Chapter 6

Content of the Patient Record: Inpatient, Outpatient, and Physician Office

Chapter Outline
- Key Terms
- Objectives
- Introduction
- General Documentation Issues
- Hospital Inpatient Record—Administrative Data
- Hospital Inpatient Record—Clinical Data
- OPPS Major and Minor Procedures
- Hospital Outpatient Record
- Physician Office Record
- Forms Control and Design
- Internet Links
- Summary
- Study Checklist
- Chapter Review

Key Terms
addressograph machine
admission note
admission/discharge record
admitting diagnosis
advance directive
advance directive notification form
against medical advice (AMA)
alias
ambulance report
ambulatory record
ancillary reports
ancillary service visit
anesthesia record
antepartum record
anti-dumping legislation
APGAR score
attestation statement
automatic stop order
autopsy
autopsy report
bedside terminal system
birth certificate
birth history
case management note
certificate of birth
certificate of death
chief complaint (CC)
clinical data
clinical résumé
comorbidities
complications
conditions of admission
consent to admission
<table>
<thead>
<tr>
<th>Consultation</th>
<th>Consultation Report</th>
<th>Medication Administration Record (MAR)</th>
<th>Postpartum Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death Certificate</td>
<td>Dietary Progress Note</td>
<td>Necropsy</td>
<td>Preanesthesia Evaluation Note</td>
</tr>
<tr>
<td>Differential Diagnosis</td>
<td>Discharge Note</td>
<td>Necropsy Report</td>
<td>Prenatal Record</td>
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<tr>
<td>Discharge Order</td>
<td>Discharge Summary</td>
<td>Neonatal Record</td>
<td>Preoperative Note</td>
</tr>
<tr>
<td>Doctors Orders</td>
<td>DRG Creep</td>
<td>Newborn Identification</td>
<td>Principal Diagnosis</td>
</tr>
<tr>
<td>Durable Power of Attorney</td>
<td>Emergency Record</td>
<td>Newborn Physical Examination</td>
<td>Principal Procedure</td>
</tr>
<tr>
<td>Encounter</td>
<td>Encounter Form</td>
<td>Newborn Progress Notes</td>
<td>Progress Notes</td>
</tr>
<tr>
<td>Face Sheet</td>
<td>Facility Identification</td>
<td>Non-Licensed Practitioner</td>
<td>Read and Verified (RAV)</td>
</tr>
<tr>
<td>Family History</td>
<td>Fee Slip</td>
<td>Nurses Notes</td>
<td>Recovery Room Record</td>
</tr>
<tr>
<td>Final Diagnosis</td>
<td>First-Listed Diagnosis</td>
<td>Nursing Care Plan</td>
<td>Rehabilitation Therapy Progress Note</td>
</tr>
<tr>
<td>Follow-Up Progress Note</td>
<td>Forms Committee</td>
<td>Nursing Discharge Summary</td>
<td>Respiratory Therapy Progress Note</td>
</tr>
<tr>
<td>Graph Sheet</td>
<td>Graphic Sheet</td>
<td>Nursing Documentation</td>
<td>Review of Systems (ROS)</td>
</tr>
<tr>
<td>Health Care Proxy</td>
<td>History</td>
<td>Obstetrical Record</td>
<td>Routine Order</td>
</tr>
<tr>
<td>History</td>
<td>History of Present Illness (HPI)</td>
<td>Operative Record</td>
<td>Secondary Diagnoses</td>
</tr>
<tr>
<td>Informed Consent</td>
<td>Integrated Progress Notes</td>
<td>Outpatient Visit</td>
<td>Secondary Procedures</td>
</tr>
<tr>
<td>Interval History</td>
<td>Labor and Delivery Record</td>
<td>Past History</td>
<td>Short Stay</td>
</tr>
<tr>
<td>Licensed Practitioner</td>
<td>Macroscopic</td>
<td>Pathology Report</td>
<td>Short Stay Record</td>
</tr>
<tr>
<td>Maximizing Codes</td>
<td>Medication Administration Record (MAR)</td>
<td>Patient Identification</td>
<td>Social History</td>
</tr>
<tr>
<td>Postanesthesia Care Unit (PACU) Record</td>
<td>Necropsy</td>
<td>Patient Record Documentation Committee</td>
<td>Standing Order</td>
</tr>
<tr>
<td>Postanesthesia Evaluation Note</td>
<td>Neonatal Record</td>
<td>Physical Examination</td>
<td>Stop Order</td>
</tr>
<tr>
<td>Postmortem Report</td>
<td>Non-Licensed Practitioner</td>
<td>Physician Office Record</td>
<td>Superbill</td>
</tr>
<tr>
<td>Postoperative Note</td>
<td>Nurses Notes</td>
<td>Physician Orders</td>
<td>Telephone Order Call Back Policy</td>
</tr>
<tr>
<td>Postoperative Record</td>
<td>Nursing Care Plan</td>
<td>Postanesthesia Care Unit (PACU) Record</td>
<td>Tissue Report</td>
</tr>
<tr>
<td>Postoperative Progress Notes</td>
<td>Nursing Discharge Summary</td>
<td>Nursing Documentation</td>
<td>Transfer Order</td>
</tr>
<tr>
<td>Postoperative Summary</td>
<td>Obstetrical Record</td>
<td>Occasion of Service</td>
<td>Uniform Ambulatory Care Data Set (UACDS)</td>
</tr>
<tr>
<td>Postoperative Report</td>
<td>Operative Record</td>
<td>Outcome</td>
<td>Uniform Hospital Discharge Data Set (UHDDS)</td>
</tr>
<tr>
<td>Postoperative Screening</td>
<td>Outpatient Record</td>
<td>Physician Orders</td>
<td>Upcoding</td>
</tr>
<tr>
<td>Postoperative Summary</td>
<td>Review of Systems (ROS)</td>
<td>Postanesthesia Care Unit (PACU) Record</td>
<td>Verbal Order</td>
</tr>
<tr>
<td>Postoperative Report</td>
<td>Secondary Diagnoses</td>
<td>Postoperative Note</td>
<td>Written Order</td>
</tr>
</tbody>
</table>

**Objectives**

*At the end of this chapter, the student should be able to:*

- Define key terms
- Explain general documentation issues that impact all patient records
- Differentiate between administrative and clinical data collected on patients

- List the contents of inpatient, outpatient, and physician office records
- Detail forms design and control requirements, including the role of the forms committee
INTRODUCTION

Health care providers (e.g., hospitals, physician offices, and so on) are responsible for maintaining a record for each patient who receives health care services. If accredited, the provider must comply with standards that impact patient record keeping (e.g., The Joint Commission). In addition, federal and state laws and regulations (e.g., Medicare Conditions of Participation) provide guidance about patient record content requirements (e.g., inpatient, outpatient, and so on). To appropriately comply with accreditation content requirements (e.g., inpatient, outpatient, and so on), participating inpatient, outpatient, and so on), refer to Delmar Cengage Learning’s Comparative Records for Health Information Management by Ann Peden.

GENERAL DOCUMENTATION ISSUES

The Joint Commission standards require that the patient record contain patient-specific information appropriate to the care, treatment, and services provided. Patient records contain clinical/case information (e.g., documentation of emergency services provided prior to inpatient admission), demographic information (e.g., patient name, gender, etc.), and other information (e.g., advanced directive). Medicare Conditions of Participation (CoP) require each hospital to establish a medical record service that has administrative responsibility for medical records, and the hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed, properly retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services. All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his or her entry—authentication may include signatures, written initials or computer entry.

Medical records must be retained in their original or legally reproduced form for a period of at least 5 years, and the hospital must have a system of coding and indexing medical records to allow for timely retrieval by diagnosis and procedure to support medical care evaluation studies. The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released by the hospital only in accordance with federal or state laws, court orders, or subpoenas.

The patient record is a valuable tool that documents care and treatment of the patient. It is essential that every report in the patient record contain patient identification, which consists of the patient’s name and some other piece of identifying information such as medical record number or date of birth. Every report in the patient record and every screen in an electronic health record (EHR) must include the patient’s name and medical record number. In addition, for paper-based reports that are printed on both sides of a piece of paper, patient identification must be included on both sides. Paper-based documents that contain multiple pages (e.g., computer-generated lab reports) must include patient identification information on all pages.

NOTE: Some patients insist on the use of an alias, which is an assumed name, during their encounter. The patient might be a movie star or sports figure; receiving health care services under an alias affords privacy (e.g., protection from the press). The name that the patient provides is accepted as the official name, and the true name can be entered in the master patient index as an AKA (also known as). However, the true name is not entered in the patient record or in the billing files. Patients who choose to use an alias should be informed that their insurance company probably will not reimburse the facility for care provided, and the patient will be responsible for payment. In addition, use of an alias can adversely impact continuity of care.

EXAMPLE

A pregnant patient was admitted to the hospital and signed in under an alias. Her baby was delivered, and the baby’s last name was entered on the record using the alias. The patient explained that an order of protection...
had been issued because her spouse was abusive and she didn’t want him to know that she had been admitted to deliver the baby. Upon discharge, she and the baby traveled to a safe house.

It is common for health care facilities to print the attending/primary care physician’s name and the date of admission/visit on each form using an addressograph machine (Figure 6-1), which imprints patient identification information on each report. A plastic card that looks similar to a credit card is created for each patient and placed in the addressograph machine to make an impression on the report. Using an addressograph also allows forms to be imprinted prior to patient admission, creating the record ahead of time. (Some facilities print computer-generated labels, which are affixed to blank forms.) Addressograph imprints and computer-generated labels should be in the same location on each report (e.g., upper right corner).

Facility identification, including the name of the facility, mailing address, and a telephone number, must also be included on each report in the record so that an individual or health care facility in receipt of copies of the record can contact the facility for clarification of record content.

Dating and Timing Patient Record Entries

For a record to be admissible in a court of law according to Uniform Rules of Evidence, all patient record entries must be dated (month, date, and year, such as mmdyyyy) and timed (e.g., military time, such as 0400). Providers are responsible for documenting entries as soon as possible after the care and treatment of a patient, and predated and postdated entries are not allowed. (Refer to the discussion of addendums in Chapter 4 for clarification on how providers should amend an entry.)

NOTE: When nurses summarize patient care at the end of a shift, documentation should include the actual date and time the entry was made in the record.

Content of the Patient Record

Because patient record content serves as a medicolegal defense, providers should adhere to guidelines (Table 6-1) that ensure quality documentation.

Exercise 6–1 General Documentation Issues

True/False: Indicate whether each statement is True (T) or False (F).

1. Every report in the patient record must contain patient identification, which consists of the patient’s name and some other piece of identifying information such as medical record number and date of birth.

2. Facility identification includes the name of the facility, mailing address, and a telephone number, all of which are included on each report in the record.
Table 6-1  Patient Record Documentation Guidelines

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authentication</td>
<td>• Entries should be documented and signed (authenticated) by the author.</td>
</tr>
<tr>
<td>Change in Patient’s Condition</td>
<td>• If the patient’s condition changes (e.g., worsens) or a significant patient care issue develops (e.g., patient falls out of bed and breaks hip), documentation must reflect this as well as indicate follow-through.</td>
</tr>
<tr>
<td>Communication with Others</td>
<td>• Any communication provided to the patient’s family (e.g., discharge requirements) or physician (e.g., change of condition on night shift) should be properly documented.</td>
</tr>
<tr>
<td>Completeness</td>
<td>• Significant information related to the patient’s care and treatment should be documented (e.g., patient condition, response to care, treatment course, and any deviation from standard treatment/reason).</td>
</tr>
<tr>
<td></td>
<td>• All fields on preprinted forms should be completed (e.g., flow sheets). For information not entered, document N/A for not applicable.</td>
</tr>
<tr>
<td></td>
<td>• If an original entry is incomplete, the provider should amend the entry (e.g., document in the next blank space in the record and refer to the date of the original entry).</td>
</tr>
<tr>
<td></td>
<td>• If documentation is reported by exception (e.g., only when a specific behavior occurs), the form should indicate these charting instructions.</td>
</tr>
<tr>
<td>Consistency</td>
<td>• Document current observations, outcomes, and progress.</td>
</tr>
<tr>
<td></td>
<td>• Entries should be consistent with documentation in the record (e.g., flow charts).</td>
</tr>
<tr>
<td></td>
<td>• If documentation is contradictory, an explanation should be included.</td>
</tr>
<tr>
<td>Continuous Documentation</td>
<td>• Providers should not skip lines or leave blanks when documenting in the patient record.</td>
</tr>
<tr>
<td></td>
<td>• Do not generate a new form (e.g., progress note sheet) until the previous form is filled.</td>
</tr>
<tr>
<td></td>
<td>• If a new form is started, the provider should cross out any remaining space on the previous form. (An entry documented out of order should be added as a late entry.)</td>
</tr>
<tr>
<td></td>
<td>• Blank space on a form raises the question that the record may have been falsified (e.g., blank page inserted or pages out of order because the provider backdated an entry).</td>
</tr>
<tr>
<td>Objective Documentation</td>
<td>• State facts about patient care and treatment, and avoid documenting opinions.</td>
</tr>
<tr>
<td></td>
<td>INCORRECT: Patient is peculiar.</td>
</tr>
<tr>
<td></td>
<td>CORRECT: Patient exhibits odd behavior . . .</td>
</tr>
<tr>
<td>Referencing Other Patients</td>
<td>• If other patient(s) are referenced in the record, do not document their name(s). Reference their patient number(s) instead.</td>
</tr>
<tr>
<td>Permanency</td>
<td>• Documentation entries in the patient record are considered permanent, and policies and procedures should be established to prevent falsification of and tampering with the record.</td>
</tr>
<tr>
<td>Physical Characteristics</td>
<td>• Select white paper with permanent black printing (e.g., laser, not inkjet printer) to ensure readability of paper-based records.</td>
</tr>
<tr>
<td></td>
<td>• Require providers to enter documentation using permanent black ink.</td>
</tr>
<tr>
<td></td>
<td>• Plain paper (not thermal paper) faxes are best if filed in the patient record.</td>
</tr>
<tr>
<td></td>
<td>• File original documents in the patient record, not photocopies.</td>
</tr>
<tr>
<td></td>
<td>• Avoid using labels on reports because they can become separated from the report.</td>
</tr>
<tr>
<td>Specificity</td>
<td>• Be sure to document specific information about patient care and treatment. Avoid vague entries.</td>
</tr>
<tr>
<td></td>
<td>INCORRECT: Eye exam is normal.</td>
</tr>
<tr>
<td></td>
<td>CORRECT: Eye exam reveals pupils equal, round, and reactive to light.</td>
</tr>
</tbody>
</table>
record so that an individual or health care facility in receipt of copies of the record can contact the facility for clarification of record content.

3. Providers are encouraged to document all patient record entries after the patient has been discharged.

4. When documenting on preprinted forms it is acceptable to leave a blank field.

**HOSPITAL INPATIENT RECORD—ADMINISTRATIVE DATA**

As defined in Chapter 4, *administrative data* includes demographic, socioeconomic, and financial information, which is gathered upon admission of the patient to the facility and documented on the inpatient face sheet (or admission/discharge record). Some facilities gather this information prior to admission through a telephone interview. The following reports comprise administrative data:

- Face sheet (or admission/discharge record)
- Advance directives
- Informed consent
- Patient property form
- Birth certificate (copy)
- Death certificate (copy)

**Face Sheet**

The Joint Commission standards do not specifically require a *face sheet*, but it does require that all medical records contain identification data. The Joint Commission requires completion of the medical record within 30 days following patient discharge. Medicare CoP requires a final diagnosis with completion of medical records within 30 days following patient discharge. Both the paper-based and computer-generated *face sheet* (or admission/discharge record) (Figures 6-2A and 6-2B) contain patient identification or demographic, financial data, and clinical information (Table 6-2). The face sheet is usually filed as the first page of the patient record because it is frequently referenced. Upon admission to the facility, the attending physician establishes an admitting diagnosis that is entered on the face sheet by the admitting department staff. The *admitting diagnosis* (or provisional diagnosis) is the condition or disease for which the patient is seeking treatment. The admitting diagnosis is often not the patient’s *final diagnosis*, which is the diagnosis determined after evaluation and documented by the attending physician upon discharge of the patient from the facility.

**NOTE:** Financial data is collected from the patient upon admission and submitted to third-party payers for reimbursement purposes.

The *Uniform Hospital Discharge Data Set* (UHDDS) is the minimum core data set collected on individual hospital discharges for the Medicare and Medicaid programs, and much of this information is located on the face sheet. The official data set consists of the following items:

- Personal Identification/Unique Identifier
- Date of Birth
- Gender
- Race and Ethnicity
- Residence
- Health Care Facility Identification Number
- Admission Date and Type of Admission
- Discharge Date
- Attending Physician Identification
- Surgeon Identification
- Principal Diagnosis
- Other Diagnoses
- Principal Procedure and Dates
- Other Procedures and Dates
- Disposition of Patient at Discharge
- Expected Payer for Most of This Bill
- Total Charges

In early 2003, the National Committee on Vital and Health Statistics (NCVHS) recommended that the following be collected as the standard data set for persons seen in both ambulatory and inpatient settings, unless otherwise specified:

- Personal/Unique Identifier
- Date of Birth
- Gender
- Race and Ethnicity
- Residence
- Living/Residential Arrangement
- Marital Status
- Self-Reported Health Status
- Functional Status
- Years Schooling
- Patient’s Relationship to Subscriber/Person Eligible for Entitlement
- Current or Most Recent Occupation/Industry
- Type of Encounter
- Admission Date (inpatient)
### Inpatient Face Sheet

| Alfred State Medical Center | **Inpatient Face Sheet**
|-----------------------------|------------------------------------------------------
| 100 Main St, Alfred NY 14802 | (101) 555-1111

**Patient Name and Address**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Race</th>
<th>Birth Date</th>
<th>Patient No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Telephone Number: ( ) -</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) -</td>
</tr>
</tbody>
</table>

**Admission Date** | **Time** | **Room** | **Discharge Date** | **Time** | **Length of Stay** | **Employer Telephone Number** |
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
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<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

**Guarantor Name and Address**

**Next of Kin Name and Address**

<table>
<thead>
<tr>
<th>Guarantor Telephone No.</th>
<th><strong>Relationship to Patient</strong></th>
<th>Next of Kin Telephone Number</th>
<th><strong>Relationship to Patient</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) -</td>
<td>( ) -</td>
<td>( ) -</td>
<td></td>
</tr>
</tbody>
</table>

**Primary Payer** | **Primary Payer Policy No.** | **Secondary Payer** | **Secondary Payer Policy No.**
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Admitting Physician** | **Service** | **Admit Type** | **Room Number/Bed**
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Attending Physician** | **Admitting Diagnosis**
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

### Diagnoses and Procedures

<table>
<thead>
<tr>
<th><strong>ICD Codes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Principal Diagnosis</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Secondary Diagnoses</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Principal Procedure</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Secondary Procedures</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Signature of Attending Physician:**

**Figure 6-2A** Paper-Based Patient Record Face Sheet (Courtesy Delmar/Cengage Learning.)
### ABC Hospital
1000 Inpatient Lane
Hospital City, New York 12345

**FACE SHEET**

<table>
<thead>
<tr>
<th>PATIENT RECORD NUMBER: 23345670</th>
<th>TYPE OF ADMISSION: Inpatient</th>
<th>6/08/YYYY</th>
<th>13:40</th>
</tr>
</thead>
</table>
| NAME/ADDRESS: Sam Jones  
123 Wood Street  
Endwell, NY 13456 | AGE: 085Y  
SEX: M  
RACE: W  
ROOM/BED: MD 220 1 | ATTENDING DOCTOR: Best, Sarah |
| NEAREST RELATIVE: Sandy Jones (daughter)  
45 Brook Street  
Liberty, PA 56789  
(607) 123-3456 | EMPLOYER NAME: Retired  
EMERGENCY CONTACT: Sandy Jones (daughter)  
45 Brook Street  
Liberty, PA 56789  
(607) 123-3456 |
| GUARANTOR #: 1123 | GUARANTOR EMPLOYER: R |

**ADMITTING DIAGNOSIS:** Dyspnea, Dehydration.

**INS # 1:** Medicare  
**SUBSCRIBER:** Sam Jones  
**ID #:** 098586389T  
**PLAN:** 10

**INS # 2:** Mutual of Omaha  
**SUBSCRIBER:** Sam Jones  
**ID #:** 67890TNH  
**PLAN:** 20

**COMMENTS:** POWER OF ATTORNEY: None  
ADVANCE DIRECTIVE: On file

**CONSULTANT:** Fenton, Sean

**ATTENDING PHYSICIAN:** Keen, Abby

**DISCHARGE:** 6/12/YYYY  
**CONDITION AT DISCHARGE:** Improved

**SIGNATURE**  **DATE**  
Abby Keen  
06/12/YYYY

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**Figure 6-2B** Computer-Generated Face Sheet (Courtesy Delmar/Cengage Learning.)

