Wake Forest University Baptist
MEDICAL CENTER

NORTH CAROLINA BAPTIST HOSPITAL

MEDICAL RECORD DEPARTMENT

HOUSE OFFICER

ORIENTATION – 2003

(Rev. 6/12/03)

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North Carolina Baptist Hospital
Winston-Salem, North Carolina

Authentication Form
Electronic Signature, Computer Key, Rubber Stamp Signature Acknowledgement

MEMORANDUM

TO: Attending Physicians, House Staff, and Other Providers

FROM: Jeanne Goode, Director - Medical Record Department

SUBJECT: **Authentication of Medical Records**

To meet regulatory standards on authentication of medical records entries:

Please sign on the line below as you will authenticate your medical record entries. If there are several ways you may authenticate (such as full name, initials only, first and last name only, etc), please include all of them on the signature line.

Some medical record entries may be authenticated with electronic signature, computer key, or rubber stamp signature. Your signature below also indicates you agree that: you will be the sole user of your electronic signature, computer key or rubber stamp signature; you will not delegate the use of the electronic signature, computer key or rubber stamp signature to any other user; and that you assume responsibility for any part of the medical record upon which the electronic signature, computer key or rubber stamp signature is used.

Please enter the current date below and include your department in the space provided.

Please return this form to Jeanne Goode in the Medical Record Department.

Print Name:_____

_____
Signature (s)

_____ _____
Department Date

Affix Rubber Stamp, if applicable: _____

SECTION 1 **HOUSE STAFF ORIENTATION**
MEDICAL RECORD DEPARTMENT

GENERAL POLICIES, SERVICES, AND INFORMATION

LOCATION: First Floor, Meads Hall

Staffed Hours:

File Area/Medical Record Numbers:
24 Hours/Day, 7 Days/Week
Furnishes medical records for patient care.

Doctors Workroom:
Monday - Friday, 7:00 am to 11:00 pm
Saturday, 8:00 am to 4:00 pm
Furnishes incomplete records for physicians to complete. If a physician wishes to complete records outside of staffed hours, arrangements must be made during staffed hours.

Transcription:
Monday - Friday, 8:00 am to 5:00 pm
Saturday - Sunday, 7:00 am - 3:30 pm
(See Section 5 for Stat Dictation)

Director: Jeanne Goode, RHIA

Assistant Directors: Gina Rose Everhart, RHIA
Kim Withers, RHIA

LOCATION**:** Downtown Health Plaza

Staffed Hours: Monday, Wednesday: 7:30am – 7:00pm
Tuesday, Thursday, Friday: 7:30am – 5:30pm

Manager: Angela F. Ruiz, RHIT

CHAIRMAN, MEDICAL RECORD INFORMATICS TECHNOLOGY COMMIITTEE:
Dr. Fred Kahl, Cardiology

EXTENSIONS**:** See Medical Center Directory under Medical Record Department

SECTION 1 **HOUSE STAFF ORIENTATION**
MEDICAL RECORD DEPARTMENT

GENERAL POLICIES, SERVICES, AND INFORMATION

AUTHENTICATION OF MEDICAL RECORDS

The Medical Record Department maintains a file of how physicians authenticate their entries in the medical record. Physicians are requested to fill in an authentication form and return it to Medical Records. **Beginning July, 2003, electronic authentication will be implemented by clinical service for transcribed documents such as H&Ps, Operative Reports, Discharge Summaries, and Clinic Notes. Until the implementation for all clinical services is complete, some documents must continue to be signed on paper.**

MEDICAL RECORD INFORMATICS TECHNOLOGY COMMITTEE (MRIT)

The Medical Record Informatics Technology Committee is a Medical Staff Committee comprised of Physicians, Nursing, Hospital and WFUP Administration, Information (Computer) Services, Risk Management, Pharmacy and Medical Record Department. Duties include: establishing and approving medical record policies and documentation requirements; overseeing the implementation of the computerized patient record; assuring JCAHO, DRG, reimbursement, legal and other requirements are met; approving forms for inclusion in medical records; and monitoring the operation of the Medical Record Department.

FORMS COMMITTEE

The Forms Committee is a subcommittee of the Medical Record Informatics Technology Committee whose primary responsibility is to approve forms for inclusion in the Medical Record.

MEDICAL RECORD REVIEW COORDINATION COMMITTEE

The Medical Record Review Coordination Committee is a subcommittee of the Medical Record Informatics Technology Committee whose primary responsibility is to provide compliance with JCAHO standards for Medical Record review.

MEDICAL RECORD/UNIT NUMBERS

Each patient treated at the Medical Center is assigned a medical record number. Medical record numbers are controlled by the Medical Record Department. The Master Patient Index has over 1,662,300 patients. Medical record numbers may have 6 or 7 digits. The medical record number must be documented on all reports that are to be included in the medical record. Information needed for a medical record/unit number assignment is: full name of patient, address, maiden name (if appropriate), date of birth, race, sex, mother's first name, social security number (if appropriate.)

CONTENT OF MEDICAL RECORD

A single, lifetime medical record number is issued for each patient, and is used for inpatient hospitalizations, and for outpatient visits on the main campus, at the Downtown Health Plaza, CompRehab, and in the Wake Forest University Physician Practice (WFUP).

A medical record is maintained for every patient hospitalized, treated in the Emergency Department, the Hospital sponsored Outpatient Department Clinic, Ambulatory Surgery, Day Hospital, or in the Partial Hospitalization program. Records may be maintained in hardcopy and/or electronically. Paper based medical records may be filed in the Medical Record Department and in the outpatient location where the patient was seen (such as in the WFUP

clinics, the Downtown Health Plaza, CompRehab, or in the Outpatient Psychiatry Clinic**). There are some medical record documents, such as outpatient lab and radiology results, that are not on file in a paper record. LastWord must be accessed to obtain the information.**

COMPUTERIZED PATIENT RECORDS AND INFORMATION

Separate training and documentation will be provided and access assigned. There are two computerized patient record systems: **LastWord** and **Logician**. Neither is totally complete at this time.

OBTAINING A MEDICAL RECORD

Access to medical records of patients shall be afforded to members of the medical staff for study and research consistent with preserving the confidentiality of personal information concerning the individual patient. Researchers will be asked to provide IRB approval documentation, or to complete paperwork when chart review is preparatory to research. In case of re-admission of a patient, previous Hospital records shall be available for the use of the treating physician.

For Patient Care: Paper-based medical records are pulled for patients re-admitted to the Hospital, seen in the Outpatient Department, Emergency Department, Day Hospital, or Ambulatory Surgery when needed. Records are provided to the WFUP when requested. It is the responsibility of the clinic and secretary to request records 48 hours prior to scheduled appointments. Records for patient appointments are picked up on the day of the appointment and MUST BE RETURNED THE SAME DAY.*

For Research: The Medical Record Department will pull records for research (see above). Statistical information to identify patients by diagnosis and operative procedure is available to assist physicians. It is requested you discuss research requests with the Research/Statistics Database Manager at extension 6-2446. Research is not handled on a stat basis. A minimum five(5) workday notice is required.

