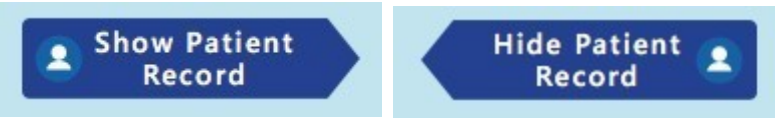
NR509 iHuman Documentation Guide

Use this guide to help you complete documentation within the iHuman Virtual Patient Encounter. All documentation for the patient visit must be entered into the iHuman platform.

EMR Documentation

Use the Patient Record to document pertinent information related to your history and physical exam. You are able to access and update the patient record any time while you are playing your assignment by clicking on the Show Patient Record button. Click the Hide Patient Record button to return to your patient.



Include pertinent information for the focused assessment using the tabs within the EMR:

EMR tips

- Chief complaint (CC) is a BRIEF statement identifying why the patient is here - in the patient's own words - for instance "headache", NOT "bad headache for 3 days". Sometimes a patient has more than one complaint. For example, if the patient presents with cough and sore throat, identify which is the CC and which may be an associated symptom
- Use OLD CARTS to document history of present illness (HPI)
- Be sure to include all past medical history, medications, and allergies.
- Include reaction/response to each allergen.
- Include dosage, frequency, length of time used and reason for use for each medication; also include OTC or homeopathic products.
- Limit preventive health, family, and social history to findings pertinent to the HPI.
- Social history may include but not limited to occupation and major hobbies, family status, tobacco and alcohol use, and any other pertinent data. Include health promotion such as seat belt use all the time or
  functional smoke detectors in the house, etc.