Who to Call in Health Information Management

Administration
Ext. #21918

Record Completion
Ext. #26890

Access to Patient Records
Ext. #22400

Dictation/Transcription
Ext. #26890

www.utmb.edu/him
TABLE OF CONTENTS

UTMB’s Legal Medical Record ................................................................. 3

Use and Disclosure of Protected Health Information .................. 5

Medical Record Access for General, Research and Statistical Use ..... 11

Record Completion ................................................................................ 25

Dictation Information ............................................................................ 49

UTMB Medical Abbreviations Guide ...................................................... 55
UTMB’s
Legal Medical
Record
UTMB’S LEGAL MEDICAL RECORD

In order to track both physical and electronic versions of Protected Health Information, the following serves as a guide for defining legal medical records and obtaining these documents at UTMB.

The Legal Medical Record (LMR), identified with a unique medical record number (MRN) and previously known as the Unit History # (UH#), is maintained by the Health Information Management Department and contains UTMB’s original/official patient care information. The LMR is designed to contain the written interpretations of all significant clinical information gathered on a given patient. These records have permanent retention. The entire patient’s medical record is in paper or electronic form under one MRN and can be located:

- Epic EMR
- MyUTMB
- Meditech EMR (ADC)
- Allscripts EMR (ADC)
- Paper records – Hospital Records and Subsidiary Records (Galveston, ADC, and Iron Mountain)

Records acquired through purchase or assimilation (e.g. Gulf Coast Medical Group, community physicians, etc.) whether paper or electronic do not have a permanent retention but are maintained for a period of 21 years (AC+21).

Records from the merge with Angleton Danbury Medical Center will be maintained permanently.
Use and Disclosure of Protected Health Information
MEDICAL RECORD INFORMATION IS PROTECTED HEALTH INFORMATION (PHI)

IT IS CONFIDENTIAL AND PRIVILEGED INFORMATION AND IS LEGALLY PROTECTED FROM DISCLOSURE

As you use PHI and discuss patients with your colleagues, be sure to do so in a private area. Even accidental release of information is an unlawful disclosure. Please be sensitive to every patient’s right to privacy.

All PHI created on your patients is to be incorporated into the UTMB medical record as soon as possible. This is to insure a complete medical record for:

- Continuity of patient care
- Legal protection for UTMB and the physician
- Legally required retention period
- Financial and quality audits by third party payers
- Research, statistics, and teaching purposes

Failure to maintain a complete, adequate and timely medical record could lead to a finding that you were negligent in treating your patient.

Numerous laws govern the release of confidential PHI. Refer all requests for release of PHI to the Release of Information Section of the Health Information Management Department, extensions 21965 or 29259.

If you need PHI on a patient which was created by a non-UTMB provider, complete Form #7034, “Authorization to Release Protected Health Information to UTMB” (located on inpatient units and in clinic areas), obtain patient’s signed authorization on the form, and mail. If you need assistance, contact the Galveston Health Information Management Department, extensions 21965 or 29259.

Both civil and criminal laws make the medical record the legal property of UTMB Health, and its unauthorized removal may be criminal theft. All information in the record is CONFIDENTIAL and should be treated as such at all times.

To ensure the confidentiality of the hardcopy medical records, these records will only be released to authorized UTMB requestors presenting a valid UTMB badge. Hardcopy medical records are not to be taken from the UTMB Health and clinic premises without written permission from the director of Health Information Management. Anyone else removing a medical record from the University of Texas Medical Branch Hospitals is risking serious medicolegal actions and is subject to severe disciplinary action including suspension or termination.

If a subpoena duces tecum is received to produce a medical record in court, it shall be directed to the Subpoena Coordinator in the Galveston Health Information Management Department.
CLARIFICATION ON THE RULES OUTLINING THE PROPER RELEASE OF PROTECTED HEALTH INFORMATION (PHI) BY UTMB HEALTHCARE PROVIDERS

The Health Information Management (HIM) Dept. is the main department authorized to release protected health information (PHI). However, in order to continue to support the needs of our patients, the following are also allowed:

- UTMB healthcare providers may share PHI with non-UTMB providers in emergency care situations. UTMB healthcare providers should get the request for the release in writing or via fax from the non-UTMB provider requesting the PHI.

- During a patient’s appointment, UTMB healthcare providers may give the patient copies (up to 20 pages) of medical information that has been created within the past 30 days.

- UTMB healthcare providers may share recent test results (within 30 days from receiving the results) with patients over the phone. Phone I.D. verification must be made.

