

urgent care note template

Urgent care note template

In the fast-paced environment of urgent care facilities, documentation plays a crucial role in ensuring high-quality patient care, legal compliance, and seamless communication among healthcare providers. An urgent care note template serves as a standardized framework that helps clinicians efficiently record patient encounters, streamline administrative tasks, and maintain consistency across notes. Well-designed templates can reduce documentation errors, save time, and ensure that all critical aspects of patient assessment and management are thoroughly captured. This article explores the essential components of an effective urgent care note template, provides guidance on customizing templates for specific needs, and discusses best practices for efficient and compliant documentation.

Understanding the Importance of an Urgent Care Note Template

Why Use a Standardized Template?

- Consistency: Ensures all providers document encounters uniformly, facilitating easier review and continuity of care.
- Efficiency: Speeds up the documentation process, allowing clinicians to spend more time with patients.
- Legal Protection: Provides thorough and structured records that can be vital in legal or insurance scenarios.
- Billing Accuracy: Helps capture all necessary details for correct billing and coding.
- Quality Assurance: Facilitates audits and reviews by maintaining comprehensive and standardized records.

Challenges Without a Proper Template

- Omissions of critical information
- Time-consuming documentation process
- Increased risk of errors or incomplete records
- Difficulty in retrieving consistent data for quality improvement initiatives

Core Components of an Urgent Care Note Template

A well-structured urgent care note typically includes several key sections that comprehensively document the patient encounter. Below are the fundamental components that should be incorporated into any template.

1. Patient Identification and Visit Details

- Patient Name
- Date of Birth
- Medical Record Number
- Date and Time of Visit
- Provider Name and Credentials
- Visit Type (e.g., walk-in, follow-up)

2. Chief Complaint (CC)

- A brief statement describing the primary reason for the visit, recorded in the patient's own words.

3. History of Present Illness (HPI)

- Detailed narrative of symptoms, onset, duration, severity, aggravating or relieving factors, associated symptoms, and relevant context.
- Use of standardized frameworks like OLDCARTS (Onset, Location, Duration, Characteristics, Aggravating factors, Relieving factors, Timing, Severity).

4. Past Medical History (PMH) and Medical Background

- Chronic conditions
- Prior surgeries or hospitalizations
- Allergies (medications, foods, environmental)
- Current medications

5. Social and Family History

- Tobacco, alcohol, and drug use
- Occupation and living conditions
- Family health history relevant to presenting complaints

6. Review of Systems (ROS)

- Systematic review covering key organ systems related to presenting symptoms
- Usually brief in urgent care settings but should be documented as pertinent positives and negatives

7. Physical Examination

- Vital signs (temperature, pulse, blood pressure, respiratory rate, oxygen saturation)
- General appearance
- Head, ears, eyes, nose, throat (HEENT)
- Cardiovascular
- Respiratory
- Abdomen
- Musculoskeletal
- Skin
- Neurological
- Any other relevant findings

8. Assessment and Impression

- Summarize findings
- Differential diagnosis considerations
- Clinical impression based on the exam and history

9. Plan and Management

- Diagnostic tests ordered (labs, imaging)
- Treatments administered (medications, procedures)
- Patient education and counseling
- Follow-up instructions
- Referrals or specialist consultations if needed

10. Billing and Coding Information

- Appropriate CPT codes
- ICD-10 diagnosis codes
- Notes on procedures performed for billing purposes

11. Provider Signature and Date

- Electronic or handwritten signature
- Date and time of documentation completion

Designing an Effective Urgent Care Note Template

Customization Tips

- Tailor sections based on common presenting complaints (e.g., trauma, infections, minor illnesses)
- Incorporate checkboxes or dropdown menus for quick data entry
- Use templates compatible with electronic health records (EHR) systems for seamless integration
- Include prompts or guidelines within the template to remind providers of essential documentation elements
- Ensure compliance with legal, privacy, and billing regulations

Sample Sections in a Practical Template

- Header: Includes patient info, date/time, provider details
- Chief Complaint: [Text box]
- History of Present Illness: [Structured prompts]
- Review of Systems: [Checklist]
- Physical Exam Findings: [Structured fields or checkboxes]
- Assessment: [Summary paragraph]
- Plan: [Ordered tests, treatments, follow-up]
- Signature: [Electronic signature field]