- Discharge Date (inpatient)
- Date of Encounter (ambulatory and physician services)
- Facility Identification
- Type of Facility / Place of Encounter
- Provider Identification (ambulatory)
- Attending Physician Identification (inpatient)
- Operating Physician Identification (inpatient)
- Provider Specialty
- Principal Diagnosis (inpatient)
- First-Listed Diagnosis (ambulatory)
- Other Diagnoses (inpatient)
- Qualifier for Other Diagnoses (inpatient)
- Patient’s Stated Reason for Visit or Chief Complaint (ambulatory)
- Physician’s Tentative Diagnosis (ambulatory)
- Diagnosis Chiefly Responsible for Services Provided (ambulatory)
- Other Diagnoses (ambulatory)
- External Cause of Injury

---

### Table 6-2 Face Sheet—Sections and Content

<table>
<thead>
<tr>
<th>Section</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification (or demographic) data</td>
<td>• Complete name</td>
</tr>
<tr>
<td></td>
<td>• Mailing address</td>
</tr>
<tr>
<td></td>
<td>• Phone number</td>
</tr>
<tr>
<td></td>
<td>• Date and place of birth, and age</td>
</tr>
<tr>
<td></td>
<td>• Patient record number</td>
</tr>
<tr>
<td></td>
<td>• Patient account number</td>
</tr>
<tr>
<td></td>
<td>• Gender</td>
</tr>
<tr>
<td></td>
<td>• Race and ethnicity</td>
</tr>
<tr>
<td></td>
<td>• Marital status</td>
</tr>
<tr>
<td></td>
<td>• Admission and discharge date and time*</td>
</tr>
<tr>
<td></td>
<td>• Type of admission (e.g., elective, emergency)</td>
</tr>
<tr>
<td></td>
<td>• Next-of-kin name and address</td>
</tr>
<tr>
<td></td>
<td>• Next-of-kin contact information</td>
</tr>
<tr>
<td></td>
<td>• Employer name, address, and phone number</td>
</tr>
<tr>
<td></td>
<td>• Admitting and/or referring physician</td>
</tr>
<tr>
<td></td>
<td>• Hospital name, address, and phone number</td>
</tr>
<tr>
<td></td>
<td><strong>Military time is usually reported on the face sheet (e.g., 3:00 p.m. is 1500).</strong></td>
</tr>
<tr>
<td>Financial data</td>
<td>• Third-party payer</td>
</tr>
<tr>
<td></td>
<td>• Name</td>
</tr>
<tr>
<td></td>
<td>• Address</td>
</tr>
<tr>
<td></td>
<td>• Phone number</td>
</tr>
<tr>
<td></td>
<td>• Policy number</td>
</tr>
<tr>
<td></td>
<td>• Group name and/or number</td>
</tr>
<tr>
<td></td>
<td>• Insured (or guarantor)*</td>
</tr>
<tr>
<td></td>
<td>• Name</td>
</tr>
<tr>
<td></td>
<td>• Date of birth</td>
</tr>
<tr>
<td></td>
<td>• Gender</td>
</tr>
<tr>
<td></td>
<td>• Relationship to patient (e.g., self, spouse)</td>
</tr>
<tr>
<td></td>
<td>• Name and address of employer</td>
</tr>
<tr>
<td></td>
<td>• Secondary and/or supplemental payer information. (All information collected for primary payer is also collected for secondary and/or supplemental payers.)</td>
</tr>
<tr>
<td></td>
<td><strong>This is primary payer information.</strong></td>
</tr>
<tr>
<td>Clinical information</td>
<td>• Admitting (or provisional or working) diagnosis</td>
</tr>
<tr>
<td></td>
<td>• Principal diagnoses (1)</td>
</tr>
<tr>
<td></td>
<td>• Secondary diagnoses (e.g., comorbidities and/or complications, up to 8)</td>
</tr>
<tr>
<td></td>
<td>• Principal procedure (1)</td>
</tr>
<tr>
<td></td>
<td>• Secondary procedure(s), up to 5</td>
</tr>
<tr>
<td></td>
<td>• Condition of patient at discharge</td>
</tr>
<tr>
<td></td>
<td>• Authentication by attending physician</td>
</tr>
<tr>
<td></td>
<td>• ICD-9-CM or CPT/HCPCS Level II codes</td>
</tr>
<tr>
<td></td>
<td>• Birth Weight of Newborn (inpatient)</td>
</tr>
<tr>
<td></td>
<td>• Principal Procedure (inpatient)</td>
</tr>
<tr>
<td></td>
<td>• Other Procedures (inpatient)</td>
</tr>
<tr>
<td></td>
<td>• Dates of Procedures (inpatient)</td>
</tr>
<tr>
<td></td>
<td>• Services (ambulatory)</td>
</tr>
<tr>
<td></td>
<td>• Medications Prescribed</td>
</tr>
<tr>
<td></td>
<td>• Medications Dispensed (pharmacy)</td>
</tr>
<tr>
<td></td>
<td>• Disposition of Patient (inpatient)</td>
</tr>
<tr>
<td></td>
<td>• Disposition (ambulatory)</td>
</tr>
<tr>
<td></td>
<td>• Patient’s Expected Sources of Payment</td>
</tr>
<tr>
<td></td>
<td>• Injury Related to Employment</td>
</tr>
<tr>
<td></td>
<td>• Total Billed Charges</td>
</tr>
</tbody>
</table>
NOTE: Terms in parentheses indicate items collected for those settings only. The NHVCS also provides specifications as to data to be collected for each item (e.g., patient/unique identifier involves collection of patient’s last name, first name, middle initial, suffix, and a numerical identifier).

The identification and financial sections of the face sheet are completed by the admitting (or patient registration) clerk upon patient admission to the facility (or prior to admission as part of the preadmission registration process). Third-party payer information is classified as financial data and is obtained from the patient at the time of admission. If a patient has more than one insurance plan, the admitting clerk will determine which insurance plan is primary, secondary, and/or supplemental. This process is important for billing purposes so that information is appropriately entered on the face sheet. The admitting clerk enters the patient’s admitting diagnosis (obtained from the admitting physician), and the attending physician documents the following:

- **Principal diagnosis** (condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care)

**EXAMPLE**

Patient admitted with chest pain. EKG is negative. Chest X-ray reveals hiatal hernia. **Principal diagnosis** is hiatal hernia.

- **Secondary diagnoses** (additional conditions for which the patient received treatment and/or impacted the inpatient care), including:
  - **Comorbidities** (pre-existing condition that will, because of its presence with a specific principal diagnosis, cause an increase in the patient’s length of stay by at least one day in 75 percent of the cases)

**EXAMPLE**

Patient is admitted for acute asthmatic bronchitis and also treated for uncontrolled hypertension during the admission. **Comorbidity** is hypertension.

- **Complications** (additional diagnoses that describe conditions arising after the beginning of hospital observation and treatment and that modify the course of the patient’s illness or the medical care required; they prolong the patient’s length of stay by at least one day in 75 percent of the cases)

**EXAMPLE**

Patient is admitted for viral pneumonia and develops a staph infection during the stay. The infection is treated with antibiotics. **Complication** is “staph infection.”

- **Principal procedure** (procedure performed for definitive or therapeutic reasons, rather than diagnostic purposes, or to treat a complication, or that procedure which is most closely related to the principal diagnosis)

**EXAMPLE**

Patient is admitted with a fracture of the right tibia for which a reduction of the tibia was performed. While hospitalized, patient developed appendicitis and underwent an appendectomy. **Principal diagnosis** is fracture, right tibia. **Secondary diagnosis** is appendicitis. **Principal procedure** is open reduction, fracture, right tibia. **Secondary procedure** is appendectomy.

- **Secondary procedures** (additional procedures performed during inpatient admission)

**EXAMPLE**

The patient is admitted for myocardial infarction and undergoes EKG and cardiac catheterization within 24 hours of admission. On day 2 of admission, the patient undergoes coronary artery bypass graft (CABG, pronounced “cabbage”) surgery. **Principal procedure** is CABG. **Secondary procedure** is cardiac catheterization. (Most hospitals do not code an inpatient EKG.)

Health information personnel with the title of “coder” assign numerical and alphanumerical codes (ICD-9-CM, CPT, and HCPCS codes) to all diagnoses and procedures. These codes are recorded on the face sheet and in the facility’s abstracting system. (Some facilities allow coders to enter diagnoses/procedures from the discharge summary onto the face sheet or to code directly from the discharge...
summary if the face sheet does not contain diagnoses/procedures. If, upon review of the record, coders determine that additional diagnoses/procedures should be coded, they contact the responsible physician for clarification.)

**NOTE:** Abstracting is discussed in Chapter 8.

Prior to 1995, the Health Care Financing Administration (HCFA, now called Centers for Medicare and Medicaid Services, CMS) required physicians to sign an **attestation statement**, which verified diagnoses and procedures documented and coded at discharge. Medicare originally required the statement because, when the diagnosis-related groups’ prospective payment system was implemented in 1983, there was concern that physicians would document diagnoses and procedures that resulted in higher payment for a facility (called **upcoding** or **maximizing codes**, and also known as **DRG creep**). In 1995, the attestation requirement was discontinued. At the same time, some hospitals also eliminated the requirement that physicians document diagnoses/procedures on the face sheet since this information is routinely documented as part of the dictated/transcribed discharge summary. Hospitals now establish facility policy regarding documentation of diagnoses and procedures upon discharge of patients.

**Advance Directives**

The **Patient Self Determination Act (PSDA) of 1990** required that all health care facilities notify patients age 18 and over that they have the right to have an **advance directive** (e.g., health care proxy, living will, medical power of attorney) placed in their record. Facilities must inform patients, in writing, of state laws regarding advance directives and facility policies regarding implementation of advance directives. Upon admission, an **advance directive notification form** (Figure 6-3) is signed by the patient to document that the patient has been notified of his or her right to have an advance directive. The patient record must document whether the individual has executed an **advance directive** (Table 6-3), which is a legal document in which patients provide instructions as to how they want to be treated in the event they become very ill and there is no reasonable hope for recovery. The written instructions direct a health care provider regarding a patient’s preferences for care **before** the need for medical treatment.

**NOTE:** State laws regarding advance directives vary greatly.

**EXAMPLE**

Anne lives in the state of Washington and writes a living will allowed by law, which documents her requests in the event that she is diagnosed with a terminal condition or is permanently unconscious. She relocates to New York State and gives a copy of her living will to her new health care provider. The provider informs her that living wills are not legal in New York State; however, she can designate a health care proxy.

**Informed Consent**

The Joint Commission standards require that a patient consent to treatment and that the record contain evidence of consent. The Joint Commission states evidence of appropriate informed consent is to be documented in the patient record. The facility’s medical staff and governing board are required to develop policies with regard to informed consent. In addition, the patient record must contain “evidence of informed consent for procedures and treatments for which it is required by the policy on informed consent.” Medicare CoP state that all records must contain written patient consent for treatment and procedures specified by the medical staff, or by federal or state law. In addition, patient records must include documentation of “properly executed informed consent forms for procedures and treatments specified by the medical staff, or by federal or state law if applicable, to require written patient consent.”

**Informed consent** is the process of advising a patient about treatment options and, depending on state laws, the provider may be obligated to disclose a patient’s diagnosis, proposed treatment/surgery, reason for the treatment/surgery, possible complications, likelihood of success, alternative treatment options, and risks if the patient does not undergo treatment/surgery. Informed consent should be carefully documented whenever applicable. An informed consent entry should include an explanation of the risks and benefits of a treatment or procedure, alternatives to the treatment or procedure, and evidence that the patient or appropriate legal surrogate understands and consents to undergo the treatment or procedure.
Your answers to the following questions will assist your Physician and the Medical Center to respect your wishes regarding your medical care. This information will become a part of your patient record.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>PATIENT'S INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Have you been provided with a copy of the information called "Patient Rights Regarding Health Care Decisions"?

2. Have you prepared a "Living Will"? If yes, please provide a copy for your patient record.

3. Have you prepared a "Health Care Proxy"? If yes, please provide a copy for your patient record.

4. Have you prepared a Durable Power of Attorney for Health Care? If yes, please provide a copy for your patient record.

5. Have you provided this facility with an Advance Directive on a prior admission and is it still in effect? If yes, Admitting Office will contact Health Information Department to obtain a copy for your current patient record.

6. Do you wish to execute a Living Will, Health Care Proxy, and/or Durable Power of Attorney? If yes, Admitting Office will notify:
   a. Physician
   b. Social Service
   c. Volunteer Service

ADMITTING OFFICE STAFF: Enter a checkmark when each step has been completed.

1. Verify the above questions where answered and actions taken where required.

2. If the "Patient Rights" information was provided to someone other than the patient, state reason:

   Name of Individual Receiving Information
   Relationship to Patient

3. If information was provided in a language other than English, specify language and method below.

4. Verify patient was advised on how to obtain additional information on Advance Directives.

5. Verify the Patient/Family Member/Legal Representative was asked to provide the Medical Center with a copy of the Advance Directive, which will be retained in the patient record.

6. File this form in the patient record, and give a copy to the patient.

   Name of Patient or Name of Individual giving information, if different from Patient

   Signature of Patient  Date

   Signature of Medical Center Representative  Date

ALFRED STATE MEDICAL CENTER 100 MAIN ST, ALFRED NY 14802 (607) 555-1234

Figure 6-3  Advance Directive Admission Form and Checklist (Courtesy Delmar/Cengage Learning.)
Table 6-3  Advance Directives—Types and Descriptions

<table>
<thead>
<tr>
<th>Advance Directive</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do Not Resuscitate (DNR) Order (Figure 6-4)</td>
<td>• Tells medical professionals not to perform cardiopulmonary resuscitation (CPR), which means that doctors, nurses, and emergency medical personnel will not attempt emergency CPR if the patient’s breathing or heartbeat stops.</td>
</tr>
<tr>
<td></td>
<td>• DNR orders are written for patients in a hospital or nursing home, or for patients at home. Hospital DNR orders tell the medical staff not to revive the patient if cardiac arrest occurs. If the patient is in a nursing home or at home, a DNR order tells the staff and emergency medical personnel not to perform emergency resuscitation and not to transfer the patient to a hospital for CPR.</td>
</tr>
<tr>
<td></td>
<td>• An adult patient may consent to a DNR order through a health care proxy, which allows patients to appoint someone to make decisions about CPR and other treatments if they are unable to decide for themselves.</td>
</tr>
<tr>
<td>Living Will (Figure 6-5)</td>
<td>• Legal document in which patients state the kind of health care they do or do not want under certain circumstances.</td>
</tr>
<tr>
<td></td>
<td>• Written document that informs a health care provider of a patient’s desires regarding life-sustaining treatment.</td>
</tr>
<tr>
<td>Health Care Proxy (or durable power of attorney) (Figure 6-6)</td>
<td>• Legal document in which patients name someone close to them to make decisions about health care in the event they become incapacitated.</td>
</tr>
<tr>
<td>Organ or Tissue Donation (Figure 6-7)</td>
<td>• Persons under 18 years of age must have a parent’s or guardian’s consent.</td>
</tr>
<tr>
<td></td>
<td>• Medical suitability for donation is determined at the time of death.</td>
</tr>
<tr>
<td></td>
<td>• Indicate intent to be an organ and tissue donor on your driver’s license, and inform family members of your intention.</td>
</tr>
</tbody>
</table>

Do Not Resuscitate (DNR) Consent

I, ________________________________, do not authorize resuscitation in the event of cardiac or respiratory arrest. I understand that this order remains in effect until revoked by me. I acknowledge that cardiopulmonary resuscitation (CPR) will not be performed if breathing or heartbeat stops. I understand this decision will not prevent me from obtaining other emergency care by emergency medical services personnel and/or care directed by a physician prior to my death. I understand I may revoke this DNR consent at any time by destroying this consent form.

<table>
<thead>
<tr>
<th>Patient or Legal Representative Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address of Patient</td>
<td></td>
</tr>
<tr>
<td>Attending Physician Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Address of Attending Physician</td>
<td></td>
</tr>
<tr>
<td>Witness Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Address of Witness</td>
<td></td>
</tr>
</tbody>
</table>

Figure 6-4  Do Not Resuscitate (DNR) Advance Directive Consent Form (Courtesy Delmar/Cengage Learning.)
**Consent to Admission**

Upon admission the patient may be asked to sign a *consent to admission* (or *conditions of admission*) (Figure 6-8), which is a generalized consent that documents a patient’s consent to receive medical treatment at the facility.