For Review: If a record is needed by a House Officer for review only, it must be reviewed in the Medical Record Department. It is preferable for the House Officer to call the File Area at extension 6-3217 prior to coming to the Medical Record Department (main campus). To request a record to be pulled at the Downtown Health Plaza, call 3-9800 and follow menu instructions.

For Conference: Records needed for conference must be requested at least 48 hours in advance (2 working days.) Records may be removed from the Medical Record Department on the day of the conference; but **MUST BE RETURNED THE SAME DAY**.*

* Incomplete medical records may not be removed from the Medical Record Department except for patient care or completion of chart work by Faculty Physicians.

Other: Contact the Supervisor of the File Area.

Electronic: All typed reports which are complete are uploaded immediately after transcription from the Medical Record Department's word processing system to electronic systems for viewing.

GENERAL POLICIES, SERVICES, AND INFORMATION

REMOVING MEDICAL RECORDS FROM THE MEDICAL RECORD DEPARTMENT OR HOSPITAL PREMISES

Hospital records are the property of the Hospital and removal from hospital premises is prohibited. If a subpoena or court order is received requesting removal, contact the Director or one of the Assistant Directors of Medical Records.

It is medical staff policy that all records removed from the Medical Record Department, except for records of re-admission to nursing units, be returned to the Medical Record Department the same day. Records must be available and accessible when needed for patient care.

GENERAL POLICIES, SERVICES, AND INFORMATION

IMPORTANT, PLEASE REVIEW!

DISCHARGE RECORDS

Medical Records of patients discharged should be returned to the Medical Record Department the day after discharge. At the time of discharge, nursing will place records of discharged patients in a locked location on the Nursing Units. If a record is needed by a House Officer or other staff, they must (1) contact someone at the Nursing Unit; (2) provide their name, beeper number, and location the record will be taken if removing the record from the Nursing Unit; (3) ensure the record is returned to the Nursing Unit by midnight the day of discharge so Nursing can return the record to the locked location. Nursing will verify at 2:00 am each morning that the records of all discharged patients are accounted for and/or in the locked location. **If the physician/person checking out the record or removing it from the Nursing Unit does not return the record timely, Nursing will beep the person some time before 2:00 am to follow-up on the location of the record. That person will be responsible for immediately returning the record to the Nursing Unit**.

(If any discharged patient's record is needed for dictation or review after it has been returned to the Medical Record Department, please call 6-4787. The record will be retrieved immediately for you.)

GENERAL POLICIES, SERVICES, AND INFORMATION

STATISTICAL INFORMATION

There is a Decision Support system which contains statistical information on hospital patients. It includes demographic data, diagnoses and operative codes, and physician data. Statistical requests should be discussed with the Research/Statistics Database Manager.

RELEASE OF PATIENT INFORMATION

North Carolina Statute recognizes the confidentiality of medical information and confers a right on all patients to have their medical records treated as confidential and privileged.

Written consent of the patient is required for access or release of medical information to persons not otherwise authorized to receive the information.

The original medical record is owned by the Hospital and will not be released to anyone outside the Medical Center. Copies will always be made.

The Medical Record Department is responsible for responding to any court order or subpoena for copies of the Hospital record. The Downtown Health Plaza Medical Record Department responds to subpoenas and court orders for records created or maintained at that facility.

Releasing WFUP office records is the responsibility of the physician's academic office or the WFUP Business Office. Requests received for WFUP records may be routed to Physicians' academic offices or the WFUP Business Office.

If a patient requests copies of their Hospital record, which they have a right to do, the attending physician's academic office will be notified a request has been processed by the Medical Record Department. This communication is done after the information has been furnished. Note: The exceptions to this policy are Department of Psychiatry admissions or outpatient visits, which are reviewed by the Psychiatrist prior to the release of psychiatry records.

The Correspondence Section within the Medical Record Department is responsible for releasing medical information for the Hospital. This section is available to answer further questions concerning release of medical information. The Downtown Health Plaza is responsible for releasing records created or maintained at that location.

There are occasions when the Risk Management Department is requested to become involved in releasing medical information.

RUBBER STAMP SIGNATURES

Rubber stamp signatures are not acceptable for use by House Staff.

COMMUNICABLE DISEASE REPORTING

A North Carolina Administrative Code requires all known or suspected patients with a communicable disease be reported to the Forsyth County Health Department. Physicians are encouraged to report a communicable disease as soon as they become aware of it.

GENERAL POLICIES, SERVICES, AND INFORMATION

CANCER REGISTRY

A Cancer Registry, approved by the American College of Surgeons, is maintained by North Carolina Baptist Hospital. The purpose of the Cancer Registry is to maintain surveillance over the course of each patient with a malignancy and selected benign neoplasms which include brain, central nervous system and salivary gland tumors. A patient is accessioned by the Cancer Registry at the time of first pathology report indicating a malignant or benign disease. Basic information related to the diagnosis and treatment should be documented in the patient's medical record so it can be accurately abstracted. When documenting a final diagnosis of malignancy, it should include staging and a histological classification. TNM Staging is the responsibility of the managing/treating physician according to the American College of Surgeons' Commission on Cancer. The TNM Staging documentation will be monitored by the Cancer Registry. The lack of staging information can affect the approval status. The Cancer Registry is available to assist physicians in research.

ABBREVIATIONS AND SYMBOLS

Symbols and abbreviations used in the medical record should be only those appearing on the published list of approved medical staff abbreviations and symbols. The abbreviation/symbol list is posted on the Wake Forest University Baptist Medical Center's Intranet. **Absolutely no abbreviations are accepted on the discharge order and summary form when documenting final diagnoses and operative procedures**.

DEATH CERTIFICATES

At the time of death, the physician who pronounces the patient dead must immediately fill in and sign the certification portion of the death certificate. Under no circumstances are death certificates to be signed by students. Permanent black ink must be used in filling in and signing death certificates. In a medical examiner's case, the medical examiner is responsible for signing the death certificate. The Pathology Department is responsible for assuring death certificates are filled in and processed.

ERROR CORRECTIONS

When making a handwritten entry in the medical record, check the patient's name on the chart to make sure the information is being recorded in the proper medical record. If an error is made, identify it by drawing one line through the incorrect information, writing the date and time, and signing the entry. Do not mark out the incorrect information so it is not readable.

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AMBULATORY SURGERY/DAY HOSPITAL/OUTPATIENT CLINIC CHART DOCUMENTATION/COMPLETION REQUIREMENTS

A complete, legible medical record, which is pertinent and current, will be created for each inpatient.

