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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

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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

Documenting a normal exam of the
head, eyes, ears, nose and throat should

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look something along the lines of the following: Head - The head is normocephalic and atraumatic without tenderness, visible or palpable masses, depressions, or scarring. Hair is of normal texture and evenly distributed. Eyes - Visual acuity is intact.

The 411 on Documenting a HEENT

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Exam | ThriveAP

Abnormal findings on an extremity or neuro exam, for example, may indicate pathology associated with the spine. You should always accompany an exam of the back and neck with an extremity, abdominal, neurological, respiratory, and cardiovascular exam, at least to some extent. You Might Also Like: The

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Skinny on Documenting an Abdominal Exam

Documenting a Back and Neck Exam Made Simple | 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:

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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**
The 1995 guidelines identify Body Areas

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and Organ Systems as a framework for documenting the physical exam, but do not say what to chart under either. The 1997 guidelines define mandatory physical exam elements and called them Bullets. A comprehensive exam requires all bulleted items to be examined, and at least 2 per system to be documented.

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ED Charting and Coding: Physical Exam (PE)

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History and Physical Examination

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(H&P) Examples | Medicine ...

Nursing assessment is an important step of the whole nursing process.

Assessment can be called the “base or foundation” of the nursing process. With a weak or incorrect assessment, nurses can create an incorrect nursing diagnosis and plans therefore creating wrong interventions and evaluation. To

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prevent those kind of scenarios, we have created a cheat sheet that you can print and use to ...

Complete Head-to-Toe Physical Assessment Cheat Sheet ...

Sample Detailed Normal Exam Documentation. If you are documenting a more in-depth neurological exam, your

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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,

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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.

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Breast Examination documentation examples - Clinical ...

The diagnosis of any skin lesion starts with an accurate description of it. To do that, you need to know how to describe a lesion with the associated language. This language, reviewed here, can be used to describe any skin finding.

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Dermatology Exam: Learning the Language | Stanford ...

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

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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 ...**
PELVIC EXAM TERMINOLOGY. To
document findings, use terms from the

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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

Physical Exam 1. Vital Signs:

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temperature 100.2 Pulse 96 regular with occasional extra beat, respiration 24, blood pressure 180/100 lying down 2. Generally a well developed, slightly obese, elderly black woman sitting up in bed, breathing with slight difficulty.

Example of a Complete History and Physical Write-up

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Typical findings on clinical examination include a unilateral, fluctuant mass, which may or may not be tender. Lichen sclerosus It presents with pruritis and clinical examination typically reveals white thickened patches .

Vaginal Examination (PV) - OSCE Guide | Geeky Medics

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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

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Guide to the Comprehensive Pediatric H&P Write Up

The 1995 evaluation and management (E/M) guidelines allow the physician to complete the physical exam by documenting organ systems or body areas, which can be subjective but allows providers more leeway and

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“wobble room.”

How to Document the Physical Exam - The Rheumatologist

The physical exam can, of course, be valuable, but even Osler said 95% of the diagnosis is in the history. He was right. We should listen to our patients. He might have loved telemedicine, where

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we listen to and observe our patients. Value of Video PE Also, we are doing physical examinations. We always do one via video.

Why the Telemedicine Physical is Better Than You Think ...

Symptoms and exam findings for lumbar and sacral root pathology are described

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below. Of note, L5 and S1 are the most commonly affected roots. L2 root dysfunction: Pain radiates from the low back to the upper leg.

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