ATI EHR Clinical Documentation Guide

Use this guide while charting. Complete only what applies to your patient. Do NOT fill in sections for things that do not exist (leave blank).

Patient Information

Section	What to Enter	Notes
Name	YOUR Name	Do not enter patient's real name
Sex Assigned at Birth	Select correct option	
Gender Identity	Select correct option	
Age	Enter patient age	
Provider	*Bernard Robinson, MD*	Required
Code Status	Full/Partial/DNR	
Comments	Clinical Instructor + Unit	Example: *Instructor Smith / Hope 4 Tower*

Provider Section

Area	What to Document
Chief Complaint & HPI	Reason patient is here; brief-summary
Admission Problems	Primary diagnosis + additional conditions
History - PMH	Past Medical History
History - PSH	Past Surgical History

Allergies & Home Medications

Task	Requirement
Allergies	Enter known allergens
Home Medications	Complete if applicable

Notes

Task	Requirement
Free-Form Note	Optional, may add brief clinical notes

Flowsheets

Vital Signs

Requirement	Instruction
Vital Signs	Enter full set (do NOT click no measurements)

Assessment

Required Assessment Area	Notes
Head/Face/Neck	
Eyes/Ears/Nose/Throat	
Neurological	Do NOT complete DTRs
Glasgow Coma Scale	NOT required
Respiratory	
Cardiac	
Peripheral Vascular	
Integumentary	
Braden Scale	
Musculoskeletal	
Morse Fall Scale	
Gastrointestinal	
Genitourinary	
Pain Assessment	

Intake & Output

Area	Documentation Needed
Oral Intake	Enter amount if applicable
IV Intake	Enter if applicable
Stool	Last BM, color, amount, continence
Urine	Color, amount, order, continence

Interventions

Section	Examples
IVs/Lines	Peripheral, Central
Urinary Catheters	Foley, Straight
Gastric Tubes	NG, PEG
Drains	JP, Hemovac

Orders & Medications

Requirement	Instruction
Add New Orders	Type order name
Order Type	Entered by Provider
Medications	Enter at least **3**
Include	Dose, Route, Frequency
Admin Instructions	Drug class, Therapeutic reason, Adverse reactions
Student Notes “Relevant to your patient”	4 patient teachings per medication

Example:
New Order: Normal Saline 150 mL/hr
(Search "sodium chloride 0.9% injectable:injection 1000mL")
Dose: 1000 mL
Rate: 100 mL
Route: IV
Frequency: Continuous

Admin Instructions/Comments:
Drug Class: Isotonic Crystalloid Solution
Therapeutic Reason: Dehydration, Electrolyte Balance, Maintenance Fluid
Adverse Reactions: Fluid overload, Electrolyte imbalance, Edema, Pulmonary congestion

Student Notes: Patient Teaching
1.Monitor for swelling or shortness of breath – may indicate fluid overload
2.Report any discomfort at IV site – could indicate infiltration or phlebitis
3.Encourage oral intake if appropriate – supports hydration
4.Explain purpose of IV fluids – helps maintain blood pressure and hydration

New Order: Lisinopril 25mg po daily
Admin Instructions/Comments:
Drug Class: Ace-Inhibitor
Therapeutic Reason: Hypertension
Adverse Reactions: Hypotension, Dizziness, Angioedema, etc.

Student Notes: Patient Teaching
1. Caution when ambulation- drop in BP
2. Take with meals- GI upset
3. Watch for cough- ACE cough report to provider
4. Patient is pregnant, Avoid while pregnant.

Blank: (to copy and paste)
Admin Instructions/Comments:

Drug Class:
Therapeutic Reason:
Adverse Reactions:

Student Notes: Patient Teaching
1.
2.
3.
4.

SBAR

Add giver: YOU | Add receiver: Instructor

S – Situation

Include: Age/Gender/Room, Code Status, Reason for admission, Status

B – Background

Include: Hospital day #, allergies, diagnosis, relevant history, labs, treatments, changes

A – Assessment

Include: Assessment update, vitals, pain, mental status, mobility, skin, I&O

R – Recommendation

Include: Follow-ups, pending labs, meds due, education, discharge needs, monitoring concerns

Final Reminders

• Only chart what applies to YOUR patient
• Do NOT invent data

- Be clinically relevant
- Chart should tell the patient’s story