Documentation requirements are established by:

- Medical Staff Rules and Regulations
- Medical Staff Policy
- JCAHO, CMS, Licensure and other Requirements
- WFUP (Wake Forest University Physicians Practice) Requirements to support reimbursement of professional fees by Medicare

The Medical Record Department audits inpatient charts after discharge and will require deficiencies to be completed relative to: discharge summaries, admission history and physicals, operative notes, and the discharge order and summary form.

Clinical Departments/Sections designate documentation responsibilities for attending physicians and house officers.

CHART DOCUMENTATION/COMPLETION REQUIREMENTS ARE AS FOLLOWS:

ADMISSION HISTORY AND PHYSICAL

1. An admission history and physical must be completed and on the record within 24 hours of admission.

2. If a history and physical is dictated, an interim note must be handwritten on the record. The format elements for transcribed history and physicals are listed in the Transcription Section of this handbook. The typed report will be placed on the inpatient record for signature within 24 hours. You must review and sign the reports you dictate as soon as possible.

3. A Family Practice physician may be responsible for completing a history and physical on dental patients who are admitted for oral surgery when the surgeon is not a M.D.

4. If a complete history and physical has been obtained within 30 days prior to admission, such as in the office of a physician, a legible copy of this report may be used for the inpatient record, provided there have been no subsequent changes or any changes are recorded at the time of admission.

5. If a patient is re-admitted within 30 days for the same or a related problem, an interval history and physical may be documented in the inpatient record provided the original information is readily available and any changes/additions are recorded.
6. The attending physician must countersign the history and physical when completed by a House Officers or medical student.

7. If a history and physical has been dictated and typed, the attending physician may be asked to sign it even though there may be a handwritten H&P on the record signed by the attending. If available, the typed H&P is sent to the referring physicians or others requesting copies of the record; therefore, the physician is asked to sign it.

AMBULATORY SURGERY/DAY HOSPITAL/OUTPATIENT CLINIC CHART DOCUMENTATION/COMPLETION REQUIREMENTS

8. A history and physical must be on a patient's record prior to any surgery.

9. IF A PATIENT IS ADMITTED FROM DAY HOSPITAL OR AMBULATORY SURGERY, the history and physical must be updated and the reason for admission stated.

PROGRESS NOTES

1. Progress notes may be written by attending physicians, house officers, medical students, or designated nurse practitioners. Medical students' notes must be countersigned by a physician.

2. Progress notes must be dated and authenticated.

3. Progress notes shall be recorded as frequently as the patient's condition requires, but in any case at intervals of 72 hours (3 days) or less. If a patient has had surgery, a progress note is required for 5 consecutive days after surgery.

PROCEDURE NOTES

1. A procedure note is required to be written in the progress note section of the record for every procedure requiring patient consent.

2. For professional reimbursement for some patient financial types, such as Medicare, the attending physician is required to document his/her presence for the key portions of procedures performed and/or documented by a House Officer.

OPERATIVE REPORTS - see also Section 4 -- Incomplete Medical Records Policies - Transcription

1. Operative reports **MUST BE DICTATED IMMEDIATELY AFTER SURGERY**. Please refer to format for dictation in the Transcription Section of this handbook.

2. Operative reports must be signed by the Dictator and Attending Surgeon.
A handwritten operative note must be written in the progress note section of the record immediately after surgery. The note should include the following:

   - Preoperative diagnosis
   - Postoperative diagnosis
   - Name of the primary surgeon and assistants
   - Findings
   - Technical procedures used
   - Specimens removed

3. Typed operative reports are placed on inpatients' records.

TRANSFER/ACCEPTANCE NOTE

1. An order should be written on the physician order form in the medical record indicating to whom and when the patient is to be transferred.

AMBULATORY SURGERY/DAY HOSPITAL/OUTPATIENT CLINIC CHART DOCUMENTATION/COMPLETION REQUIREMENTS

2. If a patient is transferred from one clinical service to another while hospitalized, a transfer note must be written on the day of transfer by the service to which the patient is transferred.

3. The attending physician to whom the patient is transferred may write a note or countersign a note written by a house officer. For professional reimbursement for some patient financial types, such as Medicare, the attending physician may be required to document a transfer note.

DEATH NOTES

1. In the event of a death in the hospital, the deceased shall be pronounced dead by the attending physician or his designee.

2. The body shall not be removed from the floor until a full explanatory death note is written. "Fully explanatory" means a note which succinctly describes the circumstances of the death in such a way that the pathologist or other reviewer of the record can properly relate the final event to the preceding course.

PRE-ANESTHESIA NOTES

1. A pre-anesthesia evaluation must be documented in the record.

2. The pre-anesthesia note may be documented by a House Officer. For professional reimbursement for some patient financial types, such as Medicare, a faculty anesthesiologist may be required to document a pre-anesthesia note.

ANESTHESIA RECORDS

1. An anesthesia record is required.

2. For professional reimbursement for some patient financial types, such as Medicare, the faculty anesthesiologist must document involvement and authenticate the anesthesia record.

POST-ANESTHESIA NOTES

1. A post-anesthesia note should be documented in the medical record.

2. A post-anesthesia note may be written and signed by a House Officer.

3. For professional reimbursement for some patient financial types, such as Medicare, a post-anesthesia note by the faculty anesthesiologist may be required, including procedures done under local standby.

4. Post-anesthesia notes by Anesthesiology are not required for local anesthesia.

AMBULATORY SURGERY/DAY HOSPITAL/OUTPATIENT CLINIC CHART DOCUMENTATION/COMPLETION REQUIREMENTS

PHYSICIAN ORDERS

1. All orders written for a patient are to be accurately dated, timed, and signed. The order **must** also include signature, ID#, printed name, and beeper #. (ID# = your computer [LastWord] user number, which is same as your dictation number.)

2. Any verbal or telephone orders must be countersigned by the responsible as soon as possible. The countersignature **must** include the date.

3. Only members of the service of an individual patient may write orders for the patient. Any orders written by consultants and other services must be countersigned. Exceptions are:

   - Medication ordered by members of the Anesthesia Department in the Recovery Room or ICU, and for pre-anesthetic medication
   - Preoperative orders written by members of the Radiology Department.

4. Computerized physician order entry (CPOE) is being implemented on inpatient patient care areas. Training will be provided as you work with patients on nursing units that have implemented CPOE.

CONSULTATION REPORTS

1. It is a policy of the Medical Staff to respond to all routine requests for consultations within 24 hours.

2. Consultation reports should be documented on the consult form.

3. The consult report should contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record.

4. If a consult report is completed by a house officer, the attending consultant must countersign the report, as appropriate, and indicate he/she has seen the patient and agrees with the documentation. Professional reimbursement may be affected if the consult is not signed by the attending physician.

DISCHARGE ORDER AND SUMMARY FORM

1. The Discharge Order and Summary Form must be completed before a patient is discharged. Please note this form is used as one method of communicating to referring physicians. (See attached Example 1) Please read the instructions carefully on the back of the form.