Sample Urgent Care Note Template Outline

```plaintext

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ MRN: \_\_\_\_\_  
Visit Date/Time: \_\_\_\_\_ Provider: \_\_\_\_\_

Chief Complaint:

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History of Present Illness:

- Onset:
- Location:
- Duration:
- Characteristics:
- Aggravating factors:
- Relieving factors:
- Timing:
- Severity:

Past Medical History:

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Medications:

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Allergies:

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Review of Systems:

- General: [ ] Fever [ ] Weight loss
- Respiratory: [ ] Cough [ ] Shortness of breath
- Cardiovascular: [ ] Chest pain
- Gastrointestinal: [ ] Nausea, vomiting
- Others as pertinent

Physical Examination:

- Vital Signs:
- Temp: \_\_\_\_\_ °F
- HR: \_\_\_\_\_ bpm
- BP: \_\_\_\_\_ / \_\_\_\_\_ mm Hg
- RR: \_\_\_\_\_ breaths/min
- SpO2: \_\_\_\_\_ %
- General Appearance:
- HEENT:
- Chest/Lungs:
- Heart:
- Abdomen:
- Extremities:
- Skin:
- Neurological:

Assessment:

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Plan:

- Diagnostic Tests:
- Treatment Administered:
- Patient Education:
- Follow-up Instructions:
- Referrals:

Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

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## Best Practices for Using Urgent Care Note Templates

### Ensuring Completeness and Accuracy

- Review each section thoroughly before finalizing documentation.
- Use checklists to confirm all critical elements are addressed.
- Document in real-time whenever possible to improve accuracy.

## **Maintaining Compliance and Privacy**

- Follow HIPAA and other privacy regulations.
- Avoid abbreviations that could be misinterpreted.
- Ensure all documentation is legible and properly stored.

## **Adapting Templates for Electronic Health Records (EHR)**

- Use customizable fields and prompts within the EHR system.
- Incorporate auto-populated data such as vital signs.
- Enable quick access to common templates for different presenting complaints.

## **Training and Continuous Improvement**

- Train staff on the proper use of templates.
- Regularly review and update templates based on feedback and evolving clinical practices.
- Incorporate quality assurance measures to identify documentation gaps.

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## **Conclusion**

An effective urgent care note template is a vital tool that enhances clinical efficiency, documentation quality, and legal safeguard. By systematically including all critical components—ranging from patient identification to detailed clinical assessment and management plans—providers can deliver comprehensive care while ensuring compliance with regulatory standards. Customization and adherence to best practices further optimize the utility of these templates, ultimately contributing to better patient outcomes and streamlined clinic operations. Whether in paper form or integrated within an EHR system, a well-designed urgent care note template is an indispensable resource in the fast-paced world of urgent care medicine.

## **Frequently Asked Questions**

### **What is an urgent care note template and why is it important?**

An urgent care note template is a standardized document used to record patient visits, diagnoses, and treatments in urgent care settings. It ensures consistency, completeness, and compliance with medical documentation

standards.

## **What are the key components typically included in an urgent care note template?**

Key components include patient demographics, chief complaint, history of present illness, physical exam findings, assessment and diagnosis, treatment plan, medications prescribed, and follow-up instructions.

## **Can I customize an urgent care note template to fit my practice's needs?**

Yes, most urgent care note templates are customizable to accommodate specific workflows, specialties, or documentation requirements, ensuring they align with your practice standards.

## **Are there digital or electronic urgent care note templates available?**

Absolutely. Many electronic health record (EHR) systems offer digital urgent care note templates that streamline documentation, improve accuracy, and facilitate easy sharing and storage.

## **How can using an urgent care note template improve patient care?**

Using a structured template helps ensure comprehensive documentation, reduces errors, speeds up charting, and supports better communication among healthcare providers, ultimately enhancing patient care quality.

## **What should I consider when choosing an urgent care note template?**

Consider factors like compliance with legal and billing requirements, ease of use, customization options, integration with your EHR system, and whether it captures all necessary clinical information.

## **Are there any free urgent care note templates available online?**

Yes, several websites and medical organizations offer free downloadable urgent care note templates, which can be a good starting point for small practices or clinics.

## How do I ensure my urgent care note template complies with healthcare regulations?

Ensure your template aligns with HIPAA, OSHA, and other relevant regulations by including necessary privacy and safety information, and consider consulting legal or compliance experts when customizing your template.

