP

Breast Examination documentation examples. Normal breast examination documentation. Abnormal breast examination documentation. Clinical Skills Teaching and Learning Centre. 70 Pembroke Place L69 3GF Liverpool United Kingdom. 0151 794 8242. clinicalskills@liverpool.ac.uk.

Breast Examination documentation examples – Clinical ...

Example documentation of a normal cranial nerve examination Example documentation of an abnormal cranial nerve examination

Cranial Nerves example documentation – Clinical Skills ...

PELVIC EXAM

TERMINOLOGY. To document findings, use terms from the FGGT and the pelvic exam case report forms. y. When the term from the case report form is more specific than the term from the FGGT, use the term from the case report form. y.

Pelvic Exams and Evaluations - Microbicide Trials Network

2. The documentation

of each patient encounter should include: reason for encounter and relevant history, physical examination findings, and prior diagnostic test results;

1997 DOCUMENTATION GUIDELINES FOR EVALUATION AND ...

EXAMINATION of the EAR • Inspection • External ear - observe position and shape,

inspect for symmetry, lesions, drainage from external auditory meatus • Position: Top of auricle should be abo ve line drawn between outer canthus of eye and occipital protuberance. Low set auricle may signify chromosomal abnormality. • Possible findings

EXAMINATION of the EAR - University of Virginia

PHYSICAL EXAM The following outline for the Pediatric History and Physical Examination is comprehensive and detailed. In order to assimilate the information most easily, it is suggested that you read through the whole section before examining your first patient to get a general idea of the scope of the pediatric evaluation. Then, as

Guide to the Comprehensive Pediatric H&P Write Up

If your department uses the 1997 guidelines, read through the bullets and pick 2 per system to include in your exam. Your examination is part of your decision making. The chief complaint will indicate certain positive or negative findings to be

documented.

ED Charting and Coding: Physical Exam (PE)

Exam may be remarkable for confusion (range from mild to severe), cranial nerve palsy (CN 3, 4, 6--> impaired extra ocular movements), nystagmus, ataxia and peripheral neuropathy. Video of patient with vertical and horizontal nystagmus.

UC San Diego's Practical Guide to Clinical Medicine

They range from limited examinations of single body areas to general multi-system or complete single organ system examinations. Documentation Guidelines. Specific abnormal and relevant negative findings of the examination of the affected or

symptomatic body area (s) or organ system (s) should be documented.