**NOTE:** The Health Insurance Portability and Accountability Act (HIPAA) privacy rule specifies that facilities are no longer required to consent to admission, but most still obtain the patient’s signed consent. (HIPAA mandates administrative simplification regulations that govern privacy, security, and electronic transactions standards for health care information.)

**Consent to Release Information**

Patient authorization to release information for reimbursement (Figure 6-9) is routinely obtained as part of the consent to admission. Releases of information for other purposes require the patient’s authorized consent to release information.

**NOTE:** The HIPAA privacy rule specifies that facilities are no longer required to consent to release information for the purpose of reimbursement, research, and education, but most still obtain the patient’s signed consent.

**Special Consents**

Health care facilities require separate consents, such as a consent to surgery (Figure 6-10), and consents for diagnostic, therapeutic, and surgical procedures. Prior to the patient undergoing medical or surgical treatment, it is required that written consent be obtained from the patient or representative, which indicates that the patient acknowledges informed consent as to the nature of treatment, risks, complications, alternative forms of treatment available, and the consequences of the treatment or procedure. The surgeon (or other provider, such as radiologist) will discuss the procedure to be performed with the patient. Patients sign special consents, which include the following elements:

- Patient identification
- Proposed care, treatment, and services
- Potential benefits, risks, and side effects, including likelihood of patient achieving goals, and any potential problems that might occur during recuperation

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**LIVING WILL DECLARATION**

![Living Will Declaration](image-url)

My name is _____________________________ and my address is _____________________________, If I am determined by my attending physician to be in a terminal condition or a persistent vegetative state, and I am no longer able to make or communicate decisions regarding my medical treatment, then I direct my attending physician to withhold or withdraw all life-sustaining treatment that is not necessary for my comfort or to alleviate pain; and if there is any conflict at that time between this document and any other document I may have signed previously then this document shall control.

<table>
<thead>
<tr>
<th>My Signature</th>
<th>Date</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

**WITNESSES’ SIGNATURES**

The above named _____________________________, in my presence, voluntarily signed this writing or directed another to sign this writing on his/her behalf.

<table>
<thead>
<tr>
<th>Witness Signature</th>
<th>Date</th>
<th>Witness Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Witness Signature</th>
<th>Date</th>
<th>Witness Address</th>
</tr>
</thead>
</table>
Health Care Proxy

I, __________________________________, hereby appoint ____________________________________ (name)
____________________________________________________ (home address and telephone number)
as my health care agent to make any and all health care decisions for me, except to the extent that I state
otherwise. This proxy shall take effect only when and if I become unable to make my own health care
decisions.

Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall
remain in effect indefinitely. This proxy shall expire ____________________________________________
(specify date and/or conditions)

I direct my health care agent to make health care decisions according to my wishes and limitations, as he
or she knows or as stated below. I direct my health care agent to make health care decisions in
accordance with the following limitations and/or instructions:
__________________________________________________________ (state wishes or limitations above)

Identification
Name __________________________________________________________
Signature __________________________________ Date ____________________
Address ______________________________________________________

Statement by Witnesses
(Witnesses must be 18 years of age or older and cannot be the health care agent.)

I declare that the person who signed this document is personally known to me and appears to be of sound
mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this
document in my presence.

Name of Witness #1 ____________________________________________
Signature of Witness #1 __________________________________ Date ________________
Address of Witness #1 __________________________________________
Name of Witness #2 ____________________________________________
Signature of Witness #2 __________________________________ Date ________________
Address of Witness #2 __________________________________________

Figure 6-6 Health Care Proxy (or Durable Power of Attorney) (Courtesy Delmar/Cengage Learning.)
Organ/Tissue Donor Card

I wish to donate my organs and tissues. I wish to give:

☐ any needed organs and tissues
☐ only the following organs and tissues:

________________________________________
Donor Signature

Date

________________________________________
Witness

________________________________________
Witness

Figure 6-7  Organ/Tissue Donation Card (Reprinted according to OrganDonor.gov Web reuse policy.)

- Reasonable alternatives to proposed care, treatment, and services
- Circumstances under which information about patient must be disclosed or reported (e.g., reportable diseases such as HIV, Tb, viral meningitis)
- Signature of person qualified to give consent and date
- Name of surgeon performing procedure
- Physician/Surgeon signature (per facility policy)
- Witness signature and date

Patient Property Form

The patient property form (Figure 6-11) records items patients bring with them to the hospital. This form is completed and signed by a hospital staff member and also signed by the patient. It is important for the staff member to complete this form correctly as some patients may claim that they arrived at the hospital with items they do not actually possess.

Certificate of Birth

The certificate of birth (or birth certificate) (Figure 6-12) is a record of birth information about the newborn patient and the parents, and it identifies medical information regarding the pregnancy and birth of the newborn. The National Center for Health Statistics (NCHS) developed a standard certificate of birth, which states can adopt for their use. Birth certificate information is submitted to state departments of health or

CONSENT TO ADMISSION

I, ______________________, hereby consent to admission to the Alfred State Medical Center and I further consent to such routine hospital care, diagnostic procedures, and medical treatment which the medical and professional staff of the Alfred State Medical Center may deem necessary or advisable. I authorize the use of medical information obtained about me as specified above and the disclosure of such information to my referring physician(s). This form has been fully explained to me, and I understand its contents. I further understand that no guarantees have been made to me as to the results of treatments or examinations done at the Alfred State Medical Center.

________________________________________
Signature of Patient

________________________________________
Date

________________________________________
Signature of Parent/Legal Guardian for Minor

________________________________________
Date

________________________________________
Relationship to Minor

WITNESS: Alfred State Medical Center Staff Member

________________________________________
Date

Figure 6-8  Consent to Admission (Courtesy Delmar/Cengage Learning.)
offices of vital statistics (or records, depending on state title), usually within 10 days of birth. State policies and procedures for birth certificates vary, and some states require electronic submission of birth certificate information. Other states do not require electronic submission because they require that a physician sign the certificate. Birth certificate contents include:

- Infant’s and parents’ demographic information
- Parents’ occupation, education, ethnicity, race
- Pregnancy information
- Medical risk factors, complications, and/or abnormal conditions of newborn

NOTE: Some states do not allow a copy of the birth certificate to be filed in the patient record. However, they usually allow the worksheet used to collect birth certificate data to be filed in the record.

Certificate of Death
The certificate of death (or death certificate) (Figure 6-13) contains a record of information regarding the decedent, his or her family, cause of death, and the disposition of the body. The National Center for Heath Statistics (NCHS) also developed a standard certificate of death, which states can adopt for their use. The death certificate, signed by a physician, is filed with the state department of health’s office of vital statistics (or records, depending on the title of the state agency), usually with five days. While each state develops its own death certificate, in general it contains the following information:

- Name of deceased
- Deceased’s date and place of birth
- Usual residence of deceased at time of death
- Cause of death
- Deceased’s place of burial
- Names and birth places of both parents
- Name of informant (usually a relative)
- Name of doctor
- Method and place of disposition of body
- Signature of funeral director
- Signature of certifying physician
### CONSENT TO OPERATION OR PROCEDURE

I ___________ (patient or guardian), hereby authorize Dr. ___________ or his/her designee and such other physicians, medical residents, physicians-in-training or other persons as are needed to assist him/her to perform ___________ (operation/procedure). I understand the reason for the procedure is ___________.

Alternatives to performing this procedure include ___________.

**RISKS:** This authorization is given with the understanding that any operation or procedure involves some risks and hazards. The more common risks include infection, bleeding (including severe loss of blood requiring a blood transfusion), nerve injury, blood clots, heart attack, allergic reactions and pneumonia. These are not all the possible risks associated with this procedure, but these risks can be serious and possibly fatal. Some significant and substantial risks of this particular operation or procedure include ___________.

**ANESTHESIA:** I understand the act of delivering intravenous sedation and analgesia has benefits of relief and protection from pain, but carries no guarantees. Intravenous sedation also involves risks including infection or bleeding from needle sticks, damage to vessels and nerves (including paralysis), pneumonia, seizures, heart attack, stroke, adverse reaction (allergic reaction) and death. I consent to the use of such anesthetics as may be considered necessary by the person responsible for these services.

**ADDITIONAL PROCEDURES:** If my physician discovers a different, unsuspected condition at the time of surgery, I authorize him/her to perform such treatment, as he/she deems necessary.

**PHOTOGRAPHY:** I consent to the photographing of operations performed, including appropriate portions of my body for medical, scientific or educational purposes, providing my identity is not revealed by the pictures or by the descriptive texts accompanying them.

**TISSUE DISPOSAL:** I consent to the examination and disposal by hospital authorities of any tissues or body parts that may be removed.

**SOCIAL SECURITY NUMBER:** I authorize the disclosure of my social security number to the manufacturer of a medical device implanted during this procedure and for which tracking is required by the FDA under the Safe Medical Devices Act. Documenting the social security number (SSN) in a consent form links documentation to a patient. The use of the SSN as a patient identifier has been discontinued in most facilities.

**BLOOD TRANSFUSIONS:** It has been explained to me that I may need a blood transfusion to promote recovery, stabilize my condition or save my life. I understand in general what a transfusion is, the procedures that will be used and that there is a small but definite risk of potentially serious infectious disease transmission and/or other reactions, including, but not limited to, hepatitis, acquired immune deficiency syndrome (AIDS), fever, chills, hives, the destruction of transfused cells, immunization, bacterial infections or rarely death. I understand steps to safeguard the blood supply include: volunteer donations, donor questioning about health history/risk factors and testing blood, although no process or testing is 100% reliable. My physician will decide the amount and type of blood product needed based on my particular needs. Options/alternatives to receiving blood from the community supply for elective transfusions include autologous donation (pre-donation of my own blood), directed donation (blood donated by my family/friends), autotransfusion (my own blood lost during surgery, processed and rein infused). Benefits/risks of transfusion and the consequences of refusal that include seriously jeopardizing my health or resulting in death have been explained to me by my physician.

__________ (initials) I consent to a blood transfusion if my physician determines it is needed.

__________ (initials) I DO NOT consent to a blood transfusion and I assume all risks and hazards that may occur due to this refusal to consent.

**NO GUARANTEE:** I understand that no guarantee or assurance has been made as to the results of the procedure and it may not cure the condition.

**PATIENT’S CONSENT:** I have read and fully understand this consent form. I understand I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction, or if I do not understand any of the terms or words contained in this consent form. I understand that I can withdraw this consent to the operation/procedure at any time before the beginning of the procedure/operation. Do NOT sign unless you have read and thoroughly understand this form.

<table>
<thead>
<tr>
<th>Patient/Responsible Party Signature (state relationship)</th>
<th>Date/Time</th>
<th>Witness Signature</th>
</tr>
</thead>
</table>

**PHYSICIAN DECLARATION:** I have explained to the patient/patient’s representative the procedure/operation and the risks, benefits, recuperation and alternatives (including the probable or likely consequences if no treatment is pursued). I have answered all of the patient’s questions and to the best of my knowledge, I believe the patient has been adequately informed.

Physician Signature

---

**Figure 6-10  Consent to Surgery (Courtesy Delmar/Cengage Learning.)**
Content of the Patient Record: Inpatient, Outpatient, and Physician Office

PATIENT PROPERTY RECORD

I understand that while the facility will be responsible for items deposited in the safe, I must be responsible for all items retained by me at the bedside. (Dentures kept at the bedside will be labeled, but the facility cannot assure responsibility for them.) I also recognize that the hospital cannot be held responsible for items brought in to me after this form has been completed and signed.

Signature of Patient ___________________________ Date __________

Signature of Witness ___________________________ Date __________

I have no money or valuables that I wish to deposit for safekeeping. I do not hold the facility responsible for any other money or valuables that I am retaining or will have brought in to me. I have been advised that it is recommended that I retain no more than $5.00 at the bedside.

Signature of Patient ___________________________ Date __________

Signature of Witness ___________________________ Date __________

I have deposited valuables in the facility safe. The envelope number is ____________________.

Signature of Patient ___________________________ Date __________

Signature of Person Accepting Property __________ Date __________

I understand that medications I have brought to the facility will be handled as recommended by my physician. This may include storage, disposal, or administration.

Signature of Patient ___________________________ Date __________

Signature of Witness ___________________________ Date __________

ALFRED STATE MEDICAL CENTER ■ 100 MAIN ST, ALFRED NY 14802 ■ (607) 555-1234

Figure 6-11  Patient Property Record (Courtesy Delmar/Cengage Learning.)
Exercise 6–2  Hospital Inpatient Record—Administrative Data

Matching: For each data element, state whether it represents clinical (C), financial (F), or patient identification (I).

1. First-listed diagnosis
2. Patient name
3. Insurance policy number
4. Patient medical record number
5. Admitting diagnosis
6. Patient address

True/False: Indicate whether each statement is True (T) or False (F).

7. A health care proxy is a legal document a patient uses to name someone to make health care decisions in the event the patient becomes incapacitated.

8. A death certificate, signed by a physician, is filed with the National Center for Health Statistics, usually within five days.

9. The identification and financial sections of the face sheet are completed by the admitting nurse when the patient arrives on the nursing unit.

10. The National Center for Health Statistics (NCHS) has developed a standard certificate of birth that states must adopt for their use.

11. Upon admission, all patient records must contain documentation as to whether an individual has executed an advance directive.

HOSPITAL INPATIENT RECORD—CLINICAL DATA

Clinical data includes all health care information obtained about a patient’s care and treatment, which is documented on numerous forms in the patient record.
**Figure 6-13  Standard Death Certificate (Reprinted according to HHS Content Reuse Policy)**
For inpatients, the first clinical data item is the admitting diagnosis that is entered on the face sheet. Sometimes, a patient is admitted through the emergency department (ED), and the first clinical data item is the chief complaint recorded as part of the ED record.

**Emergency Record**

The Joint Commission standards outline the following documentation requirements in the emergency room record: time and means of arrival, whether the patient left against medical advice (AMA), and conclusion at termination of treatment, including final disposition, condition at discharge, and instructions for follow-up. The Joint Commission standards require that pertinent inpatient and ambulatory care patient records (including emergency records) be made available upon request by the attending physician or other authorized individuals. The emergency record is to be authenticated by the practitioner responsible for its clinical accuracy. To ensure continuity of care, The Joint Commission standards also state that a copy of the emergency record should be sent to the provider who administers follow-up care (if authorized by the patient or legal representative).

The emergency record (Figure 6-14A) documents the evaluation and treatment of patients seen in the facility’s emergency department (ED) for immediate attention of urgent medical conditions or traumatic injuries. The record includes documentation of the immediate assessment and treatment of patients, reason for the patient’s disposition (whether admitted, discharged, or transferred), and a copy of the discharge instructions provided to the patient (Figure 6-14B). Some patients are transported to the ED via ambulance, and an ambulance report (Figure 6-15) is generated by emergency medical technicians (EMTs) to document clinical information such as vital signs, level of consciousness, appearance of the patient, and so on. A copy of the ambulance report is placed on the ED record. (The original ambulance report is the property of the ambulance company.)

**Anti-dumping legislation** (Emergency Medical Treatment and Labor Act, EMTALA) prevents facilities licensed to provide emergency services from transferring patients who are unable to pay to other institutions, and it requires that a patient’s condition must be stabilized prior to transfer (unless the patient requests transfer).

**EXAMPLE 1:**

A woman in active labor cannot be transferred to another facility due to inability to pay for care.

**EXAMPLE 2:**

If permanent disability or death would result from delayed treatment, a patient cannot be transferred to another facility due to inability to pay.

Contents of an emergency record include:

- Patient identification
- Time and means of arrival at the emergency department

**EXAMPLE**

Patient transported via ambulance.

- Pertinent history of illness or injury

**EXAMPLE**

Patient pulled foley catheter out at nursing home. He was unable to void the next morning and started running a very high fever (105 degrees). He was brought to the ED for evaluation.

- Physical findings, including vital signs

**EXAMPLE**

Skin warm and moist. Fever of 104.9 degrees at present. Color pale. Pulse 112. Respirations 32. BP 110/50.

- Emergency care provided prior to arrival

**EXAMPLE**

Patient received IV D5NSS 200 cc/hr. Kefzol 1 gram IV stat.

- Diagnostic and therapeutic orders

**EXAMPLE**

Chest X-rays. CBC. Foley catheter insertion. Urinalysis. Electrolytes. BUN.

- Clinical observations, including results of treatment

**EXAMPLE**

Foley catheter insertion attempted, which failed. Consult with Dr. Bellinger who was able to insert Foley without significant difficulty. Dr. Bellinger evaluated the patient and did not feel further treatment was necessary.

- Reports of procedures, tests, and results
**Content of the Patient Record: Inpatient, Outpatient, and Physician Office**

**Alfred State Medical Center**

**Emergency Department Record**

<table>
<thead>
<tr>
<th>FIELD</th>
<th>CONTENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DATE</strong></td>
<td>TIME IN</td>
</tr>
<tr>
<td><strong>PATIENT ADDRESS</strong></td>
<td>STREET, CITY, STATE, ZIP CODE</td>
</tr>
<tr>
<td><strong>NEXT OF KIN</strong></td>
<td>ADDRESS</td>
</tr>
<tr>
<td><strong>NEXT OF KIN PHONE #</strong></td>
<td></td>
</tr>
<tr>
<td><strong>REFERRING PHYSICIAN</strong></td>
<td><strong>PRIMARY PAYER</strong></td>
</tr>
<tr>
<td><strong>SECONDARY PAYER</strong></td>
<td><strong>POLICY #</strong></td>
</tr>
<tr>
<td><strong>LAST HOSPITAL DISCHARGE</strong></td>
<td><strong>BP</strong></td>
</tr>
<tr>
<td><strong>R</strong></td>
<td><strong>T, P, O2MNR</strong></td>
</tr>
</tbody>
</table>

**CHIEF COMPLAINT:**

- CARDIAC MONITOR
- GLUCOSE
- N/G/G
- FOLEY
- O2 SAT
- O2
- IV/IVSAI
- IV FLUID
- SOCIAL WORKER
- NA
- CL
- CO2
- BUN
- CR
- MG
- PHOS
- CK
- TROPONIN
- AMY
- BIJ
- LIPASE
- LFTs
- PT/PTT
- INR
- HCG URINE
- ETOH
- TRAUMA LAB
- T&S
- ANKLE L/R
- T&C x __ UNITS
- HIPP/PELVIS L/R
- pH
- CT HEAD
- CT ABDOMEN
- G-SPINE
- L-SPINE
- T-SPINE
- TRAUMA SERIES
- ULTRASOUND
- OTHER

**LAB TESTS**

- WBC
- HGB
- HCT
- PLTS
- DIFF
- GLU
- K
- CO2
- BUN
- CR
- MG
- PHOS
- CK
- TROPONIN
- AMY
- BIJ
- LIPASE
- LFTs
- PT/PTT
- INR
- HCG URINE
- ETOH
- TRAUMA LAB
- T&S
- ANKLE L/R
- T&C x __ UNITS
- HIPP/PELVIS L/R
- pH
- CT HEAD
- CT ABDOMEN
- G-SPINE
- L-SPINE
- T-SPINE
- TRAUMA SERIES
- ULTRASOUND
- OTHER

**MEDICATIONS / DIAGNOSTIC / TREATMENT ORDERS**

<table>
<thead>
<tr>
<th>TIME</th>
<th>ORDER</th>
<th>ORDERED BY</th>
<th>TIME / GIVEN BY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**X-RAYS ORDERED**

- CHEST
- ABDOMEN
- WRIST L/R
- HAND L/R
- FOOT L/R
- ANKLE L/R
- HIP/PELVIS L/R
- CT HEAD
- CT ABDOMEN
- G-SPINE
- L-SPINE
- T-SPINE
- TRAUMA SERIES
- ULTRASOUND
- OTHER

**ECG & X-RAY RESULTS:**

- ECG

**DISCHARGE DIAGNOSES & PLAN**

1. 
2. 
3. 