## Additional Resources

### Urgent Care Note Template: A Comprehensive Guide for Healthcare Providers

In the fast-paced environment of urgent care, accurately documenting patient encounters is essential for quality care, legal compliance, and smooth communication between providers. An urgent care note template serves as a vital tool that streamlines the documentation process, ensuring that all necessary information is captured efficiently and consistently. Whether you're a seasoned practitioner or new to urgent care, understanding the structure and components of an effective note template can significantly enhance patient outcomes and operational workflow.

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### Why a Standardized Urgent Care Note Template Matters

Before diving into the specifics, it's important to appreciate the value of using a standardized note template in urgent care settings:

- Efficiency: Speeds up documentation, allowing providers to see more patients.
- Consistency: Ensures all relevant information is captured uniformly across providers and visits.
- Legal and Billing Compliance: Meets legal documentation standards and supports accurate billing.
- Continuity of Care: Facilitates seamless communication among healthcare professionals.
- Quality Assurance: Provides a clear record for review and quality improvement initiatives.

With these benefits in mind, let's explore how to craft an effective urgent care note template.

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### Core Components of an Urgent Care Note Template

A well-structured urgent care note typically includes the following sections:

#### 1. Patient Identification and Visit Details



- Patient Name
- Date of Birth
- Medical Record Number (MRN) or ID
- Date and Time of Visit
- Provider Name and Credentials
- Visit Type (e.g., walk-in, follow-up)

## 2. Chief Complaint (CC)

A concise statement describing the primary reason for the visit, ideally in the patient's words. For example:

- "Severe right ankle pain after twisting during basketball."
- "Persistent cough and fever for three days."

Tip: Keep this section brief but descriptive to guide the assessment.

## 3. History of Present Illness (HPI)

A detailed narrative that expands on the chief complaint, covering:

- Onset, duration, and frequency
- Severity and quality of symptoms
- Factors that alleviate or exacerbate symptoms
- Associated symptoms
- Prior episodes or treatments

Sample HPI:

"Patient reports sudden onset of sharp right ankle pain approximately 2 hours ago after twisting during basketball. Pain is rated 8/10, worsened with movement, and relieved somewhat with rest. No associated numbness or swelling reported."

## 4. Past Medical, Surgical, and Social History (PMH/PSH/PSSH)

Gather relevant background information:

- Chronic illnesses (diabetes, hypertension)
- Past surgeries
- Allergies (medications, latex, environment)
- Current medications
- Social factors (smoking, alcohol use, employment, living situation)

## 5. Review of Systems (ROS)

A systematic review of symptoms across body systems to identify other relevant issues. For example:

- General: Fever, chills, weight loss
- HEENT: Headache, sore throat
- Respiratory: Shortness of breath, cough

- Musculoskeletal: Joint pain, swelling
- Skin: Rashes, lesions

Note: In urgent care, ROS can be abbreviated but should still be thorough enough to detect significant findings.

## 6. Physical Examination (PE)

Objective assessment findings, including:

- Vital signs (temperature, pulse, respiratory rate, blood pressure, oxygen saturation)
- General appearance
- Head, eyes, ears, nose, throat
- Neck
- Chest and lungs
- Heart
- Abdomen
- Extremities (edema, deformity, tenderness)
- Skin

Tip: Use bullet points for clarity and brevity.

## 7. Assessment

A concise summary of the clinical impression based on history and physical exam. Examples:

- "Sprained right ankle with moderate swelling and tenderness."
- "Acute bronchitis likely secondary to viral infection."

## 8. Plan

Outline the treatment plan, including:

- Diagnostic tests ordered (X-ray, labs)
- Medications prescribed (analgesics, antibiotics)
- Procedures performed (wound care, splinting)
- Disposition (discharge instructions, follow-up care)
- Patient education topics discussed

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## Sample Urgent Care Note Template

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

MRN: \_\_\_\_\_

Visit Date: \_\_\_\_\_

Provider: \_\_\_\_\_

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Chief Complaint:

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History of Present Illness:

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Past Medical History:

- \_\_\_\_\_

Surgical History:

- \_\_\_\_\_

Allergies:

- \_\_\_\_\_

Medications:

- \_\_\_\_\_

Social History:

- Smoking: \_\_\_\_\_

- Alcohol: \_\_\_\_\_

- Others: \_\_\_\_\_

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Review of Systems:

- General: \_\_\_\_\_

- HEENT: \_\_\_\_\_

- Respiratory: \_\_\_\_\_

- Musculoskeletal: \_\_\_\_\_

- Skin: \_\_\_\_\_

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Physical Examination:

Vital Signs:

- Temp: \_\_\_\_\_ °F/°C, HR: \_\_\_\_\_ bpm, RR: \_\_\_\_\_ bpm, BP: \_\_\_\_\_/\_\_\_\_\_ mmHg,

