

# Nursing Assessment

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

# Emergency Nursing Assessment Documentation Example

**AN Whitehead**



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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

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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     "*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     **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, 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, 2009*" ,2009 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, 2015*" ,2015 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     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

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