- At the request of the patient and after phone I.D. verification is made, UTMB personnel may mail up to 20 pages of a patient’s medical record if the information requested is less than 30 days old, and only to the patient’s address as it is listed in the online Master Patient Index. If the patient is requesting that we send it to a new or changed address, we will require the patient to go through HIM for the request, where patient authorization will be obtained.

- PHI may be disclosed when the disclosure is legally required or authorized, such as when reporting suspected child or adult abuse, reporting sexually transmitted diseases, etc.

Reference:
IHOP 6.2.0 Maintaining Patient Confidentiality through the Appropriate Use and Disclosure of PHI
IHOP 6.2.1 Use and Disclosure of PHI Based on Patient Authorization

If you have any questions, please feel free to contact an HIM Representative at 409.772.1965 or 409.772.9259.
ADDITIONAL RULES REGARDING PROTECTED HEALTH INFORMATION (PHI) AND PATIENT RIGHTS

Both federal and state laws protect patients’ privacy and their health information. Below are several rules to follow when working with patients and their health information:

Faxing
- PHI should only be faxed for continuity of care purpose and when the PHI is needed urgently
- PHI should be faxed when mailing is not an option
- UTMB’s required fax cover sheet must be used when faxing PHI
- Refrain from faxing sensitive PHI (e.g., info on HIV, mental health, STDs)
- See IHOP Policy 6.2.9, Fax Transmittal of PHI

Legally authorized or required disclosures of PHI
- Disclosures made without a patient’s authorization and for reasons other than treatment, payment or health care operations, must be accounted for in the MyUTMB Accounting of Disclosure database
- Examples of these disclosures include reporting suspected child or adult abuse, reporting sexually transmitted diseases, reporting births and deaths
- If you disclose PHI in a situation such as these, contact the HIM Department so that disclosure can be accounted for according to the HIPAA regulations

Patient Rights
- Patients have the right to request an amendment to their medical records/PHI
- Patients have the right to request a restriction on how their PHI is used or disclosed
- Patients have the right to revoke a previously executed authorization
- Patients have the right to inspect and receive a copy of their medical record
- Patients have the right to request confidential communications
- IF YOUR PATIENTS REQUEST ANY OF THESE RIGHTS, CONTACT THE HIM DEPARTMENT FOR ASSISTANCE

PHI from other Health Care Providers
- If PHI from another health care provider (non-UTMB entity) is obtained and used in whole or in part to make decisions about a patient then that PHI becomes an official part of the UTMB medical record
- Write the UTMB medical record number on these documents and forward to appropriate staff for scanning into the UTMB medical record

CONTACT NUMBER FOR HEALTH INFORMATION MANAGEMENT DEPARTMENT PHI DISCLOSURE ADVICE: 409.772.1965 or 409.772.9259.
By signing this Authorization Form, I understand that I am giving my authorization for UTMB to receive all protected health information (PHI) relating to my diagnosis, testing or treatment. I understand that my expressed consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. I may revoke this authorization at any time by notifying UTMB in writing to the Health Information Management Department, 301 University Blvd, Galveston, Texas 77555-0782 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by UTMB before UTMB received my written notice of revocation. I understand that the information disclosed pursuant to this authorization may be re-disclosed by UTMB, and any re-disclosure to other recipients may no longer be protected under federal and Texas privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that am not required to sign this Authorization Form in exchange for the patient receiving treatment from UTMB. This authorization will expire on the 180th day of the signing.

_____________________________________________________________ _____________________
Signature of Patient or Authorized Personal Representative  
Date

______________________________
Relationship to the Patient (If signed by a Personal Representative)

IF PATIENT ID CARD IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

________________________________________________________

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI) TO UTMB

Medical Record Form 7034-Rev. 7/03
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original-Medical Record
Medical Record Access for Treatment, Payment, Health Care Operations, Research, and Statistical Use
HEALTH INFORMATION MANAGEMENT (HIM) DEPARTMENT SERVICES

RELEASE OF INFORMATION

The HIM Department’s Release of Information (ROI) Team handles disclosures of medical record/protected health information for UTMB.

All legal requirements must be met before releasing medical information to individuals or agencies not affiliated with UTMB. In most situations, a valid patient authorization (see attachment B, “Authorization for the Use and Disclosure of Protected Health Information by UTMB”) and/or a subpoena duces tecum is required.

HIM will process all requests for disclosure of PHI, including presenting medical records in court.

After-hours and weekend/holiday PHI releases for continuity of care are provided by Verisma, an outside vendor. Their after-hours contact number is (866) 390-7404.