2. All diagnoses and procedures must be documented on the discharge form. These diagnoses and procedures are the basis for coding and grouping the patient into a DRG. The patient's DRG determines the Hospital's reimbursement on Medicare patients. These codes are also used for: submitting to insurance companies for non-Medicare reimbursement; for research and statistics. THESE DIAGNOSES AND PROCEDURES ARE ALSO SUBMITTED TO THE WAKE FOREST UNIVERSITY PHYSICIANS (WFUP) FOR USE IN ATTENDING PHYSICIANS PROFESSIONAL REIMBURSEMENT.

AMBULATORY SURGERY/DAY HOSPITAL/OUTPATIENT CLINIC CHART DOCUMENTATION/COMPLETION REQUIREMENTS

3. Referring Physician - At minimum, please give first and last name, street address, city and state.

4. The terminology used to document the final diagnoses and procedures on the discharge form must be consistent with the Standard Nomenclature of Diseases and Operations.

5. No abbreviations are acceptable when documenting the diagnoses and procedures on this form.

6. The discharge form must be filled in and signed.

Note: The Discharge Order and Summary Form will be changing from a paper form to an electronic form. The electronic version of the form requires the information to be entered into the computer rather than being written. The electronic Discharge Order and Summary form should be completed without the use of abbreviations. During the implementation period, the electronic version of the form may be in some areas, the paper version (of the form) in other patient care areas.

DISCHARGE ORDER

1. Patients shall be discharged only on a written order.

2. The requirement for a written order may be met by filling in the Discharge Order and Summary Form.

DISCHARGE SUMMARY

1. A discharge summary must be dictated on all patients at the time of discharge or expiration. Formats for dictating Discharge Summaries are provided in the Transcription Section of this handbook.

2. The attending physician at the time of discharge must countersign the summary.

3. When a discharge summary is dictated, the dictator must sign off on the discharge order and summary form in the space labeled summary dictated. The sign off includes the dictator's initials and date. (See Example 1 at back of handbook.) *Note: The sign off block is available on the paper form only; if the electronic discharge order and summary form is used, there is no corresponding field for the summary sign-off.*

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MEDICAL RECORD DEPARTMENT
AMBULATORY SURGERY/DAY HOSPITAL/OUTPATIENT CLINIC
CHART DOCUMENTATION/COMPLETION REQUIREMENTS

Clinical Departments/Sections designate documentation responsibilities for attending physicians and house staffs.

AMBULATORY SURGERY

1. A history and physical examination is required on patients undergoing ambulatory surgery.

   - The history and physical must have been completed within 30 days of surgery provided there have been no subsequent changes or the changes have been recorded.
   - If a patient is admitted from Ambulatory Surgery, the History and physical must be updated to show the reason for admission and must meet inpatient History and physical requirements.

2. A handwritten operative note must be written on the record immediately after surgery.

3. An **OPERATIVE NOTE MUST BE DICTATED IMMEDIATELY AFTER SURGERY**. The format for operative notes is located in the Transcription Section of this handbook. The operative note must be signed by the surgeon.

4. Physician orders, pertinent events, and clinical observations are to be documented in the record.

5. Patient disposition and any instructions given to the patient or family should be documented.

DAY HOSPITAL/PARTIAL HOSPITALIZATIONS

1. A history and physical is required on patients admitted to Day Hospital or for partial hospitalizations.

   - If a history and physical has been obtained within 30 days prior to the admission, such as in the office of a physician, a legible copy of this report may be used, provided there have been no subsequent changes or the changes have been recorded.

   - If a patient is admitted within 30 days for the same or a related problem, an interval history and physical may be documented in the patient's record provided the original is readily available.

   - The history and physical must be signed by the dictator and/or attending physician.

   - If a patient is admitted from Day Hospital, the History and physical must be updated to show the reason for the admission and must meet inpatient History and physical requirements.

2. A handwritten procedure note must be written for any procedure performed.

3. Physician orders, clinical observations, and pertinent events are to be documented in the record.

4. Patient disposition and any instructions given to the patient of family should be documented.

MEDICAL RECORD DEPARTMENT
AMBULATORY SURGERY/DAY HOSPITAL/OUTPATIENT CLINIC
CHART DOCUMENTATION/COMPLETION REQUIREMENTS

OUTPATIENT CLINIC DOCUMENTATION

Medical record documentation is required for every patient who is seen in the Outpatient Clinic.

The documentation must include the following:

- Patient identification.
- Relevant history of the illness or injury and of physical findings.
- Diagnostic and therapeutic orders.
- Clinical observations including the results of treatment.
- Reports of procedures and tests, and their results.
- Diagnosis or impression
- Patient disposition and any instructions given to the patient and/or family for care.
- Immunization status of children and adolescents and others as determined by law and/or hospital policy.
- Growth charts for children and adolescents for whom the ambulatory care department/service is the source of primary care.
- Allergies
- Referrals to practitioners or providers of service internal or external to the organization.
- Communications to and from external practitioners or providers of service.

Documentation must be done at the time of each clinic visit.

The forms used for Outpatient Clinic documentation are maintained in each of the clinics. The forms may vary from clinic to clinic.

OPD Clinic Notes and Clinic Letters may be dictated by dialing (336) 716-9999 (internal dial 6-9999). This service is provided by an outsourced transcription service. Please see the dictation help card for more information on OPD Dictation. This card is enclosed in an envelope inserted in the front of this handbook.

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INCOMPLETE MEDICAL RECORD POLICIES
DOCTORS' WORKROOM

Medical Staff policies for completion of records are based on meeting JCAHO guidelines, Medicare (DRG) requirements, licensure, and other regulatory/legal requirements.

DOCTORS WORKROOM

The Doctors Workroom is the area where incomplete/delinquent records are made available post discharge for physicians to complete.

The Doctors Workroom is staffed as follows. If a physician wishes to complete records outside of staffed hours, arrangements must be made during staffed hours.

HOURS STAFFED: Monday - Friday, 7:00 AM to 11:00 PM
Saturday, 8:00 AM to 4:00 PM

Incomplete records are available for physicians to complete in the Doctors Workroom. If a physician knows of specific, incomplete records he/she would like within the 7 days of discharge, the individual records may be requested.

The Doctors Workroom staff maintains a record of all incomplete charts by physician.

Incomplete charts are filed in numeric order and must be pulled by Medical Record personnel for each House Officer when he/she comes to complete them.

CHART DEFICIENCY SLIP

1. A deficiency slip is placed on each incomplete inpatient medical record (See Example 2 at back of handbook).

2. The deficiencies indicated on the deficiency slip are based on the requirements for chart documentation/completion and the quantitative audit of the medical record against these criteria by the Medical Record Department.

3. The Deficiency Slip informs the attending physician and house officer what he/she needs to sign, document, or dictate for the record to be complete.

4. Clinical departments/sections designate chart documentation responsibilities for House Officers and Attending Physicians. The policies are not consistent; such as, one Department may assign dictation to the House Officer I level and others may assign the same responsibility to a House Officer II or III.

