

Guide To Clinical Documentation Book

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Documentation for an RN moving into a practitioner role can be daunting especially for me with 30+ years of charting in a nurse role. This book is a nice reference for a variety of clinical areas: acute care and primary care. I am glad I found it and am happy with the examples provided as I move into thinking and charting as a mid-level provider.

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Guide To Clinical Documentation Book

Book Descriptions. This edition has been completely revised and upgraded with more in-depth coverage of documentation and its ramifications, more documentation samples to analyze and emulate, and even more learning tools.

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Develop the skills you need to effectively and efficiently document patient care for children and adults in clinical and hospital settings. This handy guide uses sample notes, writing exercises, and EMR activities to make each concept crystal clear, including how to document history and physical exams and write SOAP notes and prescriptions.

Understand the when, why, and how! Here's your guide to developing the skills you need to master the increasing complex challenges of documenting patient care. Step by step, a straightforward 'how-to' approach teaches you how to write SOAP notes, document patient care in office and hospital settings, and write prescriptions. You'll find a wealth of examples, exercises, and instructions that make every point clear and easy to understand.

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All the forms, handouts, and records mental health professionals need to meet documentation requirements—fully revised and updated The paperwork required when providing mental health services continues to mount. Keeping records for managed care reimbursement, accreditation agencies, protection in the event of lawsuits, and to help streamline patient care in solo and group practices, inpatient facilities, and hospitals has become increasingly important. Now fully updated and revised, the Fourth Edition of The Clinical Documentation Sourcebook provides you with a full range of forms, checklists, and clinical records essential for effectively and efficiently managing and protecting your practice. The Fourth Edition offers: Seventy-two ready-to-copy forms appropriate for use with a broad range of clients including children, couples, and families Updated coverage for HIPAA compliance, reflecting the latest The Joint Commission (TJC) and CARF regulations A new chapter covering the most current format on screening information for referral sources Increased coverage of clinical outcomes to support the latest advancements in evidence-based treatment A CD-ROM with all the ready-to-copy forms in Microsoft® Word format, allowing for customization to suit a variety of practices From intake to diagnosis and treatment through discharge and outcome assessment, The Clinical Documentation Sourcebook, Fourth Edition offers sample forms for every stage of the treatment process. Greatly expanded from the Third Edition, the book now includes twenty-six fully completed forms illustrating the proper way to fill them out. Note: CD-ROM/DVD and other supplementary materials are not included as part of eBook file.

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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.

Ensure confident clinical decisions and maximum reimbursement in a variety of practice settings such as acute care, outpatient, home care, and nursing homes with the only systematic approach to documentation for rehabilitation professionals! Revised and expanded, this hands-on textbook/workbook provides a unique framework for maintaining evidence of treatment progress and patient outcomes with a clear, logical progression. Extensive examples and exercises in each chapter reinforce concepts and encourage you to apply what you've learned to realistic practice scenarios. UNIQUE! Combination textbook/workbook format reinforces your understanding and tests your ability to apply concepts through practice exercises. UNIQUE! Systematic approach to documenting functional outcomes provides a practical framework for success in numerous practice settings. Case studies show you how to format goals through realistic client examples. Practice exercises provide valuable experience applying concepts to common clinical problems. Four NEW chapters address additional aspects of documentation that rehabilitation professionals will encounter in practice: Legal aspects of documentation Documentation in pediatrics Payment policy and coding Computerized documentation

Dr. Rhonda Sutton's second edition of the straightforward guide to progress notes includes additional examples, information, documentation, and clinical language that expands on the utility and readability of the first book. Additional case studies provide examples of how to use the STEPs to format notes. New chapters include information on clinical language and documentation. This book covers everything about progress notes, from how to write them, to how to store them, and even what to do when someone requests to them. In addition, clinical terms and abbreviations are included as well as suggestions for other clinical documentation such as termination letters, privacy statements, and professional disclosure statements. Suited for all types of mental health clinicians, this book will help therapists improve upon their progress notes and other forms of clinical documentation.

This critically acclaimed work makes the case for collaboration and shows that it can be greatly enhanced with conscious understanding and systematic effort. As a healthcare specialist who has worn many hats from direct care giver to case manager to documentation specialist. Colleen Stukenberg is able to – Show how to build trust and communication and demonstrates specific opportunities where collaboration can make all the difference Identify ways that quality of care and financial factors overlap and the advantages that can be garnered through an understanding of this Explain how those in different roles view information through different types of knowledge and how an understanding of each perspective makes it easier to find the best source for important answers Discuss the education and ever-increasing role of the clinical documentation specialist who is often involved in all facets of a patient's progress, from intake and admission right up through discharge. As the author points out, good healthcare is dependent on the right person performing the right role, which promotes excellent collaboration. And when people are allowed to function in their proper roles, job satisfaction increases, which in itself leads to better attitudes, which then leads to even deeper levels of collaboration and with it, the successful promotion of safe, quality care.

Clinical Documentation Improvement (CDI) Made Easy is a great resource and reference that every Clinical Documentation Improvement Specialist/Professional (CDIS/CDIP), coder, physician champion/advisor, and others involved in the CDI must have. The book is a compendium of sound clinical knowledge and experience, clinical documentation expertise, and quality, which will help the CDIS/CDIP and others maximize their potentials in performing their core duties. Whether you are a new CDIS trying to learn CDI or an experienced CDIS hoping to stay current with CDI world, or involved in the CDI, this book will be very valuable to you. Remember, accurate and quality documentation is a reflection of great patient care. "If it wasn't documented, and documented accurately, it never happened." This book clearly explained various query opportunities by Major Disease Classifications (MDCs) with some sample queries. It defines and analyses different disease processes, creates CDIS awareness and what to look for under various MDCs, ICD-10-CM/PCS, explained current CMS Pay for Performance (P4P), and the CDI responsibility under P4P, explained some pertinent coding guidelines, 2016 Official Coding Guidelines for Coding and Reporting, AHIMA/ACDIS practice brief for queries and compliance, and much more. I have no doubt in my mind that this book is a concise but a comprehensive tool and reference that anyone involved in CDI should always have at his/her side. The Author Anthony O Nkwuaku, RN, PHN, MSN, CPHQ, CCDS is very knowledgeable and experienced as a clinician, clinical instructor, and Clinical Documentation Improvement Specialist.

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