All requests (e.g. authorizations, subpoenas, court orders) for medical record information are to be forwarded to the Galveston HIM Department, Release of Information, Route 0782, or fax number 409-772-5101.

RECORD MANAGEMENT / HIM Request Center

The HIM Request Center is a service provided by the Galveston HIM Department to enable approved requestors a way in which to request UTMB hardcopy medical records for both patient care and non-patient care reasons. The Galveston HIM Request Center is located in Room 3.300 McCullough Building and can be contacted at 409-772-2400. See attachment C, Requesting Medical Records for TPO, for guidelines on how to obtain the records you need.

The HIM Department’s main operating hours are from 8:00am to 5:00pm, Monday thru Friday.

UTMB physicians and other ancillary personnel may request hardcopy records provided they are authorized to do so by their own department and the HIM Department.

Sequestering of the hardcopy record in places such as lockers and desks or in any other way making a record unavailable for immediate access may result in appropriate disciplinary action.

Strict compliance with the Medical Record Access Procedure (see attachment E) is required. All hardcopy records must be returned the same day received.

RESEARCH

Physicians requesting medical records for research must call 409-772-1535 for assistance. Federal law and hospital policy require that specific information is retained for all medical record information viewed for research purposes. HIM must capture and maintain this information for the time period specified by law. Therefore, you must go through HIM to view medical record information (both paper and electronic information) for research purposes. In addition, research for publication or presentation outside of UTMB must have Institutional Review Board (IRB) approval. The IRB can be reached at 409-266-9485. See the Request for Research Data form (attachment F) and Guidelines for Accessing Protected Health Information (PHI) for Research Purposes (attachment G) for more information.

Physicians needing statistical information may call 409-772-8502 for assistance.

House Staff physicians are required to have a faculty physician co-sign the research or statistical request. See attachment I, Guidelines for Release of Statistical Information.
RECORD PROCESSING
The Record Processing (RP) area of the Galveston HIM Department facilitates the completion of all Inpatient, DSU, and Observation medical record documentation. RP maintains systems that track incomplete and delinquent records that need physician record work. RP is located on the third floor of Clinical Sciences Building (CSB -350) and is open from 8:00 a.m. – 5:00 p.m., Monday – Friday to assist physicians in completing records. The RP Team may be reached at 409-772-6890 or 409-772-9275.
The ADC HIM Department will assist with the completion of the patient records created in their facility.

TRANSCRIPTION
RP also processes hospital transcription/dictation and facilitates uploading the completed documents to Epic when dictated by physicians and transcribed by an outside vendor. The dictation system will guide you through the system with verbal prompts so one-on-one training is not mandatory. However, if you wish to schedule hands-on training or need assistance with dictations please contact the HIM Galveston RP Team at 409-772-6890 or the ADC HIM Team at 979-848-6082.

Enterprise MASTER PATIENT INDEX
The Epic system maintains information on all patients who have received services at UTMB Health. The Enterprise Master Patient Index (EMPI) in the Epic system holds patients' demographics and unique medical record numbers. Each patient who receives services at UTMB Health for the first time will be assigned one medical record number. HIM manages the MPI and works to ensure that each patient only has one medical record number and that all patient demographic information is correct. If you see that a patient has been assigned two numbers or if the wrong patient has been selected and information added to that patient needs to be moved to the correct patient, please contact the MPI Coordinators to assist you from 8:00 a.m. – 5:00 p.m., Monday – Friday at 409-772-1744, 409-772-1759, or 409-772-2460, or email to HIMRegistrationAssistance@utmb.edu. If there are any questions or concerns after-hours, please call the after-hours contact at 409-772-1744.

BIRTH CERTIFICATES
The coordinators will complete the birth certificate process for all babies born at UTMB. The process includes interviewing the parents of the newborns to verify information needed for the state database. The information gathered is also used for the Birth Certificate application and assigning a social security number for the newborn. All required information is gathered and entered and released to the state within 5 days of the date of birth. The office hours for the Galveston Birth Certificate office are Monday –Friday 8:30am-4:30pm and Saturday & Sunday 8am-3pm. The office contact number is 409-772-1555. Angleton Danbury and League City campuses have trained staff to assist with the Birth Certificate process.

ANGLETON DANBURY CAMPUS (ADC)
Hours of operation are 8:00 a.m. to 5:00 p.m., Monday through Friday, and are closed weekends and holidays. ADC Release of Information can be contacted at 979-849-7721 ext. 9140, or send fax to 979-849-2912.
For access to paper medical records after-hours, contact the ADC nursing supervisor.
By signing this Authorization Form, I understand that I am giving my authorization for UTMB to use and/or disclose my protected health information (PHI) as described above. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care.

