

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.

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web l objectif de ce d i u est donc de proposer à des médecins non psychiatres en fonction dans des services de psychiatrie une formation polyvalente leur permettant d acquérir les éléments théoriques de psychiatrie nécessaires à leur exercice et d intégrer les données de leur expérience pratique publics concernés

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web psikiyatri merkezi kadıköy İstanbul erenköy ruh sağlığı hastanesi 1978 yılından itibaren ssk ya bağlı olarak hastalara şu güne kadar 307 yatak kapasite ile hizmet vermektedir marmara bölgesinde ssk ya bağlı tek psikiyatri hastanesi olması nedeniyle hasta yoğunluğuna rağmen mevcut imkanlarla en iyi hizmeti vermeye