**PRIMARY PHYSICIAN NAME**

<table>
<thead>
<tr>
<th>FOLLOW-UP</th>
<th>CONTACTED</th>
<th>TIME OF DISCHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**DIAGNOSES**

- HOME
- JAIL
- NSG FAC
- AMA

**CONDITION ON DISCHARGE:**

- IMPROVED
- STABLE
- GUARDED
- EXPIRED

**TRANSFER**

- HOSPITAL
- REHAB
- PSYCH

**TIME CALLED**

<table>
<thead>
<tr>
<th>TIME CALLED</th>
<th>TIME ARRIVED</th>
<th>TIME ADDED/PROCESSED</th>
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<tbody>
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</table>

**CONSULTING PHYSICIAN**

<table>
<thead>
<tr>
<th>CONSULTING PHYSICIAN</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**ADMIT SERVICE**

- MONITOR
- YES
- NO

**ADMITTING PHYSICIAN**

<table>
<thead>
<tr>
<th>INPATIENT UNIT</th>
<th>TIME ADDED/PROCESSED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

**EMERGENCY DEPARTMENT PHYSICIAN**

<table>
<thead>
<tr>
<th>EMERGENCY DEPARTMENT PHYSICIAN</th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
</tbody>
</table>

**Figure 6-14A**  Emergency Department Record (Courtesy Delmar/Cengage Learning.)
EXAMPLE

Chest X-ray negative. CBC revealed WBC 10.6, Hgb 12.3, Hct 36.3. UA revealed 3+/H11001 WBC and 3+/H11001 gram negative rods. Blood chemistry test revealed bilirubin (direct) 1.1, bilirubin (total) 1.8, and albumin 5.6. BUN negative.

• Diagnostic impression

EXAMPLE

Diagnosis: Urinary tract infection

• Conclusion at termination of evaluation/treatment, including final disposition, patient’s condition, instructions given to the patient, and physician’s signature

EXAMPLE

Patient admitted to hospital for treatment (Kefzol 1 gram every 6 hours).

• Evidence of a patient leaving against medical advice (e.g., signed AMA form and physician documentation in progress notes)

NOTE: An appropriate filing system must be established for storage of emergency records and, when appropriate, emergency records are to be combined with inpatient and outpatient records.

Discharge Summary

The Joint Commission standards require that the discharge summary be completed by the attending physician to facilitate continuity of care. A final progress note can be documented instead of a discharge summary if a patient is treated for minor problems or interventions, as defined by the medical staff (short stay). When a patient is transferred to a different level of care within the same hospital, the discharge summary is called a transfer summary, which can be documented in the progress notes if
The Joint Commission also requires that “the use of approved discharge criteria to determine the patient’s readiness for discharge” (e.g., decreased dependency on oxygen, discharge planning, transition of patient from intravenous to oral medications, and so on) be documented in the record. (Many facilities use utilization management criteria, such as McKesson Interqual products, for this purpose. Facilities also develop criteria, which is used to discharge patients from specialty units [e.g., intensive care unit] and departments [e.g., anesthesia department].) Medicare CoP state that all records must document a discharge summary which includes the outcome of hospitalization, disposition of the case, and follow-up provisions.

The discharge summary (or clinical résumé) (Figure 6-16) provides information for continuity of care and facilitates medical staff committee review; it can also be used to respond to requests from authorized individuals or agencies (e.g., a copy of the discharge summary will suffice instead of the entire patient record). The discharge summary documents the patient’s hospitalization, including reason(s) for hospitalization; procedures performed; care, treatment, and services provided; patient’s condition at discharge; and information provided to the patient and family. The discharge summary must fully and accurately describe the patient’s condition at the time of discharge, patient education when applicable, including instructions for self-care, and that the patient/responsible party demonstrated an understanding of the self-care regimen. Contents of a discharge summary include:

- Patient and facility identification
- Admission and discharge dates
- Reason for hospitalization (brief clinical statement of chief complaint and history of present illness, HPI)
Figure 6-16  Discharge Summary (Permission to reprint in accordance with va.gov Web reuse policy.)
Patient was admitted with long-term ulcer on dorsum of left foot that has not improved, and in fact is getting worse. He was given intensive medication as an outpatient but the foot became more swollen and red, and he is admitted at this time for more intensive therapy.

- Principal/secondary diagnoses and principal/secondary procedures, including results and dates (all relevant diagnoses and operative procedures should be recorded using acceptable disease and operative terminology that includes topography and etiology as appropriate)

**EXAMPLE**

Principal diagnosis: Cellulitis and gangrene, left foot and lower leg.


Principal procedure: Amputation, left leg, above knee.

Secondary procedures: Suprapubic cystostomy with permanent suprapubic drainage.

- Significant findings, including pertinent laboratory, X-ray, and pathological findings—negative results may be as pertinent as positive

**EXAMPLE**

Blood culture revealed *staph aureus coagulase* positive septicemia. EKG revealed left bundle branch block and myocardial changes similar to previous tracings. Chest X-ray showed no active pulmonary disease, and heart was normal size. Lower leg specimen showed severe atherosclerosis with focal thrombosis, gangrene of the foot with extensive dissection of acute inflammatory exudates into the lower leg between the fascial planes. Sugars came under good control. Urinalysis showed evidence of the bleeding and minimal infection.

- Treatment provided (medical and surgical), and patient’s response to treatment, including any complications and consultations

**EXAMPLE**

Patient was placed on insulin to control new onset of diabetes. His diabetes is well controlled with insulin, but his bladder condition did not improve. He underwent suprapubic cystostomy, and following this began to improve. His temperature finally dropped to a reasonable level, and he is eating well. He remains uncommunicative, as he had been for several years. He was treated with IV Vancomycin and following surgery placed on Gentamicin and IV Vibramycin.

- Condition on discharge, as stated in specific measurable terms relative to condition on admission, avoiding use of vague terms such as improved (in addition, presence and status of drains, wounds, and sutures should be noted)

**EXAMPLE**

Patient’s medications were effective in controlling his infection. He is transferred to the nursing facility for continued care. His leg stump sutures will be removed as able, probably in about two weeks.

- Instructions to patient and/or family (relative to physical activity, medication, diet, and follow-up care)

**EXAMPLE**

Patient will continue his insulin dosage and be followed at the nursing facility as necessary. Discharge instructions, including medications, diet, physical activities, and plans for follow-up care, were discussed with the primary care nurse at the nursing facility.

- Authentication by attending physician

**History and Physical Examination**

The Joint Commission standards and Medicare CoP state the history and physical examination must be performed and documented in the patient record within 24 hours after admission (including weekends and holidays) or if a history and physical examination (H&PE) was completed within 30 days prior to admission and reviewed and updated, it can be placed on the record within 24 hours after admission. This means the patient must either have undergone no changes subsequent to the original examination or the changes must be documented upon admission. When the history and physical cannot be placed on the record within the required time frame due to a transcription delay, the physician can document a handwritten note containing pertinent findings, (e.g., enough information to manage and guide patient care). (If a patient is scheduled for surgery prior to these deadlines, a complete history and physical must be documented.)
Usually the history and physical examination is prepared as one handwritten or transcribed report, which assists the physician in establishing a diagnosis on which to base treatment and serves as a reference for future illnesses. The history (Figure 6-17) documents the patient’s chief complaint, history of present illness (HPI), past/family/social history (PFSH), and review of systems (ROS) (Table 6-4). The individual responsible for documenting the history should obtain the information directly from the patient and should document only the facts regarding the patient’s case. The source of the history should also be documented, especially when the individual providing the information is someone other than the patient.

**NOTE:** Although the history might be documented by someone other than the attending physician (e.g., intern or resident), the attending
<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chief Complaint (CC)</strong></td>
<td>Patient’s description of medical condition, stated in the patient’s own words. <strong>EXAMPLE:</strong> Chief Complaint: “My knee gives out” and “my knee hurts when I walk.” (Patient is scheduled for arthroscopy, knee.)</td>
</tr>
<tr>
<td><strong>History of Present Illness (HPI)</strong></td>
<td>Chronological description of patient’s present condition from time of onset to present. HPI should include location, quality, severity, duration of the condition, and associated signs and symptoms. <strong>EXAMPLE:</strong> HPI: Patient presents for arthroscopy, left knee. Probable torn cartilage. Knee is very bruised. Patient complains of pain, which started one week ago. Patient denies injury.</td>
</tr>
<tr>
<td><strong>Past History</strong></td>
<td>Summary of past illnesses, operations, injuries, treatments, and known allergies. <strong>EXAMPLE:</strong> Past History: Reveals a healthy individual who has been hospitalized in the past x3 for childbirth; the patient has NKA, no history of diseases, and is not currently on any medications. <strong>NOTE:</strong> NKA means “no known allergies.”</td>
</tr>
<tr>
<td><strong>Family History</strong></td>
<td>A review of the medical events in the patient’s family, including diseases that may be hereditary or present a risk to the patient. <strong>EXAMPLE:</strong> Family History: Patient states that father died at age 51 of heart disease, and mother is living and well.</td>
</tr>
<tr>
<td><strong>Social History</strong></td>
<td>An age-appropriate review of past and current activities such as daily routine, dietary habits, exercise routine, marital status, occupation, sleeping patterns, smoking, use of alcohol and other drugs, sexual activities, and so on. <strong>EXAMPLE:</strong> Social History: Patient has history of marijuana use as a teenager and currently drinks alcohol socially; previous history of smoking cigarettes (quit three years ago).</td>
</tr>
<tr>
<td><strong>Medications</strong></td>
<td>A listing of current medications and dosages. <strong>EXAMPLE:</strong> Medications: Zocor, 40 mg qd.</td>
</tr>
<tr>
<td><strong>Review of Systems (ROS)</strong></td>
<td>Inventory by systems to document subjective symptoms stated by the patient. Provides an opportunity to gather information that the patient may have forgotten to mention or that may have seemed unimportant. <strong>NOTE:</strong> Providers should not document negative or normal in response to ROS items. Instead, document a statement relative to the item. <strong>EXAMPLE:</strong> Respiratory: The patient denies shortness of breath.</td>
</tr>
</tbody>
</table>
physician is responsible for authenticating the report generated. An interval history documents a patient’s history of present illness and any pertinent changes and physical findings that occurred since a previous inpatient admission if the patient is readmitted within 30 days after discharge for the same condition. The original history and physical examination must also be made available to the attending physician (e.g., a copy filed on the current inpatient chart or the previous discharged patient record available on the unit).

EXAMPLE

Patient is discharged from the hospital with the diagnosis of acute asthmatic bronchitis. Within 30 days, the patient is readmitted for the same condition. In this situation, it would be appropriate for the attending physician to document an interval note that specifies the patient’s present complaint, pertinent changes, and physical findings since the last admission.

After the history is completed, the physician performs a physical examination (Figure 6-18), which is an assessment of the patient’s body systems (Table 6-5), to assist in determining a diagnosis, documenting a provisional diagnosis, and which may include differential diagnoses. A differential diagnosis indicates that several diagnoses are being considered as possible. The physician also summarizes results of pre-admission testing (PAT) (e.g., blood tests, urinalysis, ECG, X-rays, and so on). (PAT results are filed in the patient’s record.)

EXAMPLE

Patient is admitted to the hospital with complaints of severe pain in the pelvis region. The physician documents the following differential diagnoses: Possible endometriosis. Possible adhesions.

NOTE: While the history and physical examination is the responsibility of the attending physician, it is appropriate for house staff to perform the history and physical examination and dictate the report. The house staff member signs the report, and the attending physician reviews the report to be sure it is completed. The attending physician is responsible for documenting additional pertinent findings and authenticating the report.

Consultation Report

The Joint Commission standards state that medical records shall contain documentation of consultation reports.

A consultation (Figure 6-19) is the provision of health care services by a consulting physician whose opinion or advice is requested by another physician. (Once a patient is admitted to the hospital, the attending physician is responsible for requesting consultations.) A consultation report is documented by the consultant and includes the consultant’s opinion and findings based on a physical examination and review of patient records. The attending physician generally requests a consulting physician (e.g., specialist) to provide evaluation and, possibly, treatment of a patient. Occasionally, a general surgeon will request a general practitioner to evaluate a patient prior to surgery to determine medical risks, if any. To initiate a consultation, the attending physician:

- Documents a physician order requesting consultation with a particular doctor
- Documents a progress note that outlines the reason for consultation
- Contacts the consulting physician to discuss the patient’s case and to agree to the consultant’s role in patient care, if any

NOTE: The consulting physician may participate in patient care with the attending physician or even take over patient care and become the patient’s attending physician.

As part of the consultation process, the consulting physician:

- Reviews the patient’s record
- Examines the patient
- Documents pertinent findings
- Provides recommendations and/or opinions

Physician Orders

The Joint Commission standards require medical records to contain diagnostic and therapeutic orders and verbal orders (e.g., telephone orders) to be authenticated by the responsible physician within a time frame specified by the facility (based on state laws, if applicable). In 2004, The Joint Commission added a standard that each medication ordered be supported by a documented diagnosis, condition, or indication-for-use. (Facilities may require physicians to document either the indication for usage, such as a diagnosis, for each medication ordered. This standard also serves to facilitate patient safety because it is less likely that a medication will be misinterpreted as written [e.g., physician mistakenly documents “Paclitaxel for anxiety,” nurse questions the order,
**Figure 6-18**  Physical Examination Report (Copyright © Courtesy of Bibbero Systems, Inc., Petaluma, CA. Phone: 800-242-2376; Fax: 800-242-9330; www.bibbero.com.)
Figure 6-18 Physical Examination Report (Continued)
<table>
<thead>
<tr>
<th>Element</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Survey</td>
<td>Reveals well-developed, somewhat obese, elderly, white male in severe distress with severe substernal discomfort and pain in upper arms. Conscious. Alert. Appears to be stated age. No deformity. Patient cannot sit or stand still because he is in such agony. Gait affected only by pain; otherwise it is normal. Carriage normal. Age 67. Sex male. Height 5’11” Weight 188 lbs. Temperature 98.0°F orally. Pulse 56 and regular. Blood pressure 150/104.</td>
</tr>
<tr>
<td>Skin</td>
<td>Reveals pale, cool, moist surface with no cyanosis or jaundice. No eruption. No tumors.</td>
</tr>
<tr>
<td>Head</td>
<td>Hair, scalp, skull within normal limits. Facies anxious.</td>
</tr>
<tr>
<td>Ears</td>
<td>Examination reveals grossly intact hearing. No lateralization. External canals and ears, and left membrana tympanica clear. No tumor.</td>
</tr>
<tr>
<td>Mouth</td>
<td>Mouth edentulous. Lips, gums, buccal mucosa, and tongue within normal limits.</td>
</tr>
<tr>
<td>Throat</td>
<td>Examination reveals posterior oropharynx and tonsils to be very red and inflamed. Palate and uvula benign. Larynx not visualized.</td>
</tr>
<tr>
<td>Neck</td>
<td>Reveals cervical structures to be supple with no masses, scars, or abnormal glands or pulsations.</td>
</tr>
<tr>
<td>Chest</td>
<td>Chest inspection reveals it to have normal expansion. Thorax observation reveals it to be somewhat obese but with normal shape and symmetry without swellings or tumors or significant lymphadenopathy. Respiratory motions normal. Palpable tactile fremitus physiologically normal.</td>
</tr>
<tr>
<td>Breasts</td>
<td>Felt to be symmetrical and without masses or tenderness. Nipples normal. No axillary lymphadenopathy.</td>
</tr>
<tr>
<td>Lungs</td>
<td>Investigation reveals lungs clear on inspection, palpation, percussion, and auscultation.</td>
</tr>
<tr>
<td>Heart</td>
<td>Examination reveals heart to be indicated as normal since the area of cardiac dullness is normal in size, shape, and location. Heart rate slow. Rhythm regular. No accentuation of A2 and P2.</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Appearance is slightly obese with no striae. Has a well-healed herniorrhaphy scar on the right inguinal area. No tenderness, guarding, rigidity, or rebound phenomena. No abnormal abdominal masses palpable. No organomegaly. No distention. No herniae. Bowel sounds are normal.</td>
</tr>
<tr>
<td>Genitalia</td>
<td>Reveals male type and circumcised penis. Scrotum, testes, and epididymes appear to be normal in size, shape, and color without skin lesions or tumors.</td>
</tr>
<tr>
<td>Rectal</td>
<td>Inspection proves sphincter tone good. Lumen clear. Hemorrhoids, internal and external, found on examination.</td>
</tr>
<tr>
<td>Extremities</td>
<td>Examination reveals no loss of motor function of the extremities or back. Patient can sit, stand, squat, and walk although it causes excruciating pain and this is in the substernal chest area. Patient advised to avoid doing these things. No evidence of injury. No paralysis. Patient squirms and moves constantly in his agony. He cannot sit long nor can he stand in one position. Extremities exam reveals them to be intact. Shoulder girdle inspection reveals no tenderness, muscle spasms, or abnormality or motion. No crepititation. Examination of the back reveals a slight infected and tender pilonidal cyst over the sacrum. No deformity or limitation of motion of the back noted. No other tenderness. Arms, hands, legs, and feet investigation reveals no deformity, fracture, dislocations, injury, tremors, atrophic muscles, swelling, tenderness, muscle spasms, or abnormality of motion.</td>
</tr>
<tr>
<td>Lymphatics</td>
<td>System check reveals lymph glands to be normal throughout.</td>
</tr>
<tr>
<td>Blood Vessels</td>
<td>Investigation reveals veins to be normal. Arteries are arteriosclerotic and all peripheral pulses are palpable and undiminished.</td>
</tr>
<tr>
<td>Neurological</td>
<td>System review reveals the patient generally conscious, cooperative, mentally alert, and reasonably intelligent, although he seems to be somewhat confused. Cranial nerves intact. Superficial and deep tendon reflexes intact and equal bilaterally. No pathological reflexes. No abnormality of the sensory perception or of the associated movements, or of the autonomic or endocrine systems felt to be due to neurological disorder.</td>
</tr>
</tbody>
</table>
Figure 6-19  Consultation Report  (Copyright © Courtesy of Bibbero Systems, Inc., Petaluma, CA. Phone: 800-242-2376; Fax: 800-242-9330; www.bibbero.com.)
and physician amends it documenting “Paxil for anxiety.”). Medicare CoP state that all physician order entries must be legible, complete, authenticated (name and discipline), dated, and timed promptly by the prescribing practitioner in electronic or written form. If permitted by facility bylaws (policies), it is also acceptable for another practitioner responsible for the care of the patient to authenticate the order, even if the order did not originate with that practitioner.