SpO2: \_\_\_\_\_ %

General: \_\_\_\_\_

Head/Eyes/Ears/Nose/Throat: \_\_\_\_\_

Neck: \_\_\_\_\_

Chest/Lungs: \_\_\_\_\_

Heart: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Extremities: \_\_\_\_\_

Skin: \_\_\_\_\_

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Assessment:

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Plan:

- Diagnostics: \_\_\_\_\_
- Medications: \_\_\_\_\_
- Procedures: \_\_\_\_\_
- Follow-up instructions: \_\_\_\_\_
- Patient education topics discussed: \_\_\_\_\_

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### Best Practices for Using an Urgent Care Note Template

To maximize the utility of your urgent care note template, consider these tips:

- Customize as Needed: Adapt templates based on the specific practice or patient population.
- Be Concise but Thorough: Capture essential details without excessive verbosity.
- Use Standardized Language: Incorporate common abbreviations and medical terminology for clarity.
- Incorporate Electronic Health Record (EHR) Features: Utilize dropdowns, checkboxes, and auto-fill options to streamline documentation.
- Regularly Review and Update: Ensure the template reflects current best practices, coding requirements, and legal standards.

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### Conclusion

An urgent care note template is more than just a documentation tool; it's a cornerstone of quality patient care, legal protection, and operational efficiency. By understanding its core components and best practices, healthcare providers can ensure they deliver comprehensive, consistent, and compliant documentation for every patient encounter. Implementing a well-designed template tailored to your practice not only saves time but also enhances the overall patient experience and clinical outcomes.

## [Urgent Care Note Template](#)

**urgent care note template: Family Emergent/Urgent and Ambulatory Care** Sheila Sanning Shea, Karen Sue Hoyt, 2016-01-20 Fast-track medical settings call for "at-your-fingertips" information. Here is an easy-to-use, quick-reference guide for nurse practitioners and other health care providers in emergency, medical, screening, fast track, and/or primary care settings with family

patients. In a concise, optimally organized format that includes current, evidence-based guidelines, the resource delivers a wealth of information for assessment and management of the most commonly encountered problems in these settings. Concise yet packed with crucial knowledge, The Pocket NP is arranged in a logical head-to-toe format that includes the history and physical examination and essential medical decision-making considerations. The material is organized in a true rapid access format, with salient information presented for maximum efficiency and speed of retrieval. A variety of templates for dictation/documentation are provided to assist the clinician with the development of a concise and logical patient record. These templates can be mixed and matched as needed and, using a specific template for focused patient problems (e.g., knee pain), will facilitate assessment fine tuning. Also included are frequently used illustrations for anatomical records as well as templates to assist in identification of normal and abnormal presentations. Additional helpful features include "Tips" and "Don't Miss" boxes with bullet points of critical information, a rapid "review of systems," billing information, and a dedicated page for NP "Survival Information" and notes. Key Features: Provides ultra-quick access to patient treatment information Offers easy-to-use framework for quickly locating critical information Presents templates for identifying normal and abnormal presentations Contains a rapid "review of systems" Delivers content in head-to-toe format Includes "Tips" and "Don't Miss" boxes with bullet points of critical information

**urgent care note template: Family Emergent/Urgent and Ambulatory Care, Second Edition**  
Sheila Sanning Shea, Karen Sue Hoyt, 2020-05-31 Praise for the First Edition: "This is the best pocket guide in the market. It is easy to use and straight to the point with up to date information. I highly recommend it for anyone practicing in fast-paced settings" -Pedro Colio DNP, APRN, FNP-C, ENP-C, CCRN Emergency Department Educator/ Nurse Practitioner El Centro Regional Medical Center Updated to promote ultra-quick access to current information NPs need daily Now in its second edition, this reference guide for nurse practitioners and other health care providers in emergency, medical, screening, fast track, and/or primary care family settings continues to provide ultra-quick access to key assessment and management information. The Pocket NP delivers a wealth of information for assessment and management of the most-commonly encountered problems in fast-track settings. Arranged in a logical head-to-toe format, it includes the history, physical examination, and essential medical decision-making considerations needed to walk you step-by-step through a typical patient encounter. New to the Second Edition: Updated medical decision-making sections with documentation templates Updated pharmacology and drug administration information New ultrasound dictation templates for each section where it is performed New tables including eye chart for vision in trauma patients New ultrasound images New line drawings depicting various conditions Updated clinical guidelines Key Features: Provides ultra-quick access to patient treatment information Offers easy-to-use framework for quickly locating critical knowledge Presents templates for identifying normal and abnormal presentations Delivers content in logical head-to-toe format Includes time-tested "Tips" and "Don't Miss" boxes with bullet points of critical information Provides anatomic illustrations that assist in diagnosis/management of conditions Contains billing information

