

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. |

Clinical Documentation Guidelines

AW Rasmussen



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