Physician orders (or doctors orders) (Table 6-6) (Figure 6-20A) direct the diagnostic and therapeutic patient care activities (e.g., medications and dosages, frequency of dressing changes, and so on). They should be:

- Clear and complete
- Legible, if handwritten
- Dated and timed
- Authenticated by the responsible physician

Computerized physician order entry (CPOE) uses a computer network to communicate physician (and other qualified provider) instructions for patient care to the health care facility staff (e.g., nurses, physical therapists, consulting physicians) and the departments (e.g., pharmacy, laboratory, radiology) responsible for carrying out the orders. CPOE improves patient safety by eliminating the need for nursing, unit clerk, or ancillary staff to transcribe handwritten or verbal orders.

NOTE: Think of physician orders as prescriptions for care while the patient is an inpatient. When a patient visits the physician in the office, the doctor often “prescribes” a medication or lab test. In the hospital, the physician documents numerous such “prescriptions” as physician orders.

EXAMPLE

Adam is treated in the emergency room (ER) due to trauma sustained from an automobile accident. The ER physician evaluates Adam and starts immediate treatment due to severity of injuries. He dictates a series of orders to the registered nurse, who records them in the patient’s ER record. The ER physician authenticates the verbal order after Adam is transferred to the intensive care unit.

Progress Notes

Progress notes (Figure 6-21) contain statements related to the course of the patient’s illness, response to treatment, and status at discharge. They also facilitate health care team members’ communication because progress notes provide a chronological picture and analysis of the patient’s clinical course—they document continuity of care, which is crucial to quality care. As a minimum, progress notes should include an admission note, follow-up notes, and a discharge note (Table 6-7); the frequency of documenting progress notes is based on the patient’s condition (e.g., once per day to three or more times per day). Progress notes are usually organized in the record according to discipline (e.g., each discipline, such as physical therapy, has its own section of progress notes). Some facilities adopt integrated progress notes, which means all progress notes documented by physicians, nurses, physical therapists, occupational therapists, and other professional staff members are organized in the same section of the record. Integrated progress notes allow the patient’s course of treatment to be easily followed because a chronological “picture” of patient information is presented. Facilities also allow physicians and other staff to dictate progress notes, which are later transcribed by medical transcriptionists and placed on the patient’s record. While convenient for physicians and others, a delay in transcribing dictated notes could delay patient care. Facilities that allow the dictation of progress notes should adopt electronic authentication procedures to avoid placing another document on the patient’s record that requires signatures.

NOTE: Progress notes must be documented in a timely, accurate, and legible manner—there is no standard or regulation that specifies how often notes are to be documented except that they are to be documented as the patient’s condition warrants. This means that a patient admitted to an intensive care unit will have proportionately more progress notes documented on the chart than a patient admitted for an uncomplicated elective surgery. In addition, to being dated, timed, and authenticated, progress notes must document that adequate treatment was rendered to justify the patient’s length of stay; thus, progress notes indicate that a patient’s care required intervention by a physician and professional personnel.

EXAMPLE 1:

Sarah has a postoperative temperature of 101 and is vomiting. The nursing staff monitors her condition continually and documents multiple progress notes (e.g., nurses notes) for each shift, including date, time, and authentication for each note.
### Table 6-6  Physician Orders

<table>
<thead>
<tr>
<th>Type of Order</th>
<th>Description</th>
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| **Discharge Order**     | The final physician order documented to release a patient from a facility.  
                          **NOTE:** Patients who sign themselves out of a facility do so **against medical advice (AMA)**, and they sign a release from responsibility for discharge that includes the following language:  
                          I hereby request my discharge from this hospital against the advice of its medical staff. It has been explained to me that my present condition is such as to require further hospitalization and that I leave the hospital at my own risk. I hereby release the hospital and its staff from all responsibility for any consequences of this act.  
                          **NOTE:** The Joint Commission requires facilities to implement medication reconciliation procedures as a patient safety measure. Reconciling medications across the continuum of care involves obtaining a medication history from the patient, prescribing medications based upon review of the medication history, and comparing prescribed admission medications to those on the medication history, resolving any discrepancies. The medication reconciliation process continues upon discharge and transfer of the patient, and the complete list of patient medications is shared with the next provider of patient care and the patient's primary care physician. |
| **Routine Order**       | Physician orders preapproved by the medical staff, which are preprinted and placed on a patient’s record (e.g., standard admitting orders for a surgical patient, discharge orders following surgery, and so on). |
| **Standing Order (Figure 6-20B)** | Physician orders preapproved by the medical staff (preprinted and placed on the patient's record), which direct the continual administration of specific activities (e.g., medications) for a specific period of time as a part of diagnostic or therapeutic care. |
| **Stop Order (or Automatic Stop Order)** | As a patient safety mechanism, state law mandates, and in the absence of state law facilities decide, for which circumstances preapproved standing physician orders are automatically discontinued (stopped), requiring the physician to document a new order (e.g., 72 hours after narcotics are ordered, they are automatically stopped). |
| **Telephone Order (T.O.)** | A verbal order dictated via telephone to an authorized facility staff member. Facilities should establish a **telephone order call back policy**, which requires the authorized staff member to read back and verify what the physician dictated to ensure that the order is entered accurately. To document that the policy was followed, the staff member enters the abbreviation RAV (read and verified) below the telephone order (and then signs the order).  
                          **NOTE:** Avoid using the abbreviation P.O. (phone order) because it is also an abbreviation for the Latin phrase *per os*, which means “by mouth.” |
| **Transfer Order**      | A physician order documented to transfer a patient from one facility to another. |
| **Verbal Order**        | Orders dictated to an authorized facility staff member (e.g., registered nurse, pharmacist, physical therapist, and so on) because the responsible physician is unable to personally document the order.  
                          **NOTE:** Medical staff rules and regulations contain the qualifications of staff members authorized to record verbal orders. |
| **Voice Order (V.O.)**  | A verbal order dictated to an authorized facility staff member by the responsible physician who also happens to be present.  
                          **NOTE:** Medical staff rules and regulations must stipulate when voice orders are allowed (e.g., emergency situations only, such as when the emergency department physician has made a chest incision and inserted both hands to massage the patient’s heart to get it restarted). |
| **Written Order**       | Orders that are handwritten in a paper-based record or entered into an electronic health record by the responsible physician. |
**Figure 6-20A**  Physician Orders (Courtesy Delmar/Cengage Learning.)

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<tr>
<th>Date</th>
<th>Time</th>
<th>Orders</th>
<th>Nurse's Initials</th>
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Addressograph
1. **PASSES:** To include therapeutic leaves; individualized activities, school and programming; off campus consultations, including appointments and follow-up visits with physicians in clinic; and other diagnostic studies done off campus; and other purposes approved by the attending physician.

2. **ROUTINE TREATMENT FOR WOUND CARE AND INJURIES:**
   1. Superficial wounds: Clean with saline twice a day and apply antibiotic ointment (Neosporin or Bacitracin) until healed.
   2. Ice pack as needed.
   3. For sutures: Clean with saline twice a day and apply antibiotic ointment and remove sutures in 7 days, unless otherwise ordered.

3. **FEVER/PAIN:**
   For fever greater than 100.5°F, rectally (99.5°F oral, 98.5°F axillary), or above, and/or for pain give:
   1. Tylenol 10 mg. per kg up to 650 mg. q. 4 hours as needed or
   2. Tylenol Suppository 325 mg. per rectum for clients weighing less than 45 pounds and 650 mg. per rectum for clients weighing more than 45 pounds q. 4 hours as needed.

   For fever not relieved by Tylenol within 1 hour:
   May give Ibuprofen 10 mg. per kg. up to 800 mg. q. 6 hrs. PRN.

   For temperature of 103°F rectally (102°F oral, 101°F axillary) or above:
   3. Use a cooling blanket.
   4. Give tepid sponge bath and Tylenol/Ibuprofen as noted above.
   5. CBC with differential on A shift closest to occurrence of fever.
   6. Check complete set of vital signs and notify M.D.

4. **HYPOTHERMIA:** (temp less than 96°F rectal, 95°F oral, 94°F axillary)
   1. Put socks and cap on client.
   2. Wrap client up with a regular blanket.
   3. If temperature does not respond, put on heating blanket.

5. **NAUSEA AND VOMITING:** (New Onset)
   1. Check for fecal impaction.
   2. If positive, follow orders for impaction. If negative, and after vomiting two times, give Phenergan Suppository 25 mg., 1 whole one for clients over 45 pounds, ½ for clients under 45 pounds.

**NAME:** _________________________  **CASE NUMBER:** _______________________

---

**Figure 6-20B**  Physician’s Standing Orders. (Courtesy Hudspeth Regional Center, Whitfield, MS. Used with permission.)
6. DIARRHIA: (New Onset)
   1. Hold any laxatives or prune juice for 48 hrs.
   2. Immodium 2 mg. P.O. after 3rd loose stool. May repeat once within an hour.

7. SEIZURES:
   After 2nd Grand Mal seizure:
   1. Check for impaction.
   2. Give Ativan 2 mg. IM for clients weighing greater than 50 pounds or 1 mg. IM for clients weighing less than 50 pounds.
   3. Check complete set of vitals and notify MD if seizures are not resolved.
   4. If impaction was positive, follow orders for impaction.

8. IMPACTION:
   1. Give one Dulcolax or Bisacodyl Suppository per rectum.
   2. May manually disimpact as needed.

9. CONSTIPATION:
   1. Give MOM 30 cc by mouth or PEG.

10. MOUTH INJURIES:
    1. Glyoxide application three times a day for 5 days.
    2. Refer to the physician or dentist as needed.

11. RUNNY NOSE: Nalex-A:
    1. Age greater than 12, give 1 tablet or 2 teaspoons three times a day X 5 days, or
    2. Age less than 12, give 1 teaspoon or 1/8 tablet three times a day X 5 days with first and last dose being at least 12 hours apart and middle dose being at least 4 hours from first and last. (Ex, 7am, 4pm, 8pm, or 8am, 12am, 8pm)

OR

    Rondec:
    1. Age greater than 6, give 1 tablet or 1 teaspoon three times a day X 5 days, or
    2. Age less than 6, give 1/2 tsp. of the liquid three times a day X 5 days with first and last dose being at least 12 hours apart and middle dose being at least 4 hours from first and last. (Ex. 7am, 4pm, 8pm, or 8am, 12am, 8pm)

NAME:____________________  CASE NUMBER:_________________
### Physician’s Standing Orders (Continued)

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.</td>
<td><strong>FOR RED EYES WITH DRAINAGE/CONJUNCTIVITIS:</strong> Bacitracin or Neosporin Ophthalmologic ointment three times a day for 5 days with first and last dose being at least 12 hours apart.</td>
</tr>
<tr>
<td>13.</td>
<td><strong>DIAPER RASH:</strong> A &amp; D ointment as needed and with every diaper change.</td>
</tr>
<tr>
<td>14.</td>
<td><strong>PURULENT EAR DRAINAGE:</strong> Cortisporin Otic Suspension or Cortaine-B, 4 drops in affected ear four times a day for 7 days. Do not use if there is a known tympanic membrane perforation or PE Tubes.</td>
</tr>
</tbody>
</table>
| 15. | **COUGH:**  
1. For clients 12 and above, give Robitussin DM 3 teaspoons four times a day for 7 days.  
2. For clients 12 and under, give 2 teaspoons of Robitussin DM four times a day for 7 days. |
| 16. | **EAR WAX REMOVAL:** (Do not use if there is a known tympanic membrane perforation or PE Tubes.)  
1. Cerumenex 3 or 4 drops in affected ear at 8 PM and repeat again at 8 AM the next morning.  
2. For more stubborn cerumen: Cerumenex 3 to 4 drops in affected ear three times a day for 5 days.  
3. Then irrigate with warm water after the Cerumenex treatment. |
| 17. | **FINGER STICK GLUCOSE:** Do a finger stick glucose for signs and symptoms of hypoglycemia or hyperglycemia (nausea, diaphoresis, shakiness, decreased level of consciousness).  
1. If glucose is less than 70, give Juice and sugar or Instaglucose and recheck in 15 minutes. If still less than 70, continue with juice and sugar or Instaglucose, check complete set of vitals and notify MD.  
2. If glucose is greater than 400, check complete set of vitals and notify MD. |
| 18. | **ROUTINE MEDICATION ORDERS THAN RUN OUT ON THE WEEKENDS OR HOLIDAYS:** Continue same medications and dosages until the next working day. |
| 19. | For any acute illness or change in status, check a complete set of vitals (Blood pressure, Temperature, Pulse, Respirations) and notify MD. |

**DO NOT GIVE ANY OF THE ABOVE MEDICATIONS IF ALLERGIC. ANY SPECIFIC ORDERS ON ANY CLIENT SUPERCEDES THESE STANDING ORDERS.**

<table>
<thead>
<tr>
<th>Physician</th>
<th>Date</th>
<th>Nurse</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME:</td>
<td></td>
<td>CASE NUMBER:</td>
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Figure 6-21  Progress Notes (Copyright © Courtesy of Bibbero Systems, Inc., Petaluma, CA. Phone: 800-242-2376; Fax: 800-242-9330; www.bibbero.com.)
<table>
<thead>
<tr>
<th>Type of Progress Note</th>
<th>Definition</th>
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</table>
| Admission Note        | Progress note *documented by the attending physician* at the time of patient admission, which includes:  
  - Reason for admission, including description of patient's condition  
  - Brief HPI  
  - Patient care plan  
  - Method/mode of arrival (e.g., ambulance)  
  - Patient's response to admission  
  - Physical assessment  
  **NOTE:** The admission note is documented in addition to the dictated history and physical examination. |
| Follow-up Progress Note | Daily progress notes *documented by the responsible physicians*, which include:  
  - Patient's condition  
  - Findings on examination  
  - Significant changes in condition and/or diagnosis  
  - Response to medications administered (e.g., effectiveness of pain medications)  
  - Response to clinical treatment  
  - Abnormal test findings  
  - Treatment plan related to each of the above |
| Discharge Note         | Final progress note *documented by the attending physician*, which includes:  
  - Patient's discharge destination (e.g., home)  
  - Discharge medications  
  - Activity level allowed  
  - Follow-up plan (e.g., office appointment)  
  **NOTE:** The discharge note is documented in addition to a dictated discharge summary. |
| Case Management Note   | Progress note *documented by a case manager*, which outlines a discharge plan that includes case management/social services provided and patient education. |
| Dietary Progress Note  | Progress note *documented by the dietitian (or authorized designee)*, which includes:  
  - Patient's dietary needs  
  - Any dietary observations made by staff (e.g., amount of meal consumed, food likes/dislikes, and so on).  
  **NOTE:** The Joint Commission standards require dietary orders to be documented in the patient record prior to serving the diet to the patient. After a physician order is written, dietetic services can be provided to patients. AOA requirements state that “food and nutritional needs of the patient should be met in accordance with physician orders and recognized dietary practices.” The nutritional care of the patient is to be documented in the patient record. |
| Rehabilitation Therapy Progress Note | Progress notes *documented by various rehabilitation therapists* (e.g., occupational therapy, physical therapy, psychology, speech/audiotherapy, and so on), which demonstrate the patient's progress (or lack thereof) toward established therapy goals. The Joint Commission standards require the following to be documented in the patient record:  
  - Reason for referral to rehabilitation care  
  - Summary of patient's clinical condition  
  - Goals of treatment and treatment plan  
  - Treatment and progress records (including ongoing assessments)  
  - Assessment of physical rehabilitation achievement and estimates of further rehabilitation potential (documented at least monthly for outpatient care)  
  *(Continues)*
Table 6-7  Progress Notes (Continued)

<table>
<thead>
<tr>
<th>Type of Progress Note</th>
<th>Definition</th>
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| Respiratory Therapy Progress Note| Respiratory therapy progress notes documented by respiratory therapists include therapy administered, machines used, medication(s) added to machines, type of therapy, dates/times of administration, specifications of the prescription, effects of therapy including any adverse reactions, and reassessment of duration/frequency of respiratory therapy. Patients discharged from the hospital on respiratory therapy should be provided with instructions as to pulmonary care (e.g., indications for therapy, dosage of medications, complications of misuse, safety, maintenance of equipment, frequency/use of machine settings, postural drainage, and therapeutic percussion). Examples of respiratory therapy include:  
- Aerosol, humidification, and therapeutic gas administration  
- Mechanical ventilatory and oxygenated support  
- Coughing and breathing exercises  
- Bronchopulmonary drainage  
- Therapeutic percussion and vibration  
- Pulmonary function testing  
- Blood gas analysis  
- Cardiopulmonary resuscitation  

**NOTE:** The Joint Commission standards and Medicare CoP state that the attending physician is responsible for documenting a physician’s order for respiratory care services, including type, frequency and duration of treatment, type and dose of medication, type of dilutant, and oxygen concentration. |
| Preanesthesia Evaluation Note    | A progress note documented by any individual qualified to administer anesthesia (not just the individual who administered anesthesia to the patient) prior to the induction of anesthesia. It includes evidence of:  
- Patient interview to verify past and present medical and drug history and previous anesthesia experience(s)  
- Evaluation of the patient’s physical status  
- Review of the results of relevant diagnostic studies (EKG, pulmonary function tests, cardiac stress tests, laboratory, imaging)  
- Discussion of preanesthesia medications and choice of anesthesia to be administered (e.g., general, spinal, or other regional anesthesia)  
- Surgical and/or obstetrical procedure to be performed  
- Potential anesthetic problems (e.g., smoking) and risks |
| Postanesthesia Evaluation Note   | A progress note documented by any individual qualified to administer anesthesia (not just the individual who administered the anesthesia). It includes:  
- Patient’s general condition following surgery  
- Description of presence/absence of anesthesia-related complications and/or postoperative abnormalities  
- Blood pressure, pulse, presence/absence of swallowing reflex and cyanosis  

**NOTE:** A written order releasing the patient from the recovery room must also be authenticated by the physician responsible for release (e.g., surgeon or anesthesiologist) |
| Preoperative Note                | A progress note documented by the surgeon prior to surgery, which summarizes the patient’s condition and documents a preoperative diagnosis |
| Postoperative Note               | A progress note documented by the surgeon after surgery, which documents the patient’s vital signs and level of consciousness; any medications, including intravenous fluids, administered blood, blood products, and blood components; and any unanticipated events or complications (including blood transfusion reactions) and the management of those events  

**NOTE:** The surgeon documents the postoperative note in addition to a dictated operative record. |
EXAMPLE 2:
2/3/YYYY 1300 Patient admitted with severe pain in upper arms and a constricting, squeezing feeling in the substernal area that feels like indigestion and gas and was not relieved by soda.