**urgent care note template: Geriatric Emergent/Urgent and Ambulatory Care** Sheila Sanning Shea, Karen Sue Hoyt, 2016-01-20 Fast-track medical settings call for "at-your-fingertips" information. Here is an easy-to-use, quick-reference guide for nurse practitioners and other health care providers in emergency, medical, screening, fast track, and/or primary care settings with family patients. In a concise, optimally organized format that includes current, evidence-based guidelines, the resource delivers a wealth of information for assessment and management of the most commonly encountered problems in these settings. Concise yet packed with crucial knowledge, The Pocket NP is arranged in a logical head-to-toe format that includes the history and physical examination and essential medical decision-making considerations. The material is organized in a true rapidaccess format, with salient information presented for maximum efficiency and speed of retrieval. A variety of templates for dictation/documentation are provided to assist the clinician with the development of a concise and logical patient record. These templates can be mixed and matched as needed and,

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**urgent care note template: The Complete Step-by-Step Guide to Functional Neurological Disorder (FND)** Gaetana Yo Tate, Let’s get one thing straight—Functional Neurological Disorder (FND) is real, frustrating, and anything but simple. If you’ve ever been told, “It’s all in your head,” or “Just relax and it’ll go away,” you know exactly how absurdly unhelpful advice like that can be. FND isn’t a choice, and it certainly isn’t a moral failing. It’s a condition where your brain and body seem to be having an internal dispute—one that often leaves you dealing with unexplained symptoms, misdiagnoses, and medical professionals who sometimes don’t know what to do with you. This book is your step-by-step guide to managing FND with clarity, structure, and a little humor (because, let’s face it, this condition is ridiculous at times). It doesn’t offer magic cures, but it does provide something much more valuable: a practical roadmap for understanding your symptoms, reducing their impact, and building resilience so you can get back to living your life. What You’ll Find Inside: □ Mind-Body Healing Techniques - Learn how stress, emotions, and neurological miscommunication interact and how to break unhelpful cycles. □ Cognitive Behavioral Strategies (CBT) - Reframe irrational thoughts that make symptoms worse and replace them with rational, constructive thinking. □ Structured Daily Routines - Step-by-step morning and evening plans to help bring predictability to an unpredictable condition. □ Symptom Tracking and Reflection Tools - Identify patterns in your symptoms and use data-driven adjustments to improve management. □ Guided Mindfulness and Relaxation Exercises - Reduce anxiety, improve focus, and regain control over your body’s reactions. □ Support Networks and Community Building - How to find people who truly understand your condition (because you’re tired of explaining it to people who don’t). □ Clinician Insights and Practical Advice - What doctors and therapists should be telling you about FND management. This book is scientifically informed, emotionally validating, and unapologetically practical. It teaches real skills—not vague advice like “be more positive” or “just try harder” (because, frankly, you’ve already tried). It’s for patients, caregivers, and clinicians who want an actionable, structured plan for managing FND without false hope, pseudoscience, or sugarcoated nonsense. If you want to stop feeling at the mercy of your symptoms and start building a system that works for you, this book is your blueprint. It won’t eliminate every challenge overnight, but it will give you the tools to make each day a little easier—one practical, rational step at a time.

**urgent care note template: Geriatric Emergent/Urgent and Ambulatory Care, Second Edition** Sheila Sanning Shea, Karen Sue Hoyt, 2020-05-31 Praise for the First Edition: The pocket NP guide is an easy to use clinical companion guiding the assessment, diagnosis, and treatment of common presentations to the emergency setting. I personally use this resource in my clinical practice and also recommend it to all of my students. I highly recommend the pocket NP guide for any practitioners working or thinking of working in the emergency setting. -Theresa Campo DNP, FNP-C, ENP-BC, FAANP Updated to promote ultra-quick access to current information NPs need daily Now in its second edition, this reference guide for nurse practitioners and other health care providers in emergency, medical, screening, fast track, and/or geriatric settings continues to provide ultra-quick access to key assessment and management information. The