



My Health eVet Quick Guide VA Progress Notes



VA Progress Notes are part of a patient's permanent medical record. They describe events during a patient's care. They can be written during a patient's clinic visit or during a hospital stay. Physicians, nurses, consultants, and therapists record their progress notes in the patients medical record.

VA Progress Notes may or may not contain the following information:

- Patients health condition
- Care delivered to the patient
- Medical facts, clinical findings, opinions and treatment plans
- Progress or lack of progress made by the patient
- Clinical events related to the diagnosis and treatment of the patient
- Patient's past health condition compared to their current health status

To access **VA Progress Notes** you must:

- Be a Veteran enrolled at a VA health care facility
- Be registered as a **VA Patient** in My Health eVet
- Have a My Health eVet **Premium*** account

To get a My Health eVet **Premium* Account, you will need to go through authentication. This is a process where VA verifies a Veterans' identity. It is done before allowing access to the Veteran's VA health record.*

If you have questions, you can use **Secure Messaging** to send a message to your VA health care team. Use it to ask about test results or ways you may be able to improve your health. In addition, you can use it to set up a VA appointment or address other non-emergent issues.

Use **VA Blue Button** to share your **VA Progress Notes** with your caregivers, non-VA health care providers and others you trust. This may help them better understand your health concerns.

VA Blue Button offers you the ability to view parts of your VA health record.

Use the **VA Blue Button** to view, print or download your **VA Progress Notes**.

- Log into your My Health eVet account
- Select **Download My Data**
- Select **Continue**

You can now select the **Types of Information**

- Choose **Select one or more types of information**
- Select **VA Progress Notes**
- Select **Submit**

You can now select to **Download or View/Print** your information.

Visit the **VA Progress Notes Frequently Asked Questions**. This site has questions and answers that may help you understand more about the feature.

Va Medicaid Progress Notes Guide

J Spring

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Documentation for Physical Therapist Practice Jacqueline A. Osborne, 2015-07-31 Documentation for Physical Therapist Practice A Clinical Decision Making Approach provides the framework for successful documentation. It is synchronous with Medicare standards as well as the American Physical Therapy Association's recommendations for defensible documentation. It identifies documentation basics which can be readily applied to a broad spectrum of documentation formats including paper based and electronic systems. This key resource utilizes a practical clinical decision making approach and applies this framework to all aspects of documentation. This text emphasizes how the common and standard language of the Guide to Physical Therapist Practice and the International Classification of Functioning Disability and Health ICF model can be integrated with a physical therapist's clinical reasoning process and a physical therapist assistant's skill set to produce successful documentation. Includes content on documentation formations Initial Evaluations Re examination Notes Daily Notes Conclusion of the Episode of Care Summaries Home Exercise Program Reviews all the important issues related to style types of documentation and utilization of documentation. Covers documentation relevant in different settings inpatient home health skilled nursing facility outpatient. Helps students learn how to report findings and demonstrate an appropriate interpretation of results. Includes up to date information in line with APTA Guidelines for Defensible Documentation World Health Organization International Classification of Functioning Disability and Health Model and Medicare Reviews electronic documentation ICD 9 ICD 10 and CPT codes. Includes important chapters on Interprofessional Communication Legal Aspects Principles of Measurement. *Documentation for Rehabilitation- E-Book* Lori Quinn, James Gordon, 2009-12-18 Four NEW chapters address additional aspects of documentation that rehabilitation professionals will encounter in practice Legal aspects of documentation Documentation in pediatrics Payment policy and coding Computerized documentation

Evaluation and Management Coding and Documentation Guide Jillian H. Kuruc, 2003 *Dreeben-Irimia's Introduction to Physical Therapist Practice for Physical Therapist Assistants* Christina M. Barrett, 2016-01-13 The Third Edition of this best selling text written specifically for PTAs will help instructors introduce students to information regarding professionalism professional roles interpersonal communication physical therapist's behavior and conduct teaching and learning and evidence based practice. This comprehensive text will provide a valuable resource throughout the physical therapist assistant's education and training throughout the entire duration of the PTA program. **Medicare and Medicaid Guide**, 1969

Guide to U.S. Government Publications Donna Batten, 2006-09 *Case Management Resource Guide*, 1997

Medicare and Medicaid Guide, Transfer Binder, 1969-11 *Virginia Administrative Law Appendix*, 2016

Communicating Clinical Decision-Making Through Documentation: Coding, Payment, and Patient Categorization Eric Shamus, Debra F. Stern, William F. McGehee, 2021-02-01 Publisher's Note Products purchased from Third Party sellers are not guaranteed by the publisher for quality authenticity or access to any online entitlements included with the product Clear

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Clinical Care Classification (CCC) System Manual, Virginia K. Saba, 2007. Designated a Doody's Core Title span. The Preeminent Nursing Terminology Classification System. The Clinical Care Classification CCC System described in this manual is the only standard coded nursing terminology that is based on sound research using the nursing process model framework and that meets the Patient Medical Record Information PMRI comparability requirement. The CCC System allows patient care data generated by nurses to be incorporated into the PMRI database and enables nurses contributions to patient outcomes to be studied and acknowledged. From the Foreword by Sheryl L Taylor BSN RN Senior Consultant, Farrell Associates TESTIMONIES ABC Coding Solutions Alternative Link developed ABC codes for nursing in collaboration with Dr. Virginia Saba developer of the CCC system. Approximately two hundred ABC codes were developed from the CCC System of Nursing Interventions to accurately document nursing and integrative health care processes, classify and track clinical care and develop evidence based practice models, thus filling significant gaps in older medical code sets. Connie Koshewa, Practitioner Relations Director, ABC Coding Solutions Alternative Link. The International Classification for Nursing Practice ICNP is a program of the International Council of Nurses ICN. One of the first steps in the development of the ICNP was to collect and compare all the nursing concepts in existing nursing terminologies including the CCC. To facilitate the goal of ICNP as a unified nursing language system, a project is under way to map the CCC to the ICNP Version 1.0. This work will facilitate evaluation and ongoing development of both terminologies and allow ICN to compare data using CCC codes with data from

other standard nursing terminologies Amy Coenen PhD RN FAAN Director ICNP Program International Council of Nurses

The Omaha System Karen S. Martin,Nancy J. Scheet,1992 A comprehensive presentation of the Omaha System a patient problem classification system based on actual practice and research results Developed by practicing nurses in community health care settings this system is tested for reliability and validity and provides a basis for a total practice and recording system The authors are the principal investigators on the seven year federally funded project and present the material in a practical manner making application easy

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