5. If the Deficiency Slip requests you to complete an item in the record you do not think is your responsibility, PLEASE LET SOMEONE IN THE DOCTORS WORKROOM KNOW. You may do this by writing a note on the form or communicating directly with one of the personnel. If you do not let anyone know, the record will continue to come back to you.

INCOMPLETE MEDICAL RECORD POLICIES
DOCTORS' WORKROOM

HOUSE OFFICER NOTIFICATION OF INCOMPLETE RECORDS

1. Every other Wednesday, House Officers will be notified by memo of all incomplete records, regardless of discharge date. (See Example at back of handbook.)

2. House Officers will be responsible for coming to Medical Records within 14 days from the date of their notification and for completing chart work on all available records, which may include records not listed on the notification memo.

3. House Officers must sign a log in the Doctors Workroom indicating the date on which they came to Medical Records and completed charts.

DELINQUENT POLICY - HOUSE OFFICERS

House Officers, who do not come to Medical Records within 14 days from the date of their notification and satisfy their record responsibilities, will become delinquent at Noon every other Wednesday.

Delinquent House Officers are subject to one of the following:

1. Being placed on vacation until such records are completed. Vacation days consumed for this purpose will be subtracted from the total number of paid contractual vacation days provided the House Officer in the current year's contract.

2. If no vacation is available, being placed on suspension without pay, until such incomplete records are completed. Both pay and days-in-training will thereby be lost.

   The Department or Clinical Section will be responsible for placing House Officers on vacation or suspension.

3. Thursdays, following the Wednesday deadline for House Officers -

   The Chief of Professional Services will be notified of House Officers who have not satisfied their record responsibilities.

4. The Medical Record Department will notify the appropriate person, as defined by the Department or Clinical Section, when House Officers have completed their record responsibilities on all available records.

HOUSE OFFICER NOTIFICATION OF INCOMPLETE DOWNTOWN HEALTH PLAZA RECORDS

Notification of incomplete clinic chart work is placed in the boxes located in the Residents' Room. Please monitor boxes for forms and/or records that need to be completed.

INCOMPLETE MEDICAL RECORD POLICIES
DOCTORS' WORKROOM

INCOMPLETE MEDICAL RECORD POLICIES
TRANSCRIPTION

OPERATIVE NOTES

In addition to the brief handwritten operative note in the progress note section of the chart, a **detailed operative note must be dictated immediately after surgery**. The Medical Record Department Transcription Area concurrently monitors the compliance with this requirement.

Dictation services are available 24 hours per day. If the operative note has not been dictated the day of surgery, the attending surgeon is notified by e-mail. A list is posted in the Operating Room area of outstanding operative notes to be dictated. *(See Examples 4A and 4B)* If the operative note is not dictated within 24 hours, the attending surgeon's operating room scheduling privileges may be suspended until all outstanding notes are completed.

IF YOU ARE ASSIGNED TO COMPLETE THE DICATATION FOR AN OPERATIVE PROCEDURE, PLEASE DO SO ON THE DAY OF SURGERY.

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DICTATION/TRANSCRIPTION SERVICES
FLOW OF TYPED MEDICAL RECORD REPORTS

Transcription services are provided for the following report types:

- All reports should be dictated to **716-1777** or **6-1777**.
- Dictation may be done on any wall or desk phone in the Hospital. **DO NOT USE CORDLESS PHONES, SPEAKERPHONES, OR CELL PHONES FOR DICTATION.**
- Dictation instructions are attached and included on the Help Cards.

REPORT TYPE	DESCRIPTION	AFTER DIALING, CHOOSE OPTION #
01	Admission History & Physical	3
02	Operative Note	3
	Procedure Note	3
03	Discharge Summary	3
	Expiration Summary	3
04	Letter	4
	Miscellaneous	4
05	Discharge Summary	2
06	Adult Emergency Dept. Note	1
07	STAT Adult Emergency Dept. Note	1
09	Consult Note	4
13	Discharge Letter	4
14	OPD Clinic Letter	4
15	OPD Clinic Note	4
17	Pediatric Emergency Dept. Note	1
18	STAT Pediatric Emergency Dept. Note	1
24	Pediatric Clinic Note	4
	Pediatric Clinic Letter	4
26	Pediatric Cardiac Cath Report	4
27	Child Medical Evaluation	4
80	Downtown Health Plaza Clinic Note	4
81	Downtown Health Plaza Phone Note	4

For assistance with dictations, call 6-1777 and select Option 5.

DICTATION/TRANSCRIPTION SERVICES
FLOW OF TYPED MEDICAL RECORD REPORTS

DICTATION INSTRUCTIONS – ALL REPORTS

Dictation may be done on any wall or desk phone in the Hospital. **DO NOT USE CORDLESS PHONES, SPEAKERPHONES, OR CELL PHONES FOR DICTATION.**

1. From outside, dial **716-1777**. From in-house, dial **6-1777**.

2. Select the correct menu option:

1 to dictate an Emergency Dept. Report

2 to dictate a STAT DS for patient transfer

3 to dictate H&P, OP note, or routine DS

4 to dictate any other document type

5 for Assistance (Dictation Help Line)

3. If you are prompted for a site code, enter 24#

4. Enter 5-digit Physician ID#

5. Enter 2-digit dictation work type:

01 Admission History & Physical	**13** Discharge Letter
02 Operative Report	**14** OPD Clinic Letter
03 Routine Discharge Summary	**15** OPD Clinic Note
04 Letters/Miscellaneous	**17** Ped ER
05 STAT Discharge Summary	**18** Stat Ped ER
06 Adult ER	**24** PED Clinic Note or Letter
07 Stat Adult ER	**80** Downtown Health Plaza Note
09 Consultation	**81** Downtown Health Plaza Phone Note

6. Enter patient's **7-digit** medical record number

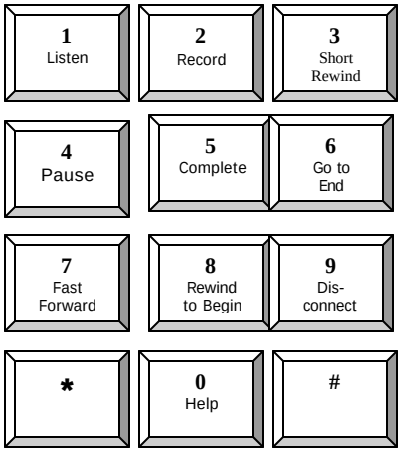
7. Begin dictation after the tone**.** **Speak slow, clear, and distinctively.**
At the beginning, state:

Your name
The type of report you are dictating (Admission H&P, Emergency Dept. Report, etc.)
The attending physician
Patient name (spell last name, first name) and medical record number
Date of dictation
Date of service/admission/operation etc.

