

5/24/2010 Room 520B Pt. W.W

**Nursing Note: SOAP format**

Time/date		Details
05/24/10	S	Patient's grand daughter requested that we be very careful with morning care as her grand mother's breast skin is very delicate, sticks together and has peeled off.
1130	O	Patient skin under breast is observed to be peeling, moist and thin
	A	Impaired Skin Integrity r/t immobility A/E: peeling skin under breasts and fungal skin infection.
	P	Assist patient with ADL. Perform ROM exercises with patient. Assess the site of skin impairment and determine cause (e.g., acute or chronic wound, burn, pressure ulcer, skin tear). Monitor the client's skin impairment at least once a day for color changes, redness, swelling, warmth and pain. Do not position the client on site of skin impairment. If consistent with overall client management goals, turn and position client at least every two hours. Avoid massaging around the site of skin impairment and over bony prominence. Assess client's nutrition status. Apply mycostatin antifungal powder to skin under breasts as ordered

## Example Of Soap Note Documentation

**Terri Ann Brame**

## **Example Of Soap Note Documentation:**

*Writing SOAP Notes* Ginge Kettenbach,1995 Chapter on the development and use of forms and documentation Coverage of computerized documentation Thorough updating including a discussion of the managed care environment and Medicare Additional exercises and examples Perforated worksheets Basic note writing rules including the POMR method are reviewed Examples provided of both correct and incorrect note writing

**Physical Therapy Documentation** Mia Erickson,Mia L. Erickson,Rebecca McKnight,Ralph Utzman,2008 Complete accurate documentation is one of the essential skills for a physical therapist This book covers all the fundamentals includes practice exercises case studies throughout

**COMLEX Level 2-PE Review Guide**

Mark Kauffman,2010-10-25 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

*Writing SOAP Notes* Ginge Kettenbach,2003 Ginge Kettenbach s workbook leads you through the process of learning two different styles of documentation SOAP Subjective Objective Assessment Plan

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documentation that are consistent with the APTA s Guide to Physical Therapist Practice are given for all decisions Book jacket

**Documentation Manual for Occupational Therapy** Crystal A. Gateley,Sherry Borcherding,2017 Documentation Manual for Occupational Therapy Writing SOAP Notes Fourth Edition presents a systematic approach to a standard form of

health care documentation the SOAP note

**Documentation for Rehabilitation - E-Book** Lori Quinn,James

Gordon,2024-04-12 Better patient management starts with better documentation Documentation for Rehabilitation 4th Edition demonstrates how to accurately document treatment progress and patient outcomes using a framework for clinical

reasoning based on the International Classification for Functioning Disability and Health ICF model adopted by the American Physical Therapy Association APTA The documentation guidelines in this practical resource are easily adaptable to different practice settings and patient populations in physical therapy and physical therapy assisting Realistic examples and practice exercises reinforce the understanding and application of concepts improving skills in both documentation and clinical reasoning Workbook textbook format with examples and exercises in each chapter helps reinforce understanding of concepts Coverage of practice settings includes documentation examples in acute care rehabilitation outpatient home care nursing homes pediatrics school and community settings Case examples for a multitude of documentation types include initial evaluations progress notes daily notes letters to insurance companies Medicare documentation and documentation in specialized settings NEW Movement Analysis Linking Activities and Impairments content addresses issues related to diagnosis NEW An eBook version included with print purchase provides access to all the text figures and references with the ability to search customize content make notes and highlights and have content read aloud Updated case examples provide clinical context for patient documentation Revised content including updated terminology from the latest updates to the Guide to Physical Therapist Practice provides the most current information needed to be an effective practitioner Updated references ensure content is current and applicable for today s practice *Legal Aspects of Documenting Patient Care for Rehabilitation Professionals* Ronald W. Scott,2006 Because communication among health care professionals can mean the difference between patient life and death clear and effective patient care documentation is as important as the delivery of care itself The rehabilitation professional faces formidable documentation responsibilities Patient care documentation created by the rehabilitation professional must be accurate comprehensive concise objective and timely In an interdisciplinary health care environment documentation must also be expeditiously communicated to other professionals on the health care team **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 **SOAP for Family Medicine** Daniel Maldonado,Cynthia Zuniga,2023-10-11 Offering step by step guidance on how to properly document patient care this updated Second Edition presents 90 of the most common clinical problems encountered on the wards and clinics in an easy to read two page layout using the familiar SOAP note format Emphasizing the patient s clinical problem not the diagnosis this pocket sized quick reference teaches both clinical reasoning and documentation skills and is ideal for use by medical students PAs and NPs during the Family Medicine rotation The Introduction offers templates tips and guidelines for writing SOAP notes A portable pocket sized format with at a glance two page layouts makes practical information quickly accessible The SOAP approach helps students figure out where to start while improving communication between physicians and ensuring accurate documentation **The OTA's Guide to Documentation** Marie J. Morreale,Sherry Borcherding,2013 Rev ed of The OTA s

guide to writing SOAP notes 2nd ed 2007

### **The OTA's Guide to Writing SOAP Notes**

Sherry Borcherding, 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 Borcherding 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.