If you are requesting psychotherapy session notes maintained by a mental health provider, a separate authorization form must be completed. I understand that I may revoke this authorization at any time by notifying UTMB in writing to the Health Information Management Department, 301 University Blvd, Galveston, Texas 77555-0782 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by UTMB before UTMB received my written notice of revocation. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that I am not required to sign this Authorization Form in exchange for the patient receiving treatment from UTMB.

_____________________________________________________________   _________________
Signature of Patient or Authorized Personal Representative

Date

__________________________________________________
Relationship to the Patient (If signed by a Personal Representative)
Requests for medical records can be delivered to the HIM Department at 3.300 McCullough Building.

HIM will retrieve requested medical records within a 1-3 day turn-around time when needed for non-direct patient care purposes (e.g. billing, quality review, risk management).

Requests for medical records can be delivered to the HIM Department at 3.300 McCullough Building, email to HIM. Record Request or faxed to 772-5101. Request for medical record at ADC can be delivered.
to the HIM Department or faxed to 979-849-2912. HIM will check for a valid ID badge and that the person dropping off the slips and/or receiving the record(s) has signed the slip with his/her full name.

- All new requestors must complete an application to receive a requestor code. Applications are available at the Request Center, 3.300 McCullough Building. After approval, the Team Leader will notify the requestor via telephone or email of the requestor code number issued.

- All medical record requests, either slips or list, must be in numerical order by the last two digits. The request must include the following:
  - Patient’s name
  - Medical record number
  - Date of Request
  - Requestor’s code
  - Requestor’s name
  - Extension number
  - Department
  - Purpose for requesting medical
  - record(s) Badge number
  - Inpatient discharge date (if applicable)

- If the requestor needs information from a specific inpatient admission, then the requestor will need to write the discharge date on the request list/slips.

- HIM will research the locations of the requested records and will return the list/slips to the requestor along with available records.

- HIM will call the requestor when the records are ready.

Available records may be picked up at 3.300 McCullough.

If the record requested is signed out of HIM to a location other than Record Processing or Coding such as a clinic or another customer, then the person requesting the record will need to re-request the record.

When the requestor is finished with the records, they must return all the records to room 3.300 McCullough Building.

All records are to be returned to HIM by 5:00 pm each business day.

If a requestor is not finished with the records by the end of the day, the records can be placed on hold in HIM at the Request Center located in 3.300 McCullough for the requestor to retrieve the next day.

** NOTE **

If records are needed for non-TPO reasons contact the HIM Team Leader for assistance
<table>
<thead>
<tr>
<th>MRN#</th>
<th>Name</th>
<th>INPT Discharge Date Only</th>
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</table>

**ABBREVIATIONS FOR SIGN-OUT LOCATIONS:**

- **IP/INPT=** Patient is currently in house. Re-request record(s) once patient is discharged.
- **S/O=** another customer has the medical record – wait 2 days and request the record again.
- **CL and Date=** medical record signed out to clinic and the date the record is going to clinic. Request the record again 2 days after the clinic appointment date.
- **Off=** medical record is at our Offsite location. (We will order. Turn-around time will be 3 to 4 days).
- **N/F=** medical record is misplaced. Record Retrieval Team Leader will be notified and will search for the misplaced record and will follow up with customer.
- **AOS/ON=** medical record is in the active file area and should be pulled for requestor.
GUIDELINES FOR RELEASE OF STATISTICAL INFORMATION

1. No release of TDCJ information is allowed without approval from the Directors of Health Information Management and Clinical Data Management.

2. All requests outside of UTMB must be received in writing. These requests must be submitted to the Directors of Health Information Management and Clinical Data Management for approval.

3. All requests within UTMB for statistical reports require the completion of an email with the specific data requirements listed along with time frames, etc. The purpose for which the data will be used must be stated.