Pocket NP delivers a wealth of information for assessment and management of the most-commonly encountered problems in fast-track settings. Arranged in a logical head-to-toe format, it includes the history, physical examination, and essential medical decision-making considerations needed to walk you step-by-step through a typical patient encounter. New to the Second Edition: Updated medical decision-making

sections with documentation templates Updated pharmacology and drug administration information New ultrasound dictation templates for each section where it is performed New tables including eye chart for vision in trauma patients New ultrasound images New line drawings depicting various conditions Updated clinical guidelines Key Features: Provides ultra-quick access to patient treatment information Offers easy-to-use framework for quickly locating critical knowledge Presents templates for identifying normal and abnormal presentations Delivers content in logical head-to-toe format Includes time-tested "Tips" and "Don't Miss" boxes with bullet points of critical information Provides anatomic illustrations that assist in diagnosis/management of conditions Contains billing information

**urgent care note template: Sociomaterial-Design** Pernille Bjørn, Carsten Østerlund, 2014-12-01 Investigates theoretically and empirically what it means to design technological artefacts while embracing the large number of practices which practitioners engage with when handling technologies. The authors discuss the fields of design and sociomateriality through their shared interests towards the basic nature of work, collaboration, organization, technology, and human agency, striving to make the debates and concepts originating in each field accessible to each other, and thus moving sociomateriality closer to the practical concerns of design and providing a useful analytical toolbox to information system designers and field researchers alike. Sociomaterial-Design: Bounding Technologies in Practice takes on the challenge of redefining design practices through insights from the emerging debate on sociomateriality. It does so by bringing forward a comparative examination of two longitudinal ethnographic studies of the practices within two emergency departments - one in Canada and one in the United States of America. A particular focus is placed upon the use of current collaborative artefacts within the emergency departments and the transformation into digital artefacts through design.

**urgent care note template: Authoring Patient Records: An Interactive Guide** Michael P. Pagano, 2010-02-11 .

**urgent care note template: Pediatric Emergent/Urgent and Ambulatory Care, Second Edition** Sheila Sanning Shea, Karen Sue Hoyt, 2020-05-31 Praise for the First Edition: This is one of the most useful pocket guides that I have used. It is a must-have for every nurse practitioner who works in the ED, urgent care, or primary care setting -Nicole Martinez, MSN, RN, FNP-BC, ENP-C, PHN Emergency Nurse Practitioner Scripps Mercy Hospital Updated to promote ultra-quick access to current information NPs need daily Now in its second edition, this reference guide for nurse practitioners and other health care providers in emergency, medical, screening, fast track, and/or pediatric settings continues to provide ultra-quick access to key assessment and management information. The Pocket NP delivers a wealth of information for assessment and management of the most-commonly encountered problems in fast-track settings. Arranged in a logical head-to-toe format, it includes the history, physical examination, and essential medical decision-making considerations needed to walk you step-by-step through a typical patient encounter. New to the Second Edition: Updated medical decision-making sections with documentation templates Updated pharmacology and drug administration information New ultrasound dictation templates for each section where it is performed New tables including eye chart for vision in trauma patients New ultrasound images New line drawings depicting various conditions Updated clinical guidelines Key Features: Provides ultra-quick access to patient treatment information Offers easy-to-use framework for quickly locating critical knowledge Presents templates for identifying normal and abnormal presentations Delivers content in logical head-to-toe format Includes time-tested "Tips" and "Don't Miss" boxes with bullet points of critical information Provides anatomic illustrations that assist in diagnosis/management of conditions Contains billing information

**urgent care note template: Pediatric Emergent/Urgent and Ambulatory Care** Sheila Sanning Shea, Karen Sue Hoyt, Kathleen Sanders Jordan, 2024-08-03 AJN Book-of-the-Year Award Winner! Now in its third edition, this quick reference for nurse practitioners and other health care providers continues to provide rapid access to key assessment and management information for pediatric patients. With its concise format, the resource provides current, evidence-based guidelines

for the most-commonly encountered problems found in this population in urgent and emergent settings. The pocket guide is arranged in a logical head-to-toe format, and includes the history, physical examination, and essential medical decision-making considerations needed to walk the clinician step-by-step through a typical patient encounter. A variety of templates for dictation/documentation can be mixed and matched as needed to assist the clinician with the development of patient records. The book also contains frequently used anatomical illustrations and templates to assist in identification of normal and abnormal presentations. New to the Third Edition: Updates crucial evidence-based clinical guidelines Delivers ultrasound figures and tables Key Features: Provides at-a-glance access to patient treatment information Offers templates assisting in identification of normal and abnormal presentations Contains a rapid review of systems Unfolds content in a head-to-toe format Includes figures and anatomic information assisting in management/diagnosis of conditions Contains information about billing