### **SOAP Notes**

Jeremiah Fleenor, 2007-03 A SOAP note records an encounter with a patient. The components are Subjective (what the patient tells the recorder), Objective (what the recorder observes), Assessment (recorder's summation), and Plan (recorder's actions based on the assessment).

**Foundations of Athletic Training** Marcia Anderson, Mary Barnum, 2021-05-17 Comprehensive and evidence-based Foundations of Athletic Training, 7th Edition integrates basic medical concepts and related scientific information to help readers develop a strong foundation in athletic training best practices. The text's practical problem-solving approach to the prevention, recognition, assessment, management, and disposition of sports-related injuries and diseases helps students learn to think like practitioners. Fully aligned with the BOC competencies, the 7th Edition has been extensively updated, expanded, and reorganized to reflect the changing role of today's athletic trainer and includes a powerful

suite of engaging learning tools to help students succeed **OT Student Primer** Karen Sladyk,1997 The OT Student Primer A Guide to College Success focuses on advice and tutorials to make a student's journey through OT school more successful and enjoyable This book is designed to help both OTA and OT students make the best of their education by providing the basic information needed to succeed and build their knowledge of OT The process of learning OT theories techniques terminology and concepts is challenging and this book addresses the core understanding of the profession that all students should know as they embark on their OT careers The primer is filled with tutorials practical skills advice helpful hints and professional skills The text provides the most up to date fieldwork issues complete coverage of documentation skills and therapeutic communication plus essential OT concepts Tables and worksheets are included to gain a better self understanding and exercises allow students to check what they have learned

*Community and Clinical Pharmacy Services: A step by step approach.* Ashley W. Ells,Justin Sherman,2013-05-22 A STEP BY STEP GUIDE TO IMPLEMENTING ADVANCED PHARMACY SERVICES IN COMMUNITY AND CLINIC SETTINGS Community and Clinical Pharmacy Services teaches pharmacy students and practicing pharmacists how to provide advanced levels of pharmacy services in community and clinic settings designed to help patients achieve specific health goals and treat common disease states This unique text provides practical rather than merely ideological ways for pharmacists to utilize their extensive clinical knowledge and fill a major gap in American health care It discusses barriers necessary skills required knowledge and issues related to preparation interventions patient outcomes economic aspects and marketing considerations for therapeutic areas commonly addressed in the outpatient setting The beginning of the book delves into the general management skills necessary to provide and implement advanced patient care services including documentation patient interviewing and medication therapy management Important chapters discuss disease states that would most likely be amenable to development of pharmacy services including Asthma Smoking Cessation Diabetes Hypertension Osteoporosis Obesity Also covered are immunizations anticoagulation and cardiometabolic services The disease state chapters include learning aids such as summary points first hand accounts from experienced pharmacists who have implemented pharmacy services for that particular condition a simulated patient case and multiple choice questions

Functional Outcomes Documentation for Rehabilitation Lori Quinn,James Gordon (Ed.D.),2003 This hands on textbook workbook teaches readers how to document functional outcomes in a clear logical progression Extensive examples and exercises in each chapter highlight the essential points of functional outcomes documentation designed to help improve client function and reduce disability as well as provide evidence of functional progress for insurance payment and reimbursement **Documentation Skills for Quality Patient Care** Fay Yocom,1999 **Documentation for Rehabilitation** Lori Quinn,James Gordon (Ed.D.),2010 In this textbook Quinn and Gordon provide a general approach to documentation that can be adapted to different settings for physical therapy students and professionals They emphasize the concept that clinical reasoning is reflected in documentation and vice versa and that

documentation is a framework for clinical decision making. They cover each documentation component and examples and exercises that relate to areas such as rehabilitation, women's health, health and wellness, orthopedics, and acute care. This edition has been revised and expanded and includes new chapters on payment policy and coding, legal aspects, pediatrics, and computerized documentation and incorporates the International Classification of Functioning, Disability and Health model.

**Documenting Physical Therapy** Angela Marie Baeten, Michael L. Moran, Lynn M. Phillipi, 1999. *Documenting Physical Therapy* provides practitioners with the tools necessary to make documentation a successful and beneficial part of clinical practice. Using the reviewer's perspective, emphasis is placed on documenting components that are essential for coverage determinations. **Documentation Manual for Writing SOAP Notes in Occupational Therapy** Sherry Borcherding, 2000. Teaches the mechanics of writing problem statements and goals and addressing documentation in different stages of treatment and practice settings.

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