4. No data can be released outside of UTMB without IRB approval.

STATISTICS HOURS: 8:00 a.m. – 4:30 p.m., Monday through Friday

Clinical Data Management Administrative Coordinator  Angela Baxley
EXTENSION: 21699
FAX: 71510
## UTMB REQUEST FOR PATIENT DATA

Please check: □ Health Information Management  □ Pathology Laboratory Information Services
□ Information Services  □ Other ________________________________

List name of Project Director and other authorized data requestors below:

<table>
<thead>
<tr>
<th>Name of Project Director:</th>
<th>Ext:</th>
<th>Pager:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Authorized Data Requestor:</td>
<td>Ext:</td>
<td>Pager:</td>
</tr>
<tr>
<td>Other Authorized Data Requestor:</td>
<td>Ext:</td>
<td>Pager:</td>
</tr>
</tbody>
</table>

**Department:**

1. Do you need patient identifiers with the data you are requesting? □ Yes  □ No

2. Please give a detailed description of the information requested. The descriptions should include items like diagnoses, procedures, ICD-9-CM codes, or lab values or other related results.

   a) ________________________________________________________________________________________
   b) ________________________________________________________________________________________
   c) ________________________________________________________________________________________
   d) ________________________________________________________________________________________

Data Time Frame: ________________________  Sex: □ Male  □ Female  □ Both

Inclusive Age Groups: _____________________  Other: ________________________________________

Deadline Date: ________________________  Data/Records Needed By: ________________________

3. **Reason for request:** □ Treatment  □ Research  □ Quality Assurance  □ Other ________________________________

4. I agree to abide by the guidelines set forth by the UTMB policies and procedures protecting the use, disclosure, storage and disposal of Protected Health Information (PHI). I also agree that if anytime in the future I decide to disclose this information or present this information outside of UTMB, I will obtain prior approval.

Signature of Project Director (Original signature required) __________________________________________

5. **If for Research, the following section must also be completed:**

   Have you applied for an IRB review of your access to PHI? □ Yes  □ No

   If ‘Yes’, provide the IRB # ________________________ and approval date ________________________.

   If ‘No’, this data retrieval request will be considered "Preparatory to Research" and you must attest to the following:

   I, ________________, understand and agree that the use or disclosure of PHI is sought solely to develop a research concept or idea and not for any other purpose. I will not remove or further disclose any PHI from UTMB in the course of the review and I will only use and access PHI necessary for the purpose of determining if a research project is feasible. I will not make contact with any of the patients whose records I have reviewed, and I will not publish any data obtained pursuant to this access. I understand that if I wish to use or disclose any PHI obtained during this review for any other purpose, I must obtain IRB approval.

   Signature: __________________________________________  Date: ______________________

Form RPD01-12/05 (for additional forms go to https://my.utmb.edu/eforms/view_print_eforms_general.asp)
Guidelines for Accessing Protected Health Information (PHI) for Research Purposes

<table>
<thead>
<tr>
<th>Audience information</th>
<th>To <em>utmb</em>Health Employees who have a need to review protected health (PHI) for conducting data reviews for research studies, including IRB approved studies and preparatory to research data reviews.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions</td>
<td><strong>HIM Coordinator</strong> – HIM employee who coordinates access to PHI for internal (<em>utmb</em>Health employees) and external (non-<em>utmb</em>Health) people reviewing PHI for research purposes.</td>
</tr>
<tr>
<td></td>
<td><strong>Review Coordinator</strong> – <em>utmb</em>Health employee who is involved in PHI reviews for research studies or preparatory to research purposes.</td>
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<tr>
<td></td>
<td><strong>External reviewer/monitor</strong> – a non-<em>utmb</em>Health person involved in a <em>utmb</em>Health research project that has IRB approval to access <em>utmb</em>Health PHI.</td>
</tr>
<tr>
<td>Procedure</td>
<td>1. Confidentiality of patient information must be maintained at all times.</td>
</tr>
<tr>
<td></td>
<td>2. Prior to any PHI being accessed, the <em>utmb</em>Health <em>Request for Patient Data</em> form must be completed and submitted to HIM. Side A must always be completed; side B is completed if external reviewers/monitors will be reviewing PHI. The request form must be signed by the Project Director. If the project is IRB approved, a copy of the IRB approval letter must be submitted along with the <em>utmb</em>Health <em>Request for Patient Data</em> form.</td>
</tr>
<tr>
<td></td>
<td>3. If any research is to be used for publication or presentation outside UTMB, an approval from the Institutional Review Board (IRB) at 266-9475 is required. This includes the use of questionnaires, surveys, and any record review studies that are conducted for the systematic collection of data.</td>
</tr>
</tbody>
</table>
4. If the Review Coordinator needs access to PHI for preparatory to research purposes and does not have an IRB approval, an attestation must be signed that states an IRB approval must be obtained before any patient can be contacted or data published. The attestation is located on the utmbHealth Request for Patient Data form (side A).

5. The HIM Coordinator will review all documents submitted by the Review Coordinator to ensure required documents have been submitted and are complete.