Tony Tierney, M.D.

EXAMPLE 3:
2/24/YYYY Less weak. Walking without instability or pain.
Patricia Smart, M.D.

2/25/YYYY Patient very much improved. To start patient walking more.
Patricia Smart, M.D.

2/25/YYYY Very upset and unable to rest all night due to his demented and very noisy roommate.
Patricia Smart, M.D.

2/27/YYYY Patient states he feels good. Clear to decrease Valium to 5 mg. Slept last night without a sleeping capsule.
Patricia Smart, M.D.

Anesthesia Record
The Joint Commission standards require documentation of a preanesthesia or presedation assessment and monitoring of the patient during administration of moderate or deep sedation or anesthesia. The patient's physiological status is assessed immediately after recovery from moderate or deep sedation or anesthesia. Medicare CoP require documentation of a preanesthesia evaluation note by an individual qualified to administer anesthesia within 48 hours prior to surgery. Medicare CoP also require that an intra-operative anesthesia record be maintained. A postanesthesia evaluation is also to be documented by the individual who administered the anesthesia no later than 48 hours after surgery, and in accordance with state law and medical staff policies and procedures.

In addition to preoperative and postoperative anesthesia, progress notes (discussed previously) documented by the individual qualified to administer, anesthesia an anesthesia record (Figure 6-22A) is required, when a patient receives an anesthetic other than a local anesthetic, to document patient monitoring during administration of anesthetic agents and other activities related to the surgical episode. The anesthesia record, pre- and postanesthesia progress notes (Figure 6-22B), and recovery room record (discussed below) provide complete documentation of the administration of pre-operative medications, anesthetic agents administered during operative procedures, evaluation of the patient pre- and postoperatively, and recovery of the patient from anesthesia during the immediate postoperative period.

NOTE: Preanesthesia and postanesthesia evaluation progress notes are sometimes documented on a special form located on the reverse side of the anesthesia record. This can prove helpful to anesthesiologists so that no documentation elements are forgotten.

Contents of the anesthesia record include:

- Preanesthesia medication administered, including time, dosage, and effect on patient
- Appraisal of any changes in the patient’s condition (since preanesthesia evaluation)
- Anesthesia agent administered, including amount, technique(s) used, effect on patient, and duration
- Patient’s vital signs (e.g., temperature, pulse, blood pressure)
- Any blood loss
- Transfusions administered, including dosage and duration
- IV fluids administered, including dosage and duration
- Patient’s condition throughout surgery, including pertinent or unusual events during induction of, maintenance of, and emergence from anesthesia.
- Authentication by the individual qualified to administer anesthesia (e.g., certified registered nurse anesthetist, anesthesiologist)

Operative Record
The Joint Commission standards require the surgeon to document the following prior to performing surgery: history, physical examination, laboratory and X-ray examinations, and preoperative diagnosis—authentication is the responsibility of the individual caring for the patient. All diagnostic and therapeutic procedures are to be documented in the patient record. According to The Joint Commission, an operative or other high-risk procedure report is to be written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care. When a full operative or other high-risk procedure report cannot be entered immediately into the patient’s medical record after the operation or procedure, a progress note is to be written in the patient record before the patient is transferred to the next level of care. The full report is written or dictated within a
### Anesthesia Record

**Pre-Procedure**
- Patient identified: Yes
- ID band verified: Yes
- Patient questioned: Yes
- Chart reviewed: Yes
- Consent form signed: Yes
- Patient reassessed prior to anesthesia: Yes
- Pre-operative pain management discussed: Yes
- Surgery was a planned procedure: Yes
- Pre-Anesthetic State:
  - Reason: Anesthesia machine 95925864 checked
  - Autonomic balance achieved: Yes
  - Unresponsive: No
- Other: None

**Monitors/Equipment**
- Stethoscope: Non-rebreather
- Blood pressure: Non-invasive
- Pulse oximeter: Finger
- Anesthesia machine 95925865 checked
- ECG: Lead II
- EEG: Monitored
- NPO status: Nil per os
- Oxygen saturations: 98%
- Ventilator settings:
  - Mode: Assist
  -潮气量: 600 ml
  -呼吸频率: 12 breaths per minute
  -吸入氧浓度: 50%

**Anesthesia Techniques**
- GA Induction: IV
- Maintenance: IV
- Inhalation: 50%
- Regional: Spinal
- Spinal injection: LUMBAR
- Infiltration:
- IV:
  - Infusion: Titration
- Continuous: Balanced
- Regional Techniques:
  - Epidural
  - Spinal
- Infiltration
- Injection:
- Ropivacaine
  - Dose: 100 ml
- IV:
  - Infusion: 100 ml

**Airway Management**
- Airway: Endotracheal
- Size: 7.0
- NIV: Non-invasive ventilation
- Suctioning: Frequency: 2 times
- Circulation:
  - Heart rate: 80 bpm
  - Blood pressure: SB 120/80 mmHg

**Sedation**
- Propofol: 200 mg
- Midazolam: 10 mg
- Fentanyl: 200 mcg

**VITALS**
- Temperature: 36.5°C
- Heart rate: 70 bpm
- Respiratory rate: 12 breaths per minute
- Blood pressure: 120/80 mmHg
- Oxygen saturation: 98%

**Blood Gas Analysis**
- pH: 7.45
- Pao2: 80 mmHg
- Paco2: 30 mmHg

**Respiratory Rate**
-潮气量: 600 ml
-呼吸频率: 12 breaths per minute
-吸入氧浓度: 50%

**Position**
- Supine

**Surgeon**
- Name: Dr. Smith

**Anesthesiologist**
- Name: Dr. Johnson

**Circulating Nurse**
- Name: Ms. Lee

**Assistant**
- Name: Mr. Brown

**Scrub Nurse**
- Name: Mrs. Green

**Signature of Anesthesiologist or C.R.N.A.**
- Dr. Johnson

---

**Figure 6-22A**  Anesthesia Report (Permission to reprint granted by www.anesthesia-nursing.com.)
**PRE- AND POSTANESTHESIA EVALUATION RECORD**

**Figure 6-22B**  Pre- and Postanesthesia Evaluation Record (Permission to reprint granted by www.anesthesia-nursing.com.)

**Addressograph**

**PREANESTHESIA EVALUATION**

**History Taken From:**
- ☐ Patient
- ☐ Parent/Guardian
- ☐ Significant Other
- ☐ Chart
- ☐ Poor Historian
- ☐ Language Barrier

**Proposed Procedure:**

**AGE**
- ☐ Male
- ☐ Female

**Height**

**Weight**

**Blood Pressure**

**Pulse**

**Respirations**

**Temperature**

**O₂ Sat %**

**Previous Anesthesia:**
- ☐ None

**Previous Surgery:**
- ☐ None

**Current Medications:**
- ☐ None

**Family Hx - Anc. Problems:**
- ☐ None

**Allergies:**
- ☐ None

**Airway**
- ☐ MP1
- ☐ MP2
- ☐ MP3
- ☐ MP4
- ☐ Unrestricted neck ROM
- ☐ T-M distance = ______

(Enter X in appropriate boxes)
- ☐ Obese
- ☐ Neck ROM
- ☐ History of difficult airway
- ☐ Short muscular neck
- ☐ Teeth poor repair
- ☐ Teeth chipped/loose
- ☐ Edentulous
- ☐ Facial hair

**Body System**

**Comments**

**Respiratory**
- ☐ WNL
- ☐ Tobacco Use: ☐ Yes ☐ No ☐ Quit
- ☐ Packs/Day for ______ Years

**Cardiovascular**
- ☐ WNL
- ☐ Pre-procedure Cardiac Assessment:

**Gastrointestinal**
- ☐ WNL
- ☐ Ethanol Use: ☐ Yes ☐ No ☐ Quit
- ☐ Frequency
- ☐ History of Ethanol abuse

**Musculoskeletal**
- ☐ WNL

**Genitourinary**
- ☐ WNL

**Other**
- ☐ WNL

**Pregnancy**
- ☐ WNL
- ☐ AFROM
- ☐ SROM
- ☐ Pitocin Drip
- ☐ Induction
- ☐ MgDrip

Weeks Gestation: ______ G: _____ P: _____ EDC: ______

**Postanesthesia Evaluation**

**Location**

**Time**

**B/P**

**O₂ Sat**

**Pulse**

**Respirations**

**Temperature**

**Controlled Medications**

**Medication**

**Used**

**Destroyed**

**Returned**

- ☐ Awake
- ☐ Mask O₂
- ☐ Somnolent
- ☐ Unarousable
- ☐ Oral/nasal airway
- ☐ Stable
- ☐ NPO
- ☐ Unstable
- ☐ T-Piece
- ☐ Intubated
- ☐ Ventilator
- ☐ Regional – dermatome level: ______
- ☐ Continuous epidural analgesia
- ☐ Direct admit to hospital room
- ☐ No anesthesia related complications noted
- ☐ See notes for anesthesia related concerns
- ☐ Satisfactory postanesthesia/analgesia recovery

_ALFRED STATE MEDICAL CENTER  100 MAIN ST, ALFRED NY 14802  (607) 555-1234_
The progress note must include the name of the primary surgeon, assistant surgeon(s), procedure performed, description of operative findings, estimated blood loss, specimens removed, and postoperative diagnosis. Medicare CoP require a complete H&PE to be documented in the patient’s record prior to surgery—if the report is not available in the patient’s record, the responsible physician must document a statement to that effect along with a complete admission note.

NOTE: The patient record often contains a comprehensive operative progress note documented by the surgeon as well as a transcribed operative record—both are authenticated by the responsible surgeon. Also, do not confuse pre- and postoperative evaluations documented by the surgeon with pre- and postanesthesia evaluations documented by the anesthesiologist. These are often documented in the progress notes and are authenticated by the responsible physician (surgeon or anesthesiologist). Some hospitals create special forms to facilitate documentation of these evaluations.

The operative record (Figure 6-23) describes gross findings, organs examined (visually or palpated), and techniques associated with the performance of surgery. It is to be dictated or handwritten immediately following the operation and authenticated by the responsible surgeon.

Documentation elements include:

- Principal participants (e.g., surgeon, assistant surgeon, anesthesiologist, and so on)
- Pre- and postoperative diagnoses
- Surgical procedure performed
- Anesthesia administered
- Detailed evidence that surgically acceptable techniques were used
- Indications for surgery
- Condition of the patient (pre-, intra-, and postoperatively)
- Detailed description of the operative procedure performed (e.g., surgical techniques), including organs explored
- Description of operative findings, unique elements in the course of procedures performed, any unusual events that occurred during the procedure, any estimated blood loss, and any specimens removed
- Description of other procedures performed during operative episode
- Documentation of ligatures, sutures, number of packs, drains, and sponges used

NOTE: Postoperative documentation includes the discharge of the patient from the postsedation or postanesthesia care area (e.g., recovery room), which is documented by the practitioner responsible (e.g., anesthesiologist); use of approved criteria to determine patient readiness for discharge; and the name of the practitioner responsible for discharge.

OPPS MAJOR AND MINOR PROCEDURES

For outpatient prospective payment system (OPPS) purposes, the Centers for Medicare and Medicaid Services (CMS) categorize procedure codes as major or minor procedures, assigning status indicators to each procedure code to differentiate them. A major procedure (e.g., carpal tunnel repair, cervical diskectomy, lumbar fusion) includes surgery that may require a hospital stay; it usually takes a longer time and is riskier than a minor procedure. (Anesthesia is usually required for major surgery and includes the administration of general, local, or regional anesthesia.) A minor procedure includes minimally invasive diagnostic tests and treatments (e.g., trigger point injection, administration of an epidural, insertion of a pain pump). The CMS has developed the following guidelines:

- Endoscopies are classified as a distinct group, regardless of duration.
- Minor procedures are usually performed in less than 5 minutes.
- Major procedures are usually performed in 5 minutes or more.

Pathology Report

The Joint Commission standards require documentation of an authenticated, dated report or examination as performed by pathology and clinical laboratory services. The pathologist is responsible for documenting a descriptive diagnostic report of gross specimens received and of autopsies performed.

The pathology report (or tissue report) (Figure 6-24) assists in the diagnosis and treatment of patients by documenting the analysis of tissue removed surgically or diagnostically (e.g., biopsy), or that was expelled by the patient (e.g., products of conception). A tissue examination request is submitted to the pathologist along with the specimen and a clinical diagnosis.
### Operative Record

<table>
<thead>
<tr>
<th>Patient Number</th>
<th>Room/Bed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name (Last, First, MI)</td>
<td>Date of Procedure</td>
</tr>
<tr>
<td>Name of Attending Physician</td>
<td>Time Started</td>
</tr>
<tr>
<td>Patient DOB</td>
<td>Gender</td>
</tr>
<tr>
<td>Surgeon:</td>
<td>Assistant:</td>
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<tr>
<td>Anesthetist:</td>
<td>Anesthetic:</td>
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<tr>
<td>Preoperative Diagnosis:</td>
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<tr>
<td>Postoperative Diagnosis:</td>
<td></td>
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<td>Procedure(s) Performed:</td>
<td></td>
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<tr>
<td>Complications:</td>
<td></td>
</tr>
<tr>
<td>Operative Findings:</td>
<td></td>
</tr>
</tbody>
</table>

**Dictation Date**

**Transcription Date**

**Signed**

**Form 4107, OCT 03**

**Addressograph**

---

**Figure 6-23** Operative Report (Courtesy Delmar/Cengage Learning.)
### PATHOLOGY REPORT

**Clinical History/Preoperative Diagnosis.**

- Patient’s diagnosis prior to review of tissue by pathologist.
- **EXAMPLE:** Breast mass. Right breast lumpectomy performed.

**Specimen(s) Obtained:**

- Specimen received by pathologist as a result of the procedure (e.g., breast tissue).
- **EXAMPLE:** Single piece of fibrofatty tissue received in formalin.

**Gross Description:**

- Pathologist views specimen without a microscope and describes size (after measuring it) and appearance (after feeling it).
- **EXAMPLE:** Fibrofatty tissue is 2 x 3 x 3 cm. A central mass is palpable.

**Microscopic Description:**

- Pathologist views specimen using a microscope and describes tissue.
- **EXAMPLE:** Tissue reveals infiltrating ductal carcinoma. Tumor contains irregular nests of infiltrating cells with minimal gland formation. Surgical margins are clear.

**Pathologic Diagnosis:**

- Pathologist documents grade, histology, and stage.
- **Grade:** nature of cells and their aggressiveness.
- **Histology:** type of cancer found and arrangement of cells.
- **Stage:** size of cancer and extent to which it has spread.
- **EXAMPLE:** Poorly differentiated infiltrating ductal carcinoma, Grade III, Stage II.

---

**Figure 6-24 Pathology Report (Permission to reprint granted by TheDoctorsDoctor.com.)**
The pathologist performs **macroscopic** (gross) and microscopic examination of tissue and documents a report. The pathology report is filed in the patient record as soon as completed, usually within 24 hours. Contents of the pathology report include:

- Date of examination
- Clinical diagnosis
- Tissue examined
- Pathologic diagnosis
- Macroscopic (or gross) examination
- Microscopic examination
- Authentication by pathologist

**NOTE:** During a frozen section procedure (e.g., for suspected cancer), rapid microscopic analysis of a specimen is performed. Tissue removed is evaluated by the pathologist during the operative episode to allow a positive margin to be corrected prior to surgical closure and reconstruction. A final pathology report is issued after all tissue removed during the procedure has been analyzed.

**Post Anesthesia Care Unit (PACU) Record**

The Joint Commission standards also require the patient’s postoperative status to be evaluated immediately after the procedure and/or administration of moderate or deep sedation or anesthesia. The patient must also be evaluated upon admission to and discharge from the postanesthesia recovery area, as follows: record of postoperative vital signs and level of consciousness, medications (including intravenous fluids) and blood and blood components administered, I.V. fluids and drugs administered including blood and blood products, any unusual events or complications, including blood transfusion reactions, and the management of those events. A qualified licensed independent practitioner discharges the patient from the recovery area or from the hospital according to criteria approved by clinical leaders.

After the completion of surgery, patients are taken to the recovery room where the anesthesiologist and recovery room nurse are responsible for documenting a post anesthesia care unit (PACU) (or recovery room) record (Figure 6-25), which delineates care administered to the patient from the time of arrival until the patient is moved to a nursing unit or discharged home. Elements of the recovery room record include:

- Patient’s general condition upon arrival to recovery room
- Postoperative/postanesthesia care given
- Patient’s level of consciousness upon entering and leaving the recovery room
- Description of presence/absence of anesthesia-related complications and/or postoperative abnormalities (may be documented in progress notes)
- Monitoring of patient vital signs, including blood pressure, pulse, and presence/absence of swallowing reflex and cyanosis
- Documentation of infusions, surgical dressings, tubes, catheters, and drains
- Written order releasing patient from recovery room (authenticated by physician responsible for release) documented in the physician orders
- Documentation of transfer to nursing unit or discharge home

**NOTE:** The recovery room record is dated, timed, and authenticated by the responsible physician (anesthesiologist) or certified registered nurse anesthetist (CRNA).

**Ancillary Reports**

The Joint Commission standards require patient records to include reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic or therapeutic procedures. Requests for ancillary testing must include the study requested and appropriate clinical data to aid in the performance of the procedures requested.

Ancillary reports (Table 6-8) are documented by such departments as laboratory, radiology (or X-ray), nuclear medicine, and so on; they assist physicians in diagnosis and treatment of patients. The responsible physician must document requests for ancillary testing to be performed in the physician orders, and the patient record must include documentation of ancillary report results as well as a treatment plan.

All ancillary reports should be filed in the patient’s records as soon as an interpretation has been made (usually within 24 hours).

