

Nombre del alumno:

Erika Yatziri Castillo Figueroa

Nombre del profesor:

Lic. Jezabel Ivonne Silvestre Montejo

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Mapa conceptual del tema:

“patient medical record”

Patient medical record

Las cuales son

Importantece of proficiency in navigating the patients medical record

Can be

Extremely overwhelming to think about the vast quantities of medical information every person has accumulated over a lifetime. Even the amount of documentation required during a hospital stay can be quite lengthy, which can make it difficult to drug therapy selection and assessment of patiente response.

Components of a patientis medical record

can be

Dissected into five primary components, including the medical history often known as the history and phsical

What are you

Laboratory tets results

How are documented

Following the initial H&P. most patients will have a basic metabolic panel and complete blood count (CBC) in addition to other parameters specific to their diagnosis and medical, conditions, including, but not limited to, cardiac enzymes , serum drug concentrations, international normalized ratio (INR), live function tests, and cultures of blood or other body fluids.

Diagnostic tests results

Initial results of diognic testing are documented within the H&P as well. such results may include electrocardiograms, ultrasounds, computed tomography (CT) scans, magnetic resonance imaging (MRI) scans, x-rays, and so on

Problema list

that points

The problem list notes, in decreasing order of priority, the issues that require management in the individual patient. The number one need on the list is the working diagnosis that matches the signs and symptoms with which the patient has

Clinical notes

how is the

the inpatient paper chart often gets thick with the many types of clinical notes written by the numerous practitioners caring for the patient.

the resident and attending physician will write daily progress notes that document an updated an abbreviated H&P, problem list, and plan.

Treatment notes

are used

Treatment notes are utilized most frequently in the inpatient setting.

Including

treatment notes include medication orders, medication administration record (MARs), documentation of surgical procedures, and documentation of services such as radiation therapy, physical therapy, occupational therapy, respiratory therapy, and nutrition.

Patient demographics

What includes

This section includes the patient s name, birth date address, phone number, gender, race, and marital status and the name of the attending physician.

It also include

This section may also include the patient's insurance information pharmacy name and phone number, and religious preference.

History of presen illness (HPI)

The history of present illness expands upon the CC, filling in the details regarding the at issue at hand.

how I know

the HPI is typically documented in choronological order, describing the patient s syptoms in detail as well as documenting related information regarding previous treatment for the CC, previous diagnostic test result, and pertinent family and social history.

Chief complaint (CC)

Which

The chief complaint is the primary reason the patient is presenting for care. Often expressed using the patients own words, it includes the symptoms the patient is currently experiencing.

Family history (FH)

the family history includes descriptions of the age, status (dead or alive) and presence or absence of chronic medical conditions in the patients, parents, siblins, and children.

Social history (SH)

The section includes a large amount of information regarding the patients lifestyle and personal.

Past medical history (PMH)

What includes

The past medical history includes a list of past and current medical conditions. Past surgical history (PSH) is often included within the PMH, as are previous hospitalizations, trauma and abtretirical history (for female patients).