6. If a research project involves access to sensitive information such as a psychiatric diagnosis, an infectious disease, substance abuse patients, or TDCJ patients, the Review Coordinator must have permission from that department’s chairman or hospital administrator to review the data. It will be the Review Coordinator’s responsibility to obtain the permission to review this data. Evidence of the Chairman’s/Hospital Administrator’s permission can be submitted via email to the HIM Coordinator or by co-signing the utmbHealth Request for Patient Data form.

7. If a Review Coordinator does not have his/her own list of patients and needs the patient population identified, the following occurs:

   a. The HIM Coordinator will scan the approved documents to the Data Management Specialist (DMS) in the Clinical Data Management Department.
   b. The DMS will acquire the appropriate ICD9 & ICD10 codes.
   c. The DMS will create the report from the HDM System and email it to the Review Coordinator with a CC: to Jennifer Amaya, Nyree Williams, and Julie David.

8. If the Review Coordinator has his/her own list of patients the list is submitted to the HIM Coordinator in the McCullough Bldg Room 3.300 or fax to HIM ext. 29200.

9. When the Review Coordinator is ready to begin accessing PHI, he/she will contact the HIM Coordinator at ext. 21537. The HIM Coordinator is available from 8:00am – 4:30pm, Monday – Friday in McCullough Bldg. Room 3.300, ext. 21775.
10. If the PHI needed for the study is in paper form the following will occur:

   a. HIM will retrieve the medical records and will place them in the CSB Room 311.
   b. As a guideline it will take 5 – 10 days to pull requested records.
   c. HIM will pull approximately 30 patients at a time if needed.
   d. No additional records will be made available until all other retrieved records have been reviewed.
   e. The record will be placed in a designated return area (basket) in CSB Room 311.
   f. The HIM Research Area can be accessed Mon-Fri 8am-5pm.
   g. The medical records stored in the HIM Research room must not be removed unless arrangements have been made with the HIM Coordinator. If records are removed, a blue “RES” sticker will be placed in front of the chart so it can be returned to the research room.
   h. If records are not reviewed on a regular basis, the HIM Coordinator must be notified or records will be returned to file.

11. If the PHI needed for the study is in the Epic EMR, see HIM policy 6.7.34, *Epic Access by Internal Reviewers for Research Purposes*.

12. If a Review Coordinator has an external reviewer/monitor who needs access to medical record data for an IRB approved research study and some/all of the medical record data is in the Epic EMR, see HIM policy 6.7.29, *Epic Access for External Reviewers*.

13. The HIM Coordinator will forward copies of PHI accessed to the HIM Accounting of Disclosure (AOD) Coordinator so that AODs can be done in accordance with IHOP 6.2.26, *Patient Rights Related to Protected Health Information*.

14. HIM will not provide copies of medical Records.

FOR FURTHER ASSISTANCE CONTACT:
HIM Coordinator, Nyree Williams @ Ext. 2-1535 or Research Team Leader, Jennifer Amaya @ Ext. 73497
I. Title

Medical Record Access

II. Policy

The medical record should be readily available to all practitioners who encounter the patient on either a scheduled or a non-scheduled (i.e., emergency) basis.

Access to the medical record is to be restricted to only those individuals who have a legitimate need to know for use in the normal course of business. It is the legal responsibility of all UTMB employees and students to protect the confidentiality of the information within the record.

III. Medical Record Access Process

A. Electronic Records

Access to the electronic medical record will be provided to those who have been authorized by their department’s trusted requestor via the Tivoli process.

B. Paper Records

1. Medical records needed for direct patient care purposes are requested by the area treating the patient (e.g. the clinic, inpatient floor, emergency department).

2. For purposes of payment and healthcare operations, access to the medical record must be approved by the Department Chairman, Director, or Executive Director, and Health Information Management (HIM). Requestors must request access by submitting an Application to Request Medical Records form to HIM. Once HIM has approved access, the requestor will be notified of the approval and their assigned unique requestor code number. This is a one-time authorization process; the unique requestor code is valid until the person leaves the university or changes their work situation.

3. When an individual requestor needs a medical record for purposes other than patient care (i.e. payment, healthcare operations, or research), the HIM Department is contacted for access to the paper medical record.

4. Access to the paper medical record will be granted to those who provide a valid UTMB ID badge and/or appropriate documentation to access the information.

5. As a general rule all authorized requestors may keep the record until 5:00pm the same day as received, and then must return records to the HIM Department. Records of deceased patients are the exception.

6. If a requesting party does not return all records to the HIM Department by the end of the day received, no additional records will be released to that party until all overdue records are returned.
IHOP Policy 9.2.6 Medical Record Access

7. Records shall not be sequestered in places such as lockers or desks or in any other way made unavailable for immediate access. Individuals who violate this policy are subject to appropriate disciplinary action up to and including termination.