**Nursing Documentation**

The Joint Commission standards require documentation of a nursing assessment, nutritional screening, and a functional screening within 24 hours after inpatient admission.
**POST ANESTHESIA CARE UNIT RECORD**

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</table>

**Postanesthesia Recovery Score**

- **Activity**
  - Moves 4 extremities voluntarily or on command (2)
  - Moves 2 extremities voluntarily or on command (1)
  - Moves 0 extremities voluntarily or on command (0)

- **Respiration**
  - Able to deep breathe and cough freely (2)
  - Dyspnea or limited breathing (1)
  - Apneic (0)

- **Circulation**
  - BP 20% of preanesthetic level (2)
  - BP + 20% of preanesthetic level (1)
  - BP + 50% of preanesthetic level (0)

- **Consciousness**
  - Fully awake (2)
  - Arousalable on calling (1)
  - Not responding (0)

- **Color**
  - Pink (2)
  - Pale, dusky, blanchy, jaundiced, other (1)
  - Cyanotic (0)

**Discharge Status**

- **Condition:**
  - Transferred by
  - R.R. Nurse:

- **Preop Visit:**

- **Postop Visit:**

**Comments & Observations:**

**Signature of Recovery Room Nurse**

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**Figure 6-25** Post Anesthesia Care Unit (PACU) Record (Courtesy Delmar/Cengage Learning.)
Table 6-8 Ancillary Reports

<table>
<thead>
<tr>
<th>Type of Ancillary Report</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory (Figure 6-26A)</td>
<td>Clinical laboratory reports document name, date and time of lab test, results, time specimen was logged into the lab, time the results were determined, reference section (that contains normal ranges for lab values), and initials of the laboratory technician. Examples include:</td>
</tr>
<tr>
<td></td>
<td>• Blood chemistry (e.g., blood glucose level, WBC, CBC, urinalysis, culture and sensitivity, and so on)</td>
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<tr>
<td></td>
<td>• Therapeutic drug assay (e.g., drug level in blood)</td>
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<td></td>
<td>• Blood gases (e.g., oxygen saturation)</td>
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<td>• Cardiac enzymes</td>
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<td>• Blood types</td>
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<td></td>
<td>• Blood factor (Rh)</td>
</tr>
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<td>• Genetic testing</td>
</tr>
<tr>
<td>Radiology (Figure 6-26B)</td>
<td>Radiology (or imaging) reports document a description of the image, techniques used, narrative report of findings, diagnosis or impression, and authentication by the radiologist. Examples include:</td>
</tr>
<tr>
<td></td>
<td>• X-rays (radiology)</td>
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<td>• CAT scans</td>
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<td>• Nuclear medicine</td>
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<td>• Ultrasound</td>
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<td>• MRI</td>
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<td>• Xerography</td>
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<td></td>
<td>• PET scans</td>
</tr>
<tr>
<td></td>
<td>• Thermography</td>
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<td></td>
<td><strong>NOTE:</strong> Obtain signed patient consent prior to performing deep X-ray therapy, radioactive isotope treatment, or special diagnostic procedures.</td>
</tr>
<tr>
<td>Electrocardiogram (EKG or ECG)</td>
<td>EKG report includes the following:</td>
</tr>
<tr>
<td>(Figure 6-26C)</td>
<td>• Printout of graphic tracing of electrical changes in heart muscle, commonly called the EKG strip, and date and time of EKG (or ECG) test</td>
</tr>
<tr>
<td></td>
<td>• Physician’s interpretation of the tracing</td>
</tr>
<tr>
<td></td>
<td>• Authentication by physician</td>
</tr>
<tr>
<td>Electroencephalogram (EEG)</td>
<td>EEG report includes the following:</td>
</tr>
<tr>
<td>(Figure 6-26D)</td>
<td>• Graphic printout of measurement of electrical activity of the brain and date and time of EEG test</td>
</tr>
<tr>
<td></td>
<td>• Physician’s interpretation of graphics</td>
</tr>
<tr>
<td></td>
<td>• Authentication by physician</td>
</tr>
<tr>
<td>Electromyogram (EMG)</td>
<td>EMG report includes the following:</td>
</tr>
<tr>
<td>(Figure 6-26E)</td>
<td>• Graphic printout of measurement of skeletal muscle activity and date and time of EMG test</td>
</tr>
<tr>
<td></td>
<td>• Physician’s interpretation of graphics</td>
</tr>
<tr>
<td></td>
<td>• Authentication by physician</td>
</tr>
<tr>
<td>Transfusion Record (Figure 6-26F)</td>
<td>Blood transfusion reports contain documentation of the complete and accurate description of the requisition for blood, date and time of transfusion, report of cross-matching (compatibility tests), blood type and Rh, report of administration of blood, donor’s identification number, and notation of any transfusion reactions.</td>
</tr>
</tbody>
</table>

Nursing documentation (Table 6-9) plays a crucial role in patient care because the majority of care delivered to inpatients is performed by nursing staff, which include registered nurses (RN), licensed practical nurses (LPN), and certified nurses’ aides (CNA). Upon admission to the hospital, a nursing assessment is documented to obtain the patient’s history and evaluate vital signs. This information is used to create a nursing care plan, which records nursing diagnoses and interventions. Nursing staff is also responsible for recording vital signs, administration of medication, observations and progress during the patient’s inpatient hospitalization, and a discharge plan. This information is documented on various forms, which include nurses notes, graphic sheets, medication sheets, and so on.

Special Reports

Records of obstetric and neonatal patients contain unique forms. The obstetrical record is the mother’s record and contains an antepartum record, labor and
### LABORATORY REPORT

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<th>TEST</th>
<th>RESULT</th>
<th>FLAG</th>
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<tbody>
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<td>BUN</td>
<td>8-25 mg/dl</td>
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<tr>
<td>Creatinine</td>
<td>0.9-1.4 mg/dl</td>
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<tr>
<td>Sodium</td>
<td>135-145 mmol/L</td>
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<tr>
<td>Potassium</td>
<td>3.6-5.0 mmol/L</td>
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<tr>
<td>Chloride</td>
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<td>HGB</td>
<td>11.7-16.1 g/dl</td>
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<td>HCT</td>
<td>35.0-47.0 %</td>
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<td>Platelets</td>
<td>140-400 thous/UL</td>
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<tr>
<td>PT</td>
<td>11.0-13.0 seconds</td>
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</table>

***End of Report***

ALFRED STATE MEDICAL CENTER ■ 100 MAIN ST, ALFRED NY 14802 ■ (607) 555-1234
Figure 6-26B Radiology Report (also called Diagnostic Imaging Report) (Courtesy Delmar/Cengage Learning.)
Figure 6-26C  Electrocardiogram (EKG) Report (Copyright © Courtesy of Bibbero Systems, Inc., Petaluma, CA. Phone: 800-242-2376; Fax: 800-242-9330; www.bibbero.com.)
ELECTROENCEPHALOGRAM REPORT

Age of Patient: 

EEG #: 

History: 

Medications: 

Conditions of the Recording: 

Analysis and Description of EEG Pattern: 

Impression: 

Signature of Physician 

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Figure 6-26D  Electroencephalogram (EEG) Report (Courtesy Delmar/Cengage Learning.)
Neurological and Electrodiagnostic Consultation:

Past History:

Social History

Neurological Examination:

Electromyographic Study:

Nerve Conduction Velocity Test:

Sensory Results:

Late Responses:

Summary:

Impression:

Recommendations:

Signature of Physician

Figure 6-26E  Electromyogram (EMG) Report (Courtesy Delmar/Cengage Learning.)
Figure 6-26F  Blood Transfusion Report (Courtesy Delmar/Cengage Learning.)

### Table 6-9  Nursing Documentation

<table>
<thead>
<tr>
<th>Nursing Documentation</th>
<th>Description</th>
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</thead>
</table>
| **Nursing Care Plan** (Figure 6-27A)   | Documents nursing interventions to be used to care for the patient.  
| **Nurses Notes** (Figure 6-27B)        | Documents daily observation about patients, including an initial history of the patient, patient’s reactions to treatments, and treatments rendered.  
| **Nursing Discharge Summary** (Figure 6-27C) | Documents patient discharge plans and instructions.  
| **Graphic Sheet** (Figure 6-27D)       | Documents patient’s vital signs (e.g., temperature, pulse, respiration, blood pressure, and so on) using a graph for easy interpretation of data.  
| **Medication Administration Record** (MAR) (Figure 6-27E) | Documents medications administered, date and time of administration, name of drug, dosage, route of administration (e.g., orally, topically, by injection, or infusion), and initials of nurse administering medication.  
| **Bedside Terminal System** (Figure 6-27F) | Computer system located at the patient’s bedside, which is used to automate nursing documentation. Patient information can be entered, stored, retrieved, and displayed.  

---

**NOTE:**

- Patient reactions to drugs are documented in nurses notes.
- **Nursing care plans are not usually filed in the permanent patient record.**
### NURSING CARE PLAN

<table>
<thead>
<tr>
<th>Date/Initials</th>
<th>Nursing Diagnosis</th>
<th>Nursing Intervention</th>
<th>Outcome Evaluation</th>
<th>Projected Date/Initials</th>
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</thead>
<tbody>
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</table>

**Figure 6-27A**  Nursing Care Plan (Reprinted according to IHS.gov Web reuse policy.)
<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>NOTES</th>
<th>SIGNATURE</th>
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</tbody>
</table>

**Addressograph**

**NURSES NOTES**

**Figure 6-27B  Nurses Notes (Courtesy Delmar/Cengage Learning.)**
## NURSING DISCHARGE SUMMARY

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Discharge to:</th>
<th>Mode:</th>
<th>Accompanied by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>❑ Home</td>
<td>❑ Ambulatory</td>
<td></td>
</tr>
<tr>
<td></td>
<td>❑ Other: _______</td>
<td>❑ Other: _______</td>
<td></td>
</tr>
</tbody>
</table>

**Activity**

Specify limitations

**Diet**

❑ No dietary restrictions
❑ Special diet

**Medications**

❑ No medications

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Frequency of Administration</th>
<th>Special Instructions</th>
</tr>
</thead>
</table>

**Treatment/Care**

Instructions:

Equipment/Supplies:

**Follow-up**

You are scheduled to see Dr. ______________________ on ______________________ at ______________________.

Date

Time

**Patient’s Conditions:**

---

Signature of Registered Nurse

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---

Figure 6-27C  Nursing Discharge Summary (Courtesy Delmar/Cengage Learning.)
<table>
<thead>
<tr>
<th>MONTH</th>
<th>HOSPITAL DAY</th>
<th>DAY OF MONTH</th>
<th>HOUR</th>
<th>PULSE</th>
<th>TEMP F</th>
<th>TEMP C</th>
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<td>105*</td>
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<td>93</td>
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<td>101*</td>
<td>37°</td>
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<td>96</td>
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</table>

**RESPIRATION RECORD**

**BLOOD PRESSURE**
- AM
- PM

**HEIGHT**

**WEIGHT**

**DIET**

**BATH**

**STOOLS**

**URINE**
- TIME OF DAY: SUGAR, ACE-TONE
  - AM
  - PM

**PATIENT'S IDENTIFICATION** (For typed or written entries give: Name: _last, first_, middle, hospital or medical facility).

![Vital Signs Record Graphic Sheet](https://ihs.gov/web/vital_signs_record.png)
Figure 6-27E  Medication Administration Record (MAR) (Copyright © Courtesy of Bibbero Systems, Inc., Petaluma, CA. Phone: 800-242-2376; Fax: 800-242-9330; www.bibbero.com.)
delivery record, and postpartum record. The **neonatal record** (Figure 6-28) is the newborn’s record and contains a birth history, newborn identification, physical examination, and progress notes.

The obstetrical record consists of the following reports:

- **Antepartum record** (or **prenatal record**) (Figure 6-29A): Started in the physician’s office and includes health history of the mother, family and social history, pregnancy risk factors, care during pregnancy including tests performed, medications administered, and so on. A summary of this information is also documented in the hospital patient record or a copy is filed at the birthing facility by the 36th week of pregnancy.

- **Labor and delivery record** (Figure 6-29B): Records progress of the mother from time of admission through time of delivery. Information includes time of onset of contractions, severity of contractions, medications administered, patient and fetal vital signs, and progression of labor.

- **Postpartum record** (Figure 6-29C): Documents information concerning the mother’s condition after delivery.

Contents of neonatal record include:

- **Birth history**: Documents summary of pregnancy, labor and delivery, and newborn’s condition at birth.

- **Newborn identification**: Immediately following birth, footprints (Figure 6-29D) and fingerprints of the newborn are created, and a wrist or ankle band is placed on the newborn (with an identical band placed on the mother); within 12 hours of birth, an identification form is also used to document information about the newborn and mother.

- **Newborn physical examination**: An assessment of the newborn’s condition immediately after birth, including time and date of birth, vital signs, birth weight and length, head and chest measurements, general appearance, and physical findings is completed.

- **Newborn progress notes**: Documents information gathered by nurses in the nursery and includes vital signs, skin color, intake and output, weight, medications and treatments, and observations.

**NOTE**: An APGAR score is documented in the newborn record (and in some states as part of the birth certificate) as an indication of infant health; it also helps direct medical personnel in determining whether intervention is necessary (e.g., oxygen therapy). The **APGAR score** measures the baby’s appearance (A) (e.g., skin color), pulse (P), grimace (G) (e.g., irritability), activity (A) (e.g., muscle tone and motion), and respirations (R) on a scale of 1 to 10, with up to 2 points assigned for each measurement and 10 being the maximum score. (Although named for pediatrician Virginia Apgar, the letters also serve as a mnemonic device or memory aid.) The APGAR score is usually measured at 1 minute and 5 minutes after birth, but may be recorded for up to 10 or 15 minutes if the infant is being resuscitated.

**Autopsy Report**

Medicare CoP state that the medical staff should attempt to obtain autopsies in all cases of unusual deaths and to pursue medical-legal and educational interest. In addition, the mechanism for documenting
permission to perform an autopsy must be defined, and there must be a system for notifying the medical staff, and specifically the attending practitioner, when an autopsy is being performed.

An autopsy (or necropsy) (Figure 6-30) is an examination of a body after death that includes the macroscopic and microscopic examination of vital organs and tissue specimens to assist in determining a cause of death and the character or extent of changes produced by disease. Prior to performing an autopsy, consent must be obtained from the legal next-of-kin of the deceased, and the signed consent becomes part of the permanent patient record (unless it is a coroner’s case, based on state law). In addition, documentation that an autopsy was performed is to be entered in the patient record (e.g., progress notes), and the record is considered incomplete until the autopsy report is filed. Elements of an autopsy report (necropsy report or postmortem report) include:

- Summary of patient’s clinical history including diseases, surgical history, and treatment
- Detailed results of the macroscopic and microscopic findings, including external appearance of the body and internal examination by body system
- Contributing factors that led to death
- Clinical-pathologic correlation (e.g., medical conclusion of patient’s disease process)
- Authentication by pathologist

**NOTE:** An autopsy is completed for suspicious deaths and in the event of an untimely death. (State laws govern when autopsies are mandated.)

Typically, an autopsy is required for the following circumstances:

- Any case where there is medical/legal necessity
- Cause of death is not related to treatment
- Dead on arrival to emergency room or dying in emergency room (without previous diagnosis or before definitive diagnosis)
Figure 6-29A  Antepartum (or Prenatal) Record (Reprinted according to IHS.gov Web reuse policy.)
### Figure 6-29B Labor Record (Reprinted according to IHS.gov Web reuse policy.)
### Initial Postpartum Period (12 Hours)

<table>
<thead>
<tr>
<th>TIME ADMITTED TO</th>
<th>AM</th>
<th>PM</th>
<th>ADMITTED BY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum Unit</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>LOCHIA</th>
<th>PROGRESS NOTES</th>
<th>INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cephalic</td>
<td>Time</td>
<td>Antepartum</td>
</tr>
<tr>
<td>Face Down</td>
<td>Time</td>
<td>Antepartum</td>
</tr>
<tr>
<td>Face Up</td>
<td>Time</td>
<td>Antepartum</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Identification</th>
<th>R. N. Signature</th>
</tr>
</thead>
</table>

**Figure 6-29C** Postpartum Record (Reprinted according to IHS.gov Web reuse policy.)
Exercise 6–3  Hospital Inpatient Record—Clinical Data

Fill-In-The-Blank: Enter the appropriate term(s) to complete each statement below.

1. A discharge summary, also known as a ________, documents the patient’s hospitalization, including reason(s) for hospitalization, ________, and condition at discharge.

2. The ________ documents the patient’s chief complaint, ________, past/family/social history, and review of systems.

3. If a patient is readmitted within ________ days after discharge for the same condition, a(n) ________ can be completed to document the patient’s history of the present illness and any pertinent changes and physical findings that occurred since the previous admission.

4. Diagnostic and therapeutic patient care activities, such as medications and dosages, and completion of a chest X-ray, are initiated by ________, also known as ________.

5. Preprinted physician orders, known as ________ or ________ orders, are preapproved by the medical staff and placed on a patient’s record, usually at the time of admission.

6. A(n) ________ is generated by emergency medical technicians to document clinical information such as vital signs, level of consciousness, appearance of the patient, and so on when a patient is transported via ambulance to the emergency department.

7. A consulting physician, as part of the consultation process, is responsible for reviewing the patient’s record, ________, documenting pertinent findings, and providing ________, and/or opinions to the referring physician.

8. Some facilities adopt ________, which means all progress notes documented by physicians, nurses, physical therapists, occupational therapists, and other professional staff members are organized in the ________ of the record.

9. The anesthesia record, pre- and postanesthesia ________, and ________ record provide complete documentation of the administration of medications and anesthetic agents administered during the pre- and postoperative time and during surgery.

10. The gross findings, organs examined (visually or palpated), and techniques associated with the performance of surgery are documented in the ________.

11. The ________ assists in the diagnosis and treatment of patients by documenting the analysis of tissue removed surgically or diagnostically, or that expelled by the patient.

12. Reports produced by the laboratory, radiology, and nuclear medicine departments are known as ________.

13. Nursing diagnoses and interventions are documented on a ________.

- Occult hemorrhage
- Pneumonia (no microbiologic diagnosis)
- Sudden infant death
- Trauma (internal)
- Pediatric and perinatal deaths
- Deaths that occur in the operating room and/or during a procedure

Figure 6-29D  Newborn Footprints (Permission to reprint granted by Precision Dynamics Corporation. Web site: PDCorp.com.)
Figure 6-30  Autopsy Report (Courtesy Delmar/Cengage Learning.)
14. The ________ documents information concerning the mother’s condition after delivery.

15. An examination of a body after death, which includes the ________ and microscopic examination of vital organs and tissue specimens to assist in determining a cause of death and the character or extent of changes produced by disease, is an ________.