**urgent care note template: Geriatrics Models of Care** Michael L. Malone, Marie Boltz, Jonny Macias Tejada, Heidi White, 2024-05-30 Following the success of the previous edition, the second edition of Geriatrics Models of Care is the definitive resource for systems-based practice improvement for the care of older adults. Several new models of care have been published in the last eight years, new outcomes have emerged to better understand the impact of existing models, and with the rise of the Age-Friendly Health Systems movement, promoting organized efforts to prepare our health care settings for older individuals is of more importance than ever. The second edition is organized based on the practice setting along a continuum of care: hospital, transitions from hospital to home, outpatient settings, and the emergency department. This book also highlights long-term care models, which is an important part of the continuum of care for older Americans. Further, this edition features models that address the needs of vulnerable populations. This new section will describe a spectrum of programs for older adults who have Alzheimer's disease or Parkinson's disease. Other models describe best practices for older adults undergoing surgery or those who want to remain functioning independently in their home. A defining feature of this book is that each chapter follows a standard template: 1) the challenge which led to the model; 2) the patient population served; 3) core components of the intervention; 4) the role of interdisciplinary health professionals; 5) evidence to support the intervention; 6) lessons learned in the implementation and dissemination of the model; 7) implications for family caregivers, and communities (particularly underserved and diverse communities); and 8) how each model will provide care across the continuum during an entire episode of care. In addition, each chapter features a "call out" box with practical tips for implementing the model.

**urgent care note template: Objective Structured Clinical Examinations** Sondra Zabar, Elizabeth Kachur, Kathleen Hanley, Colleen Gillespie, Adina Kalet, 2025-07-25 Objective Structured Clinical Examinations (OSCEs) or other Standardized Patient/Participant (SP) exercises are an important methodology for teaching and assessment in health professions education across disciplines and the continuum of training. The first edition of Objective Structured Clinical Examinations offered a systematic approach for educators to get involved in the process of creating OSCEs and similar SP exercises. The second edition uses the same successful format to make the OSCE process easy and reproducible and adds novel material and innovative best practices for OSCEs in every context. The first edition of this book was based on the editors' 20 years of experience producing OSCEs without a clinical skills center — in empty classrooms or walk-in clinics on weekends, working with well-trained SPs and using carefully designed clinical scenarios. In the 10 years since, they have engaged in multidisciplinary and inter-professional collaborations and expanded their approach to designing and implementing successful performance-based assessment, both inside and outside of high-tech simulation centers. The original chapters - (1) Introduction; (2) 10-step approach; (3) Remediation; and (4) Unannounced Standardized Patients - have been updated and charts, tables and best practices throughout these chapters are elaborated and expanded on. This second edition also features an updated Foreword by Ronald Harden and Preface by Mack Lipkin, Adina Kalet, and Sandy Zabar, along with eight new chapters in collaboration with



other educators and researchers, covering topics such as: analyzing OSCE notes for clinical reasoning; OSCE data, reporting and visualization; scholarship and a research registry; examples of performance-based assessment in practice; virtual OSCEs and telemedicine skills; OSCEs for transitions; OSCEs for teaching; and SP programs. This expanded edition will be useful to both novice and advanced educators and offers an important contribution to the health professions education literature.

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as well as charts, diagrams, and a relapse prevention plan. This workbook aims to give illness anxiety sufferers the skills needed to work through the therapeutic journey in decreasing anxiety and beginning recovery. This book is essential for those with illness- or health-related anxiety looking to do self-help or to use with therapists in sessions, along with practicing clinicians who need specialized guidance.