8. For research purposes, the research requestor must submit a UTMB Request for Patient Data form to HIM. The HIM Research coordinator will contact the research requestor with their research number. Medical records must be reviewed in the HIM research area and cannot be removed from this area.

9. All medical records are the property of the University of Texas Medical Branch Hospitals and Clinics and shall not be removed from the premises of the University of Texas Medical Branch Hospitals and Clinics except in accordance with a court order or subpoena.

10. The exception is an attending physician with joint appointment at UTMB and Shriners Burns Institute. In this situation medical records may be taken to Shriners Burn Institute.

IV. Record Return Requirements

A. As a general rule:
   1. Inpatient Nursing Units shall keep records until 6:00 a.m., of the day following patient discharge. Following discharge, records go to the Record Processing Section of the HIM Department.
   2. Outpatient treatment areas must return records the same day as the patient's visit.

B. Following an autopsy, records must be returned to Record Processing Section within three (3) working days of autopsy.

C. When a record is signed out of the HIM Department and is needed for direct patient care, the area or person in possession of the medical record must make the record available to HIM.

D. If a medical record is needed for an extended period of time, a special request must be approved by the HIM Department's director or designee.

V. Medical Record Transfer Process

If an approved medical record requestor transfers a record to another location, it is his/her responsibility to notify the HIM Department of the new location of the record.

The requestor will continue to be charged with having possession of the record until the HIM Department receives this notice.

VI. Related UTMB Policies and Procedures

IHOP - 02.01.03 - Release of Information under the Texas Public Records Act
IHOP - 09.02.01 - Management of UTMB’s Protected Health Information (PHI)
IHOP - 09.02.13 - UTMB Medical Record Policy

VII. Dates Approved or Amended

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VIII. Contact Information

Health Information Management  
(409) 772-1918
Record
Completion
INTRODUCTION

An adequate medical record shall be maintained for every individual who is evaluated or treated as an inpatient, outpatient, or emergency patient at the University of Texas Medical Branch.

The purposes of the medical records are:

- to serve as a basis for planning patient care and for continuity of care;
- to furnish documentary evidence of the course of the patient’s medical evaluation, treatment and change in condition during the hospital stay or during an outpatient or emergency visit;
- to document communication between the responsible practitioner and any other health professional contributing to the patient’s care;
- to assist in protecting the legal interest of the patient, the hospital and the responsible practitioner;
- to provide data for use in continuing education and research; and
- to submit accurate diagnostic and procedural information for billing purposes.

This section of the Medical Record and Health Information Management Services Handbook is designed to assist you with general documentation requirements. Medical specialty documentation has not been addressed in depth and should be addressed as encountered within specialties.

Official legal medical record documentation may only reside in the unit and/or subsidiary medical record (paper record), Epic Electronic Medical Record (EMR), Meditech (EMR), Allscripts (EMR) or the MyUTMB OB EMR.

INCOMPLETE RECORDS

The Record Processing (RP) area of Health Information Management is located on the third floor of Clinical Sciences Building (CSB -350) and is open from 8:00 a.m. – 5:00 p.m., Monday - Friday. The RP Team may be reached at extensions 26890 or 29275. Records are scanned /uploaded to Epic within 24 hours. If the paper record is needed for correction contact 73497.

Angleton Danbury Campus (ADC)

Record Completion is completed in the Doctor's Dictation Area (DDA) located on the first floor in the Physician Lounge. Please call 979-849-7721 ext. 2233 for assistance.
SUMMARY OF MEDICAL RECORD COMPLETION TIMELINES:

1. **History and Physical**—requires completion within 24 hours of admission, but prior to surgery or a procedure requiring anesthesia services.
2. **Operative Reports**—requires completion within 24 hours after surgery.
3. **Discharge Summary/Final Discharge Note**—recommend completion day of discharge.
4. **Telephone and Verbal Orders**—requires signature, date and time within 96 hours of being given where allowed
5. **Residents**—it is recommended that all records be completed within 14 days following discharge.
6. **Record completion by residents and faculty** is required within a period of time that in no event exceeds 30 days following discharge.
7. **Autopsy reports**—provisional anatomic diagnoses should be in the medical record within 3 days and the complete report should be in the record within 60 days of the patient’s death. Exemption: Autopsy on a patient that expired at ADC will have the work done by the County Coroner with no deadlines.