DICTATION/TRANSCRIPTION SERVICES
FLOW OF TYPED MEDICAL RECORD REPORTS

Keypad Instructions - Press:

- **1** to listen
- **2** TO DICTATE
- **3** to rewind and listen
- **4** to pause
- **2** to resume dictation
- **5** to end dictation and begin new report
- **6** to fast-forward to the end
- **7** to fast-forward one increment
- **8** to rewind to the beginning
- **9** to disconnect from the system



To dictate several reports, press **5** between reports.

Write down the **confirmation number (job number)** you are given. If this number is not given at the start of your dictation, you may get it by pressing **5** at the end of your dictation.

HELP LINE: Also listed on the help cards.
Please report promptly any problems you may have with the dictation system or transcription so that it may be corrected quickly. Direct any questions or problems regarding dictation or transcription to:

- Medical Transcription: 6-3231 (716-3231) during office hours
- Medical Transcription Supervisor: 6-9366 (716-9366) during office hours.

EQUIPMENT:
Dictation can be done by using any phone in the Hospital.

Before you begin dictating, test the equipment by dictating a few words, reversing, and then listen. If you do not hear what you have dictated, do not continue; the dictation is not being recorded. Report any problems with the equipment to extension 6-3231, 6-9366, or 6-3219.

DICTATION/TRANSCRIPTION SERVICES
FLOW OF TYPED MEDICAL RECORD REPORTS

TIPS FOR DICTATION

Listed below are some solutions to the main problems encountered when trying to transcribe reports.

PLEASE:

1. **DO NOT DICTATE ON MOBILE, CORDLESS, CELL, OR SPEAKER PHONES.**

2. **Speak slow, clear, and distinctively.** Rapid dictation is very difficult to follow; the words run together and the beginnings and endings of sentences and paragraphs are almost impossible to distinguish. Do not hold the telephone receiver too close or too far away; your speech becomes muffled and distorted. Inaudible dictation causes delays in processing.

3. Enter correct information when dictating. This includes selecting the correct option, 5-digit physician ID#, 7-digit medical record number, 2-digit report/work type, etc.

4. State the type of report you will be dictating and follow the format for that report, giving section headings.

5. State and spell **your full name**.

6. Dictate the name of the **Attending Physician** who is responsible for this patient.

7. Dictate the correct **dates** of your patient's admission, discharge, operation, or visit.

8. State and spell the **patient's full name** as it appears on the chart, indicating the surname, and state the **correct medical record number**.

9. When dictating letters give the **full name and address of the addressee**, spelling street names and towns.

10. **Pronounce and spell accurately** the names of new or infrequently used drugs, surgical instruments, procedures, etc.

11. **Pronounce all the syllables in a word.** Many words sound alike and the difference of one syllable can alter the meaning greatly.

12. **If you wish to change your dictation,** please reverse your dictation and dictate over what you want changed.

13. When dictating an **addendum/continuation,** state that "this is the continuation of …" or "this is an addendum to…" and re-state the patient's name and Medical Record Number.

For assistance with dictation or to report problems, dial 716-1777 or 6-1777 and select Option 5.

DICTATION/TRANSCRIPTION SERVICES
FLOW OF TYPED MEDICAL RECORD REPORTS

STAT DICTATIONS:

1. Stat Discharge Summary (for patient transfer) dictation may be done at any time. You **MUST** dial 716-1777 or 6-1777 and select **option 2**. Please write down the job ID number when it is given.

2. Stat dictations are transcribed within 2 hours from the ending time of the dictation.

3. If possible, the transcription department should be called at 6-3231 between 8:00a.m. and 5:00p.m.and notified of stat dictation.

CORRECTIONS TO TYPED REPORTS:

1. All documents are transcribed as dictated. The transcriptionists do not edit the dictation.
2. Corrections or revisions to transcribed reports will be made. Corrections should be made legibly on the original report and returned to the transcription department.
3. If corrections are minor, physicians are requested to sign the report and return it to the transcription department. If this is done, corrections can be made and the report will not have to be routed back to the physician for signature. If multiple corrections are made, the report may be routed back to the physician for signature.

COPIES OF TYPED REPORTS:

Copies and CC's of transcribed reports will be routed accordingly via the MedPort delivery system. Documents are readily available in LastWord (Computerized Patient Record) for viewing and/or printing as needed.

ROUTING OF TRANSCRIBED REPORTS

Admission History and Physicals- Placed on the patient's chart at the nursing unit for signature. If the patient should be discharged before the admission note is dictated or placed on the chart, the report will be placed on the discharge record and signature of the appropriate physician requested.

Operative Reports- Placed on the patient's chart at the nursing unit for signature. If the patient should be discharged before the operative report is dictated or placed on the chart, the report will be placed on the discharge record and signature of the surgeon requested.

Discharge Summaries- Routed for signature based on the procedure for each clinical service requested. Some are placed on patient records for signature, others are routed to the physicians' offices. Signature of the responsible attending physician is required. Signature by the House Officer who dictated the report is not required.

Letters- Letters dictated by House Officers are placed in their signature file in the Doctors' Workroom in the Medical Record Department. It is the House Officer's responsibility to come to the Doctors' Workroom to sign letters in a timely manner. Copies of all letters are placed on the patient's chart after signature.

OPD Clinic Notes/Letters- These are placed in the House Officer's signature file in the Doctors' Workroom in the Medical Record Department. It is the House Officer's responsibility to come to the Doctors' Workroom to sign them in a timely manner. Copies of all OPD letters are placed on the patient's chart after signature. The original signed OPD clinic note will also be placed on the patient's record.

DICTATION/TRANSCRIPTION SERVICES
FLOW OF TYPED MEDICAL RECORD REPORTS

FORMATS

ADMISSION HISTORY & PHYSICAL

Dictator's name and date of dictation
Patient's full name and spelling
NCBH Medical Record Number
Attending physician and service
Admission date
Chief complaint
Present illness, including as appropriate:
Assessment of patient's emotional, behavior, and social status.
Relevant past, social, family history
In services for children and adolescents, include, if appropriate, an evaluation of the developmental age, consideration of educational needs, immunization status, and involvement of appropriate people in care, assessment, and treatment
Physical examination – inventory of body systems
Medications
Impressions/conclusions
Plans
Dictator's name and spelling

DISCHARGE SUMMARY/DEATH SUMMARY (Complete Version – No typed H&P on chart)

Dictator's name and date of dictation
Patient's full name and spelling
NCBH Medical Record Number
Attending physician and service
Admission date
Discharge date
Chief complaint
History of present illness
Relevant past, social, family history
Physical examination
Course in hospital
Significant findings
Procedures performed
Treatment rendered
Complications, if any
Condition of patient at discharge
Comparison with condition on admission
Discharge medications
Instructions to patient – should include physical activity, medication, diet, follow-up care, and any printed instructions
Prognosis
Final diagnosis
Operations/Procedures
Dictator's name and spelling
Referring physician(s) name and address
Initial, date, and note job number on discharge sheet when dictation is complete