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**urgent care note template: More Than Just BS** Jayson Marwaha, 2012-10-04 Applying to combined BS/MD programs really, really stinks - unless you're guided by the right person. That's what Jayson - a student who got into some of the nation's top BS/MD programs at Brown, Caltech, and Penn State through countless nights of energy drinks - realized when he was in high school. This book fixes that. More Than Just BS is Jayson's unique, tested, foolproof plan to acing the apps for these crazily competitive medical programs. It's a resume-building preparation plan, a step-by-step guide to the application process, plus a safe haven for students: it's got checklists, summaries, clever shortcuts, sneaky tips, and tons of cheeky remarks.

**urgent care note template: Management of Sick Cell Pain** Wally R. Smith, Thokozeni Lipato, 2025-02-10 One of the major developmental tasks for all children is to master functioning in the school environment. This task can be difficult for children with chronic illnesses. Students must be present and engaged to develop positive relationships with same-aged peers and succeed academically. Children with SCD have been shown to have difficulties both academically and socially in school. SCD painful vaso-occlusive crises (VOCs), whether treated in the hospital or at home, are unpredictable, making it challenging for students to be present and fully engaged with their educational experience. Patients with SCD miss an average of 20-40 days of school per year. Approximately 35% of patients miss more than one month of school, a rate significantly higher than peers or sibling controls. Grade retention rates in adolescents have been reported to be as high as 40%, higher than the national average of 5-10% for unaffected students. In addition to pain, other factors related to SCD, such as chronic anemia, neurocognitive deficits, and stroke can impact school absenteeism and performance. Physical changes such as small stature and jaundice, combined with activity limitations that are often placed on students, can impair social interactions with peers. Children with SCD perceive challenges to managing their pain at school and barriers to creating a positive experience in school environment as early as elementary school. Academic challenges extend beyond racial and socioeconomic disparities, as children with SCD have disproportionately higher rates of grade retention and special education services compared with nonaffected children in the same school district. Neurologic complications, ranging from overt stroke to subtle neurocognitive changes, are among the most common complications of SCD. SCD is the most common cause of stroke in children. Patients can also have silent strokes and sickle cell related vasculopathy. Silent infarcts are associated with cognitive morbidity and increase the likelihood of future overt stroke. Patients with normal magnetic resonance imaging results and no history of stroke still may have evidence of neurocognitive decline related to underlying SCD. Full scale IQ typically declines by 1.5 points/year. Markers of disease severity such as low baseline hemoglobin have been shown--

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the use (and non-use) of an incident management system provides clear and convincing evidence of successes and failures in managing emergencies. This research provides areas where first responders have misunderstood the scope and use of an emergency incident management system and what the outcomes were. Contemporary and historical (research-based) case studies in the United States and around the globe have shown the consequences of not using emergency incident management systems, including some that led to increased suffering and death rates.

Research-based case studies from major incidents will be used to show the detrimental effects of not using or misunderstanding these principles. One of the more interesting chapters in the new edition is what incident management is used around the world.

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Massachusetts General Hospital Handbook of General Hospital Psychiatry, by Theodore A. Stern, Gregory L. Fricchione, Ned H. Cassem, Michael Jellinek, and Jerrold F. Rosenbaum, is your ideal source of guidance on consultation-liaison psychiatry! Experts from the Massachusetts General Hospital—widely respected as one of the world's premier psychiatric institutions—provide practical advice on the diagnosis and treatment of psychiatric issues experienced by in-hospital, medically ill adults and children. This compact resource reads like a handbook, but delivers all the details you'd expect from a textbook. Understand and manage the psychological impact of chronic medical problems, life-threatening diseases, disfigurement, and more. Effectively manage difficult patients, including those with hypochondriacal and conversion disorders. Find information quickly thanks to an improved chapter organization, and get just the answers you need with concise yet complete coverage appropriate for psychiatrists and generalists alike. Implement the most current, effective pharmaceutical therapies as well as cognitive-behavioral approaches.

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