**HOSPITAL OUTPATIENT RECORD**

The Joint Commission standards state that by the third visit, the patient record of a patient who receives continuing ambulatory services (e.g., physical therapy services) must contain a summary list that documents significant diagnosis and conditions, significant operative and invasive procedures, adverse or allergic drug reactions and long-term medications, including current medications (including over-the-counter medications and herbal remedies). (This summary list must be updated on subsequent visits.) Medicare CoP categorize outpatient care as optional hospital services.

Outpatient care is defined as medical or surgical care that does not include an overnight hospital stay (and not longer than 23 hours, 59 minutes, 59 seconds). Hospital outpatient services usually include diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services. (For reimbursement purposes, Medicare categorizes emergency room services as hospital outpatient care.) The provision of medical supplies (e.g., splints) and ancillary tests (e.g., lab) billed by the hospital are also included as outpatient care. Hospital outpatient records (or ambulatory records) include a patient registration form similar to the inpatient face sheet, and depending on the complexity of outpatient services provided, additional reports can include ancillary reports, progress notes, physician orders, operative reports, pathology reports, nursing documentation, and so on. In addition, some hospital outpatient departments use a short stay record (Figure 6-31), which allows providers to record the history, physical examination, progress notes, physician orders, and nursing documentation on one double-sided form.

**Figure 6-31** Short Stay Record (Reprinted according to www.vha.gov Web Reuse Policy.)
EXAMPLE 1:
Sam undergoes a laparoscopic cholecystectomy on an outpatient basis. Sam’s patient record will consist of a patient registration form, history and physical examination report, operative report, anesthesia record, recovery room record, pathology report, and so on.

EXAMPLE 2:
Omar undergoes an outpatient X-ray of his left wrist. His outpatient record consists of only a patient registration form, a physician order form, and the X-ray report.

The Uniform Ambulatory Care Data Set (UACDS) is the minimum core data set collected on Medicare and Medicaid outpatients. The goal of collecting standardized UACDS data is to improve data comparison in ambulatory and outpatient settings. Current UACDS data elements include the following:

• Patient (person receiving health care services)

EXAMPLE
VA medical centers collect patient’s name, date of birth, social security number (SSN) (to confirm eligibility), and so on.

• Date and time of encounter or ancillary service (actual date and time encounter or service occurred, usually collected from appointment scheduling software)

NOTE: An outpatient visit is the visit of a patient on one calendar day to one or more hospital departments for the purpose of receiving outpatient health care services (e.g., encounter or ancillary service visit). An encounter is a professional contact between a patient and a provider who delivers services or is professionally responsible for services delivered to a patient. An encounter is not the same as an ancillary service visit (or occasion of service), which is the appearance of an outpatient to a hospital department to receive an ordered service, test, or procedure. Ancillary services do not include exercise of independent medical judgment in diagnosing, evaluating, and/or treating conditions; an ancillary service is usually the result of an encounter.

EXAMPLE 1:
Laboratory tests or X-ray procedures are ordered as part of an encounter. A patient may undergo multiple ancillary services during one outpatient visit.

EXAMPLE 2:
A telephone contact between a physician and a patient is considered an encounter if the telephone contact includes the appropriate elements of a face-to-face encounter (e.g., history and medical decision making).

• Practitioner (e.g., physician, nurse practitioner, physician’s assistant)

NOTE: Practitioners are categorized as licensed and non-licensed. A licensed practitioner is required to have a public license/certification to deliver care to patients (e.g., MD, RN), and a practitioner can also be a provider. A provider is a business entity that furnishes health care to consumers or a professionally licensed practitioner authorized to operate a health care delivery facility (e.g., VA medical centers). A non-licensed practitioner does not have a public license/certification and is supervised by a licensed/certified professional in the delivery of care to patients (e.g., physical therapy assistant).

• Place of service (location where service was provided to outpatient)

• Active problem(s) (purpose of outpatient visit, which is the diagnosis treated and coded according to ICD-9-CM)

NOTE: When more than one active problem or diagnosis is identified for an encounter, the practitioner must determine the first-listed diagnosis (reason the patient sought treatment during that encounter). The first-listed diagnosis reflects the current, most significant reason for services provided or procedures performed. When coding pre-existing conditions, make certain the diagnosis code reflects the current reason for medical management. Chronic diseases may be coded as long as treated, but if the patient presents and a condition other than the chronic problem is treated, code only the new condition. Also, never code a diagnosis that is no longer applicable; if the disease or condition has been successfully treated and no longer exists, it is not billable and should not be coded or reported.

• Service or procedure provided (services provided or procedures performed by the practitioner, which are coded according to CPT and HCPCS Level II)

Exercise 6–4 Hospital Outpatient Records
True/False: Indicate whether each statement is True (T) or False (F).
1. The Joint Commission standards require that by no earlier than the fourth ambulatory visit the patient
Table 6-10  Physician Office Reports

<table>
<thead>
<tr>
<th>Physician Office Report</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Registration Form (Figure 6-32A)</td>
<td>Documents demographic, administrative, and financial data.</td>
</tr>
<tr>
<td>Problem List (Figure 6-32B)</td>
<td>Documents diseases, conditions, allergies, and procedures.</td>
</tr>
<tr>
<td>Medication List (Figure 6-32C)</td>
<td>Documents medications, dosage, associated diagnosis, and ordering physician.</td>
</tr>
<tr>
<td>Progress Notes (Figure 6-32D)</td>
<td>Documents the initial history and physical examination and all subsequent visits.</td>
</tr>
<tr>
<td>Ancillary Reports (Figure 6-32E)</td>
<td>Documents reports of ancillary testing completed in the office or by outside labs, including hospital labs.</td>
</tr>
<tr>
<td>Immunization record (Figure 6-32F)</td>
<td>Documents immunizations (vaccines) administered.</td>
</tr>
<tr>
<td>Growth and development chart (Figure 6-32G)</td>
<td>Documents height and weight, which is used to monitor growth patterns.</td>
</tr>
</tbody>
</table>

1. The appearance of an outpatient to a hospital department to receive an ordered service, test, or procedure is known as an ancillary service visit or a(n) ________.

**PHYSICIAN OFFICE RECORD**

The content and organization of physician office records varies greatly depending on the size of the office, ownership, and whether the practice is accredited. As a minimum, **physician office records** (Table 6-10) should contain patient registration information, a problem list, a medication record, progress notes (including patient’s history and physical examination), and results of ancillary reports. When office surgery is performed, the provider documents a report of surgery in the record.

An **encounter form** (superbill or fee slip) (Figure 6-33) is commonly used in physician offices to capture charges generated during an office visit and consists of a single page that contains a list of common services provided in the office. This form is initiated when the patient registers at the front desk and is completed by providers as the patient receives care.

**EXAMPLE**

Polly presents to the office registration desk and the medical assistant generates an encounter form, which is attached to the cover of her patient record. Polly is an established patient who is being monitored for anemia, and Dr. Healthy orders blood tests and performs an examination. Using the encounter form, the doctor selects the proper code for the level of exam completed.
Figure 6-32A  Patient Registration Form (Copyright © Courtesy of Bibbero Systems, Inc., Petaluma, CA. Phone: 800-242-2376; Fax: 800-242-9330; www.bibbero.com.)
Figure 6-32B  Problem List (Copyright © Courtesy of Bibbero Systems, Inc., Petaluma, CA. Phone: 800-242-2376; Fax: 800-242-9330; www.bibbero.com.)
## Figure 6-32C  Physician Office Medication List

<table>
<thead>
<tr>
<th>MEDICATION / SIGNATURE / AMOUNT DISPENSED</th>
<th>NURSE TO REFILL</th>
<th>DATE</th>
<th>REFILLS / DATE / STRENGTH / INITIALS</th>
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<tr>
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<td>NO</td>
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</tr>
</tbody>
</table>

**ALLERGIES-DRUG REACTIONS:**

**PATIENT**

**PHARMACY / THERAPIST**

**PHONE NO:**

ORDER # 25-7200-01  CHART ORGANIZING SYSTEMS • © 1976 BIBBERO SYSTEMS, INC. • PETALUMA, CA.
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Mfg. in U.S.A.

**Figure 6-32C**  Physician Office Medication List (Copyright © Courtesy of Bibbero Systems, Inc., Petaluma, CA., Phone: 800-242-2376; Fax: 800-242-9330; www.bibbero.com.)
Figure 6-32D  Physician Office Progress Notes (Copyright © Courtesy of Bibbero Systems, Inc., Petaluma, CA.
Phone: 800-242-2376; Fax: 800-242-9330; www.bibbero.com.)
After the medical assistant completes the *venipuncture* (drawing of blood) procedure, she selects the code on the encounter form. The completed encounter form is returned to the registration desk where the patient is scheduled for a follow-up visit. The medical assistant will use the completed encounter form to generate the patient’s bill and insurance claim, which is submitted to the third-party payer. (The blood specimen will be delivered to the hospital lab later that afternoon, where the blood test will be performed. The hospital billing department will generate a bill and claim for charges.)

**Exercise 6–5  Physician Office Record**

Matching: Match the term with its description.

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<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Ancillary reports</td>
<td>A. Documents initial history, physical examination, and all subsequent visits.</td>
</tr>
<tr>
<td>2</td>
<td>Medication list</td>
<td></td>
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<tr>
<td>3</td>
<td>Progress notes</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Patient registration form</td>
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</tr>
<tr>
<td>5</td>
<td>Problem list</td>
<td></td>
</tr>
</tbody>
</table>

B. Documents diseases, conditions, allergies, and procedures.

C. Documents medications, dosage, associated diagnosis, and ordering physician.

D. Documents reports of ancillary testing completed in the office or by outside labs, including hospital labs.

E. Documents demographic, administrative, and financial data.
MEMPHIS FAMILYCARE CENTER
IMMUNIZATION RECORD

PATIENT NAME: ________________________________ BIRTH DATE: _________________ CLINIC MR #: __________________

I have read the information contained in the "Important Information" form(s) about the disease(s) and the vaccine.
I have had an opportunity to ask questions which were answered to my satisfaction.
I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given
to me or to the person named in the identification space on the form for whom I am authorized to make this request.

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DATE GIVEN</th>
<th>AGE</th>
<th>SITE</th>
<th>VACCINE MANUFACTURER</th>
<th>VACCINE LOT NUMBER</th>
<th>HANDOUT PUB. DATE</th>
<th>NURSE INITIALS</th>
<th>SIGNATURE OF PARENT/GUARDIAN</th>
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**Figure 6-32F** Immunization Record (Courtesy of Memphis Family Case Center.)
Figure 6-32G  Height and Weight Record (Courtesy of Memphis Family Case Center.)
Figure 6-32G  Height and Weight Record (Continued)
**Figure 6-33** Encounter Form (Courtesy Delmar/Cengage Learning.)
FORMS CONTROL AND DESIGN

In a paper-based record system, it is imperative that each facility designate a person who is responsible for the control and design of all forms adopted for use in the patient record. This is usually the responsibility of the health information department, and in some facilities a forms committee (or patient record documentation committee) is established to oversee this process and to approve forms used in the record. The role of a forms committee is to scrutinize each proposed form to:

- Facilitate efficient use of the patient record (e.g., consolidation of forms, elimination of duplication of information throughout the record, and so on)
- Ensure that documentation collected on forms complies with accrediting, regulatory, and reimbursement organizations
- Enhance quality of documentation in the patient medical record
- Streamline the forms approval process

When designing a form, the following functional characteristics must be considered:

- Determine the purpose of the form.
  - Prior to designing the form, outline the purpose, use, and users of the form.
  - Make sure that the new form will not duplicate information that is already contained on another form.
- Keep the form simple.
  - The simpler the form design, the easier it will be to design and use.
- Include basic information.
  - All forms should contain the title of the form, form number, original date of form, revision date, and patient identification section.
  - Patient identification must be included on all reports (front and back), and it should be in the same general location on all forms.
- Include preprinted instructions.
  - Instructions for completion of the form should be printed on the form (e.g., reverse of the form).
- Plan spacing on the form.
  - Consider the type size and margins of the form.
  - If handwritten information is going to be entered on the form, make sure that there is sufficient space.
- Use color-coding for various sections of the record.
  - Consider using a different color border on forms for each discipline.
- Select a color of ink, usually black, that will photocopy easily.
- Allow for uniformity in size, content, and appearance.
- All headings on the various forms used should have a standard format.
- Be sure to standardize the size and appearance of individual forms.
- Consider paper requirements.
  - Consider the weight and quality of paper used.
  - Reports that are accessed frequently (e.g., face sheet) should be a heavier weight of paper so they can withstand frequent use.
- Prepare a draft of the form for review by the forms committee.
- Pilot the form for trial use (e.g., 30 days) on one nursing unit.
  - Revisions can be made if necessary.
  - Consider adopting ready-to-use forms, which can be cheaper to purchase.
  - Consider printing patient identification when form is generated (for patient safety purposes)

Some facilities require that proposed forms be accompanied by a completed application form (e.g., Application for New or Revised Patient Record Form) (Figure 6-34).

Exercise 6–6 Forms Control and Design

True/False: Indicate whether each statement is True (T) or False (F).

1. One of the roles of a forms committee is to review each proposed form to streamline the forms approval process.
2. In a paper-based record system, each department should designate a person who is responsible for the control and design of all forms adopted by the department for use in the patient record.
3. Prior to designing forms, the person designing the form should make sure that the new form will not duplicate information that is already contained on another form.
4. It is usually the responsibility of administration to oversee the forms process and to approve forms used in the record.
5. Documents that are used frequently should be printed on a heavier weight paper so they can withstand frequent use.
INTERNET LINKS

Bibbero Systems
Medicare Conditions of Participation
Go to http://www.cms.hhs.gov, click on Regulations & Guidance, click on Medicare, click on Conditions for Coverage (CfCs) & Conditions of Participation (CoPs), and click on Hospitals.
The Joint Commission
http://www.jointcommission.org
Go to http://www.bibberosystems.com to view ready-to-use forms.

SUMMARY

The patient record includes documentation about care and treatment provided to patients, and each report and every screen in an electronic health record must include the patient’s name and identification number as well as the health care facility’s name, address, and telephone number. Health care facilities often use an addressograph machine to imprint provider and patient identification information on each report of a paper-based record. Under Uniform Rules of Evidence, each patient record entry must be dated and
timed, and providers are responsible for adhering to patient record documentation guidelines.

The hospital inpatient record includes administrative data (e.g., demographic, financial, socioeconomic), which is gathered upon admission of the patient to the facility. Reports that comprise administration data include the face sheet (or admission/discharge record), advance directives, informed consent, patient property form, birth certificate (copy), and death certificate (copy). Also included in the hospital inpatient record is clinical data, which includes all health care information obtained about a patient’s care and treatment that is documented on numerous forms in the patient record (e.g., admitting diagnosis entered on face sheet). When a patient is admitted to the hospital through the emergency department (ED), the first clinical data item is the chief complaint documented as part of the ED record. Other clinical data documents include the discharge summary, history and physical examination, consultation, progress notes, nurses’ notes, and so on.

The hospital outpatient record (or ambulatory record) documents diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services. Some hospitals use a short stay record to document ambulatory surgery cases. The physician office record contains patient registration information, a problem list, a medication record, progress notes (including patient’s history and physical examination), results of ancillary reports, and reports of office surgery (if performed). An encounter form (superbill or fee slip) is used to capture charges generated during an office visit, is initiated when the patient registers at the front desk, and is completed by providers as the patient receives care.

Forms design and control are usually designated to a health information management professional who is responsible for oversight of all forms adopted for use in the patient record. Most facilities establish a forms committee (or patient record committee) to oversee this process and to approve forms used in the record.

**STUDY CHECKLIST**

- Read the textbook chapter, and highlight key concepts. (Use colored highlighter sparingly throughout the chapter.)
- Create an index card for each key term. (Write the key term on one side of the index card and the concept on the other. Learn the definition of each key term, and match the term to the concept.)
- Access chapter Internet links to learn more about concepts.
- Answer the chapter Exercises and Review questions, verifying answers with your instructor.
- Complete the chapter StudyWare activities.
- Complete WebTutor assignments and take online quizzes.
- Complete lab manual assignments, verifying answers with your instructor.
- Form a study group with classmates to discuss chapter concepts in preparation for an exam.

**CHAPTER REVIEW**

Fill-In-The-Blank: Enter the appropriate term(s) to complete each statement below.

1. A graph used to record the patient’s vital signs is called a ________.
2. The ________ record contains an antepartum record, labor and delivery record, and postpartum record.
3. The anesthesia record documents the monitoring of the patient during the administration of the ________.
4. The operative report contains both the ________ and ________ diagnoses.
5. The ________ aids in the diagnosis and treatment of the patient by documenting the pathologist’s analysis of tissue.

Multiple Choice: Select the most appropriate response.

6. The first-listed diagnosis and procedure is ________ data.
   a. administrative
   b. clinical
   c. financial
   d. identification

7. Written instruction given by a patient to a health care provider outlining the patient’s preference for care before the need for treatment is known as a(n) ________.
   a. advance directive.
   b. consent to admission.
   c. consent for surgery.
   d. health care proxy.

8. A document that provides a summary of a patient’s hospitalization is a(n) ________.
   a. clinical résumé.
   b. history.
   c. operative report.
   d. physical examination report.
9. A chronological description of the patient’s present condition from the time of onset to the present is a
   a. history of the present illness.
   b. medical history.
   c. review of systems.
   d. social history.

10. Preprinted orders that are placed on a patient’s record (e.g., upon admission) are called
    a. discharge orders.
    b. phone orders.
    c. routine orders.
    d. stop orders.

11. The completion of a history and physical examination is the responsibility of the
    a. attending physician.
    b. nurse.
    c. surgeon.
    d. therapist.

12. A tissue report is also known as a
    a. pathology report.
    b. postanesthesia report.
    c. postoperative report.
    d. specimen report.

13. A report documenting blood chemistry, blood gases, and blood type is a
    a. blood report.
    b. drug record.
    c. laboratory report.
    d. pathology report.

14. All patient information obtained through treatment and care of the patient is called
    a. administrative data.
    b. clinical data.
    c. demographic data.
    d. financial data.

15. A review of the medical events in the patient’s family, including disease which may be hereditary or present a risk to the patient, is part of the
    a. admission information.
    b. family history.
    c. medical information.
    d. social history.

True/False: Indicate whether each statement is True (T) or False (F).

16. A review of systems is a chronological description of the patient’s present condition.

17. The Joint Commission requires that a discharge summary be completed by the attending physician to facilitate continuity of patient care.

18. The admitting diagnosis is also called a principal diagnosis.

19. The Patient Self Determination Act required that all patients, age 21 and over, have the right to have an advance directive placed in their record.

20. The final order that is written to release a patient from a hospital is known as a discharge order.