

Nursing Assessment

Patient information	
Name: John Benson	
Date of birth: March 12, 1980	Gender: Male
Occupation: Construction Worker	Mobile number: (555) 123-4567
Height: 5'10" (178 cm)	Weight: 190 lbs (86 kg)
Race/Ethnicity: Caucasian	
Reason for visit: Chest pain and shortness of breath	
Medical history	
Past medical history: Hypertension, high cholesterol	Current medical conditions: Hypertension, mild asthma
Relevant family medical history: Father with heart disease; mother with diabetes	Allergies: Penicillin
Current medications: Lisinopril (10 mg), Aspirin (81 mg), Albuterol (as needed)	Immunization status: Up to date (including influenza and COVID-19)
Infectious/Isolation status: None	
Vital signs	
Temperature: 98.6°F (37°C)	Blood pressure: 145/90 mmHg
Heart rate: 85 bpm	Pain level: 6/10 (chest pain)
Respiratory rate: 20 breaths/min	AVPU/Sedation: Alert

Emergency Nursing Assessment Documentation Example

Joacim Rocklöv



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Complete Guide to Documentation Lippincott Williams & Wilkins, 2008 Thoroughly updated for its Second Edition this comprehensive reference provides clear practical guidelines on documenting patient care in all nursing practice settings the leading clinical specialties and current documentation systems This edition features greatly expanded coverage of computerized charting and electronic medical records EMRs complete guidelines for documenting JCAHO safety goals and new information on charting pain management Hundreds of filled in sample forms show specific content and wording Icons highlight tips and timesavers critical case law and legal safeguards and advice for special situations Appendices include NANDA taxonomy JCAHO documentation standards and documenting outcomes and interventions for key nursing diagnoses

AR 40-66 06/17/2008 MEDICAL RECORD ADMINISTRATION AND HEALTH CARE DOCUMENTATION, Survival Ebooks Us Department Of Defense, www.survivalebooks.com, Department of Defense, Delene Kvasnicka, United States Government US Army, United States Army, Department of the Army, U. S. Army, Army, DOD, The United States Army, AR 40 66 06 17 2008 MEDICAL RECORD ADMINISTRATION AND HEALTH CARE DOCUMENTATION Survival Ebooks Manual of Forensic Emergency Medicine Ralph Riviello, 2010 Manual of Forensic Emergency Medicine is a comprehensive guide to the clinical approach to criminal illness and injury This resource offers emergency care professionals the knowledge needed to make an accurate diagnosis of abuse neglect sexual assault or other conditions in which forensic investigation is needed This book offers information on victim services and resources available for patients as well as relevant aspects of the legal system This essential guide contains color photos a forensic glossary and forensic forms that can be used in a clinical practice Key Topics include Forensic Documentation Firearms Evidence Collection in the ED and Gang Violence *The Manual of Nursing Quality Assurance* Howard S. Rowland, Beatrice L. Rowland, 1987 The Manual of Nursing Quality Assurance is an encyclopedic source that covers every facet of nursing quality assurance Not a theoretical manual it represents the actual working experience of the nations finest nursing departments and QI experts with proven approaches and practical techniques and procedures that work in the real world The manual has hundreds of specific forms checklists and procedures developed and scrutinized by QI administrators professional associations major medical libraries and government agencies

Documentation for Rehabilitation Lori Quinn, James Gordon, 2015-12-11 Better patient management starts with better documentation Documentation for Rehabilitation A Guide to Clinical Decision Making in Physical Therapy 3rd Edition shows how to accurately document treatment progress and patient outcomes Designed for use by rehabilitation professionals documentation guidelines are easily adaptable to different practice settings and patient populations Realistic examples and practice exercises reinforce concepts and encourage you to apply what you've learned Written by expert physical therapy educators Lori Quinn and James Gordon this book will improve your skills in both documentation and clinical reasoning A practical framework shows how to organize and structure PT records making it easier to document functional outcomes in

many practice settings and is based on the International Classification for Functioning Disability and Health ICF model the one adopted by the APTA Coverage of practice settings includes documentation examples in acute care rehabilitation outpatient home care and nursing homes as well as a separate chapter on documentation in pediatric settings Guidelines to systematic documentation describe how to identify record measure and evaluate treatment and therapies especially important when insurance companies require evidence of functional progress in order to provide reimbursement Workbook textbook format uses examples and exercises in each chapter to reinforce your understanding of concepts NEW Standardized Outcome Measures chapter leads to better care and patient management by helping you select the right outcome measures for use in evaluations re evaluations and discharge summaries UPDATED content is based on data from current research federal policies and APTA guidelines including incorporation of new terminology from the Guide to Physical Therapist 3 0 and ICD 10 coding EXPANDED number of case examples covers an even broader range of clinical practice areas *Nursing Documentation* Patricia W. Iyer, Nancy Hand Camp, 1999 Accurate documentation shows managed care companies that patients receive adequate care and that health care providers are controlling costs and resources This book clearly and concisely provides guidelines for appropriate and careful documentation of care This new edition includes the latest changes and trends in nursing documentation as they relate to the newly restructured healthcare environment "Code of Massachusetts regulations, 2010" ,2010 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of January 2020 Medical Record Administration and Health Care Documentation United States. Department of the Army, 1999 **"Code of Massachusetts regulations, 2015"** ,2015 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of January 2020 *"Code of Massachusetts regulations, 2014"* ,2014 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of January 2020 "Code of Massachusetts regulations, 2009" ,2009 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of January 2020 **Charting by Exception** Laura J. Burke, Judy Murphy, 1988 A time efficient and cost effective method of documentation of nursing care through a system of charting by exception the documentation of abnormal or significant findings using a standard normal base is described in this book The method eliminates time consuming documentation of normal findings and repetitious information allowing the nurse to spend less time at the desk and more time caring for patients **"Code of Massachusetts regulations, 2013"** ,2013 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of January 2020 "Code of Massachusetts regulations, 2012" ,2012 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of January 2020 **"Code of Massachusetts regulations, 2011"** ,2011 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of

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Massachusetts register ,1987 **Nursing Documentation** Ellen Thomas Egglund,Denise Skelly Heinemann,1994
Focuses on the communication skills that are the key to good documentation

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