DISCHARGE SUMMARY/DEATH SUMMARY (Abbreviated Version- typed H&P on chart at time of dictation)

Dictator's name and date of dictation
Patient's full name and spelling
NCBH Medical Record Number
Attending physician and service
Admission date
Discharge date
Chief complaint
"For present illness, relevant past, social, and family history, and physical exam, see typed History and Physical in chart"
Course in hospital
Significant findings
Procedures performed
Treatment rendered
Complications, if any
Condition of patient at discharge
Comparison with condition on admission
Discharge medications
Instructions to patient – should include physical activity, medication, diet, follow-up care, and any printed instructions
Prognosis
Final diagnosis
Operations/Procedures
Dictator's name and spelling
Referring physician(s) name and address
Initial, date, and note job number on discharge sheet when dictation is complete

DICTATION/TRANSCRIPTION SERVICES
FLOW OF TYPED MEDICAL RECORD REPORTS

CONSULT NOTE

Dictator's name and date of dictation
Date of consult
Patient's full name and spelling
NCBH medical record number
Dictate "Consult requested by _____"
Consult information

LETTER

Dictator's name and date of dictation
Full name and address of person to receive letter
Patient's full name and spelling
NCBH medical record number
Salutation
Body of letter
Complimentary closure

DISCHARGE LETTER

Dictator's name and date of dictation
Full name and address of person to receive letter
Patient's full name and spelling
NCBH medical record number
Discharge date
Salutation
Body of letter:
Reason for hospitalization
Relevant evaluation of management strategies
including operative procedures and investigations
Suggestions for future care and follow-up
Discharge medications
Body of letter
Complimentary closure

OPERATIVE/PROCEDURE NOTE

Dictator's name and date of dictation
Patient's full name and spelling
NCBH Medical Record Number
Attending physician and service
Date of operation/procedure
"Clean" or "Dirty" case
Pre-operative Diagnosis

OPERATIVE/PROCEDURE NOTE (cont.)

Post-operative Diagnosis
Operation/procedure performed
Surgeon
Assistant(s)
Pre-medication
Anesthesia
Anesthesiologist(s)
Anesthesia time
Operating time
Specimens removed and their disposition
Description of findings
Detailed description of procedure

EMERGENCY DEPARTMENT NOTES

Dictator's name and date of dictation
Date of service
Attending physician's name
Patient's full name and spelling
NCBH Medical Record Number
Referring physician's name, city, state
Time in
Time out
Physician exam time
Chief complaint
Admitting vital signs
Allergies
Medications
Immunization status
Review of systems
Relevant past, social, family history
Physical examination – inventory of body systems
Diagnostic tests
X-rays
ED treatment, procedures, and medications
ED course
Diagnoses
Discharge vital signs
Condition at discharge
Disposition
Instructions to patient
Discharge medications
Referred to
Disability
Dictator's name and spelling

DICTATION/TRANSCRIPTION SERVICES
FLOW OF TYPED MEDICAL RECORD REPORTS

COMMUNICATING TO REFERRING PHYSICIANS

The Medical Record Department assists physicians in communicating to referring physicians as outlined below:

DISCHARGE ORDER AND SUMMARY FORM
A copy of the Discharge Order and Summary Form is routed by the Medical Record Department to a patient's referring physician(s) the day after discharge. There is space on the form to document the referring physician's name and address. Your help in documenting the referring physician(s) on this form will help the Medical Center assure a patient's referring physician is aware of their patient's status.

EMERGENCY DEPARTMENT
If a copy of the dictated and typed Emergency Department report needs to be routed to a referring physician, the dictator must dictate the name of the referring physician and any known address. If this is not done, copies may not be routed. Referring physician information is available on the patient registration forms or attachments to the registration form.

OUTPATIENT CLINIC – HOSPITAL SPONSORED
A physician may dictate a letter to a referring physician through the Hospital's dictation system on outpatient clinic patients. After the physician has signed it, the original will be routed and a copy placed on the patient's medical record.

To communicate with physicians on Clinic visits, a Clinic Letter (work type 14) must be dictated. Remember to state the referring physician as the addressee.

INPATIENT – DISCHARGE SUMMARIES
Copies of discharge summaries are routed to referring physicians based on the policies and requests of each Department/Section. In order to assure copies are routed, the dictator should include the name of the referring physician and any known address in his/her dictation. If this is not done, copies may not be routed. Referring physician information is available on the patient registration forms or attachments to the registration form.

Depending on the clinical service, some reports may be sent to referring physicians before they are signed. This is to expedite communications. Referring physicians received revised copies if revisions are made.

Copies are routed to referring physicians either electronically or by the postal system, depending on their status as a MedPort participant.

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COMMUNICATING TO REFERRING PHYSICIANS

The Medical Record Department assists physicians in communicating to referring physicians. At the time of registration, a "referring and family physician" are designated by **the patient.** This information is entered into the Hospital registration system (Medipac/Patient Management). This information appears on the registration form, which is available in the patient's medical record. Basic information is transmitted to these physicians based on individual information system policies. In addition, information will also be transmitted at your request per the below policies.

DISCHARGE ORDER AND SUMMARY FORM

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OUTPATIENT CLINIC - HOSPITAL SPONSORED

A physician may dictate a letter to a referring physician through the Hospital's dictating system on outpatient clinic patients. After the physician has signed it, the original will be routed and a copy placed on the patient's medical record.

To communicate to referring physicians on Clinic visits, a Clinic Letter (work type 14) must be dictated. Remember to state the referring as the addresser.

INPATIENTS - DISCHARGE SUMMARIES AND HISTORY AND PHYSICALS

Copies of discharge summaries and history and physicals are routed to referring physicians based on the policies and requests of each Department/Section. In order to assure copies are routed, the dictator should include the name of the referring physician and any known address in his/her dictation. If this is not done, copies may not be routed. Referring physician information is available on the patient registration forms or attachments to the registration form.

Depending on the clinical service, some reports may be sent to referring physicians before signed. This is to expedite communications. Referring physicians receive revised copies if revisions are made.

Copies are routed to referring physicians either electronically or by postal system.

