i-Human Clinical Practice Tips

The embedded iHuman Documentation Guide in the assignment is just that, a guide. It contains some information that differs from what I have listed in these Clinical Practice Tips. I expect you to follow these Clinical Practice Tips.

Start all i-Human encounters with "How can I help you today?" or "What brings you in today?"

Clinical Practice Tip1: Chief Complaint (CC) & History of Present Illness (HPI)

First, remember that what the patient reports to you and/or tells you in response to your questions is SUBJECTIVE information. The clinical visit starts with the Reason for the Encounter also known as the chief complaint or the chief concern. **Establishing the CC** is the anchor to the entire encounter note. It should be limited to 3-6 words and in the patient's words. There is only one CC even if the patient has a list of complaints. As the provider, you must make this determination. What is the true reason for the visit and which symptom(s) is/are associated complaints? Examples of the reason for the encounter/CC: "I have a sore throat" "My blood pressure is running high" "My stomach is hurting" "I hurt my back"

Then the HPI is a chronological description of the progression of the patient's present illness/problem from the first symptom to the present. **"OLD CARTS"** is a mnemonic device that assists clinicians in remembering the pertinent questions to ask while assessing and constructing a patient's HPI. The clinician uses "OLD CARTS" as a structured guideline and framework from which they will ask questions and collect information before they perform a physical exam.

ONSET: Onset and duration are not the same. Onset is when the CC began. Be specific; "7 days ago" is more informative than "about a week ago." Ask: When exactly did this start?

LOCATION: Location does not refer to geography. Think about where CC might "reside" in the body. If the CC is fatigue, the location would be "Generalized" as this complaint involves the entire body not just one system or location. Ask: Where specifically in your body is the discomfort/pain/symptom? Where exactly are you hurting?

DURATION: Duration is an interval of time. Ask: When does the pain begin? What time of day? How long does it last? How many episodes are there in 24 hours? What is the frequency of episodes?

CHARACTERISTICS: Characteristics refers to all associated symptoms and complaints. For example, if a patient presents with a cough and sore throat, you need to determine if the complaints are related, and which came first. Document the other symptom as "associated with sore throat." If the CC is pain, what are the characteristics of the pain? Ask: Can you describe your pain? Is your pain Dull? Sharp? Burning? etc. Include reported associated symptoms here.

AGGRAVATING & ALLEVIATING FACTORS: Aggravating factors must be specific. For example, "weight