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MEDICAL RECORD DEPARTMENT
GENERAL POLICIES, SERVICES AND INFORMATION

"EXAMPLES"

#1: Discharge Order and Summary Form (Red Border Sheets – page 1&2)

#2: Chart Deficiency Slip

#3: Notification of Incomplete Records

#4: Operative Note Delinquent List
- **A) Daily Notification of Operative Notes**
- **B) Operative Notes Needing Dictation**

EXAMPLE 1: Discharge Order and Summary Form (Red Border Sheet) page 1

WAKE FOREST UNIVERSITY BAPTIST MEDICAL CENTER
WINSTON-SALEM, NC 27157

DISCHARGE ORDER and SUMMARY

PHYSICIAN TO FILL IN ALL **BLACK** AREAS
NURSE TO FILL IN ALL RED AREAS

INSTRUCTIONS ON BACK • DO NOT USE MEDICAL ABBREVIATIONS OR SYMBOLS
PLEASE PRINT

ADMIT DATE	DISCHARGE DATE	REFERRING PHYSICIAN

REFERRING PHYSICIAN ADDRESS

ADMITTING / PRINCIPAL / SECONDARY / COMPLICATIONS / CO-MORBIDITIES:

DIAGNOSES

PROCEDURES

DATE OF ONSET OF PRESENT ILLNESS | ESTIMATED DATE OF TERMINATION OF DISABILITY

DO NOT WRITE IN THIS AREA

SUMMARY DICTATED
DATE _____ BY _____

INVASIVE LINES / DEVICES ☐ YES ☐ NO

DISPOSITION

HOME CARE INSTRUCTIONS

MEDICATIONS

LISTED BELOW ARE YOUR MEDICATIONS & DOSAGES	Times to Take Daily	Continue as Before	Prescription Given	Information Given	LISTED BELOW ARE YOUR MEDICATIONS & DOSAGES	Times to Take Daily	Continue as Before	Prescription Given	Information Given
					☐ NO MEDICATIONS NEEDED AT DISCHARGE				

DIET: Your Diet Is: _____

ACTIVITY: ☐ No Restrictions ☐ Resume Same Activity ☐ Up with Crutches or Walker, Weight Bearing as Instructed ☐ Complete Bedrest
☐ DO NOT: ☐ Bend ☐ Stoop ☐ Lift ☐ Drive ☐ Move Furniture ☐ Do Strenuous Activity ☐ Climb Stairs
☐ Up as Tolerated ☐ OTHER: _____

FOLLOW-UP: ☐ No Appointment Necessary ☐ Return Appointment in _____ Wks. to Dr. _____ ☐ Card to be Mailed ☐ Call Home Doctor for Appointment

DISCHARGE PATIENT: _____ ORDERING PHYSICIAN'S SIGNATURE _____ DATE / TIME _____ DISCHARGE NURSE'S SIGNATURE _____ DATE

SPECIFIC DISCHARGE CARE INSTRUCTIONS (Nurse and/or Physician) - Dressings, Incision Care, Equipment, Instructional Materials

DATE	NURSE / PHYSICIAN SIGNATURE	INSTRUCTIONS

I have been told and understand these HOME CARE INSTRUCTIONS:

SIGNATURE OF PATIENT / FAMILY REPRESENTATIVE _____ DATE

09-007200 (1/96)

MEDICAL RECORDS

EXAMPLE 1: Discharge Order and Summary Form (Red Border Sheet) page 2

N.C. BAPTIST HOSPITALS, INC. • WINSTON-SALEM, NC 27157

DISCHARGE ORDER and SUMMARY

PAGE 2

ADMITTING / PRINCIPAL / SECONDARY / COMPLICATIONS / CO-MORBIDITIES / CONTINUED:

DIAGNOSES

PROCEDURES

DO NOT WRITE IN THIS AREA

HOSPITAL COURSE AND/OR OTHER PERTINENT NOTES

OPTIONAL

09-007300 (6 / 92)

MEDICAL RECORDS

EXAMPLE 2: Chart Deficiency Slip

Report Status	Typed	On Chart
Discharge Summery	☐	☐
History & Physical	☐	☐
Operative Note	☐	☐
Operative Note	☐	☐

ChartFact
North Carolina Baptist
D E F I C I E N C Y S L I P
Monday, May 26, 2003 03:47PM

BILLING NUMBER	:	MR NUMBER	: 000-00-00
PATIENT TYPE	: INPATIENT	PATIENT NAME	: TEST, B. PATIENT
PATIENT F.C.	:	ADMISSION DATE	: 05/05/2003
VOLUME/S	: 01	DISCHARGE DATE	: 05/16/2003
DISCH. SERVICE	:		

PHYSICIAN	DEFICIENCY	TYPE	COMMENTS	RES/ATT
95886 House Officer,			Poehling	
	A. - TAG COLOR	- - - - - -		
	B. Discharge Form	COMPT DIAGNOS		
	C. Dis Summary	DICTATE		
95887 House Officer,			Chang, M.	
	A. - TAG COLOR	- - - - - -		
	E. HP Handwrtn	WRITE		
	G. Operative Note 5/10/2000	DICTATE		

The chart work you are requested to do on this chart HAS NOTHING TO DO WITH YOUR PHYSICAN PRESENCE OR BILLING. You are requested to do this chart work based on Medical Staff Rules/Regulations and JCHAO requirements. (For further assistance, call X6-6260).

EXHIBIT 3: Notification of Incomplete Records

Name, Physician _____ Type of Service _____

Notification of Incomplete Records

North Carolina Baptist Hospital

06/04/03

Listed below are the incomplete records and deficiencies currently assigned to you. You are responsible for coming to the Medical Record Department within 14 days of the date of this notification to complete all available records.

The Policy by the Chiefs of Professional Services states that you will become delinquent if all available records are not completed within 14 days from the date of this notification.

Medical Rec. No.	Patient Name	Discharge Date	Deficiencies
000-00-00	Doe, John	5/26/03	Complete Discharge Form
000-00-01	Smith, Sam	5/21/03	Dictate Discharge Summary

Total Discharges: 2

EXHIBIT 4A: Daily Notification of Operative Notes

PLEASE DICTATE TODAY!

The following operative notes are for surgeries performed June 10, 2003 that have not been dictated. JCAHO requires that all operative reports be dictated immediately after surgery. The number of outstanding operative reports cannot exceed 2% of the total operations. This is only 1 – 2 per day.

If any of the below were cancelled or incorrect, please report to Susan Harwell, Supervisor at 6-9366 or Transcription at 6,3231.

TOTAL: 3

Surgeon	Service	Pt. Name	NCBH#	I/O	Multiple Surgeons	Date of Surgery
Jones	NSU	Harry Smith	000-00-00	I		06/10/03
Harrison	SUR	Jane Doe	000-00-02	O		06/10/03
Howard	URO	Steven Green	000-00-03	I		06/10/03

* This report is posted daily in the Inpatient and Outpatient Operating Rooms

EXAMPLE

EXHIBIT 4B: Cumulative Operative Notes Needing Dictation

OPERATIVE NOTES NEEDING DICTATION
Cumulative for Surgeries

Performed Thru: 06/09/03
Date of Report: 06/11/03
Time of Report: 12:44PM

Total: 2

If any of the below were cancelled or incorrect, please report to Susan Harwell, Supervisor at 6-9366 or Transcription at 6,3231.

Surgeon	Service	Pt. Name	NCBH#	I/O	Multiple Surgeons	Date of Surgery
Jones	NSU	Harry Smith	000-00-00	O		05/02/03
Harrison	SUR	Jane Doe	000-00-02	I		04/22/03

* This report is posted every Wednesday and Friday in the Inpatient and Outpatient Operating Rooms.

EXAMPLE

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