GUIDELINES FOR COMPLETION OF RECORDS PRIOR TO VACATION, EXTENDED LEAVE, OR PERMANENT LEAVE

1. Complete all record work at the nursing stations and in the EMR (Epic).
2. Complete all record work located in your Epic In basket.
3. Return all records in your possession to the Health Information Management Department.
4. Faculty members notify residents to complete all record work one week prior to their departure to facilitate record completion work.
5. Physicians permanently leaving UTMB must obtain a UTMB Clearance & Release Form and have it signed by Record Processing personnel.
6. Faculty physicians permanently leaving UTMB must identify who will complete any unfinished record work by filling out a physician alternate form.

THE MEDICAL RECORD SHALL CONTAIN SUFFICIENT INFORMATION TO IDENTIFY THE PATIENT, TO SUPPORT THE DIAGNOSIS, TO JUSTIFY THE TREATMENT AND TO DOCUMENT THE RESULTS ACCURATELY. THE FOLLOWING MUST BE INCLUDED:

The medical record contains the following demographic information:
- The patient’s name, address, and date of birth, and the name of any legally authorized representative.
- The patient's sex.
- The patient’s race and ethnicity
- The legal status of any patient receiving behavioral health care services.
- The patient’s communication needs, including preferred language for discussing health care.
The medical record contains the following clinical information:

- The reason(s) for admission for care, treatment, and services.
- The patient’s initial diagnosis, diagnostic impression(s), or condition(s).
- Any findings of assessments and reassessments.
- Any allergies to food.
- Any allergies to medications.
- Any conclusions or impressions drawn from the patient’s medical history and physical examination.
- Any diagnoses or conditions established during the patient’s course of care, treatment, and services.
- Any consultation reports.
- Any observations relevant to care, treatment, and services.
- The patient’s response to care, treatment, and services.
- Any emergency care, treatment, and services provided to the patient before his or her arrival.
- Any progress notes.
- All orders.
- Any medications ordered or prescribed.
- Any medications administered, including the strength, dose, and route.
- Any access site for medication, administration devices used, and rate of administration.
- Any adverse drug reactions.
- Treatment goals, plan of care, and revisions to the plan of care.
- Results of diagnostic and therapeutic tests and procedures.
- Any medications dispensed or prescribed on discharge.
- Discharge diagnosis.
- Discharge plan and discharge planning evaluation

As needed to provide care, treatment, and services, the medical record contains the following additional information:

- Any advance directives.
- Any informed consent, when required by hospital policy. Note: The properly executed informed consent is placed in the patient’s medical record prior to surgery, except in emergencies.
- Any records of communication with the patient, such as telephone calls or email.
- Any patient-generated information.

**INFORMED CONSENT**

Adult patients and/or, when appropriate, patients’ families or designated surrogates, should receive from their physician information necessary to give informed consent prior to the start of any care, treatment or service.
The medical record shall contain evidence of the patient’s informed consent prior to any procedure or treatment for which it is appropriate. Consent is required for certain procedures as established by the Texas Medical Disclosure Panel. Only authorized UTMB consent forms should be used. Each patient’s need for translation of consent forms will be addressed by the health care practitioner, who may be assisted by on-site language-assistance personnel or language-assistance through the telephone. Documentation of translation, name of translator, date and time is recommended. See IHOP policy 9.3.17, Consent – Overview and Basic Requirements, for more information.

ADVANCE DIRECTIVES

The series of IHOP policies, 9.15.5, 9.15.6, and 9.15.8, establish the UTMB policies and guidelines for initiating and executing Advance Directives under the federal Patient Self Determination Act (PSDA) of 1990, the [Texas] Advance Directives Act and other applicable statutory law.

Advance Directives (including Directive to Physician, Medical Power of Attorney, and Out-of-Hospital DNR Order) are scanned into the patients’ electronic medical records (Epic) under the “External Provided” tab.

Any conversation with the patient concerning treatment decisions must also be noted in the Progress Notes section of the medical record.

HISTORY AND PHYSICAL EXAMINATION REPORT (H&P)

A complete History and Physical is required no more than 30 days prior to or within 24 hours after patient is admitted, but prior to surgery or a procedure requiring anesthesia services. For an H&P that was completed within 30 days prior to the patient being admitted, an update documenting the patient was examined and any changes in the patient’s condition must be completed within 24 hours after admission, but prior to surgery or a procedure requiring anesthesia services, whichever comes first. Medical History and appropriate physical examination is also required on all patients who have ambulatory surgery and all patients assigned to observation.

All outpatients registered by the emergency Department, held for short-term observation, or scheduled for any surgical or invasive procedure not requiring sedation or anesthesia must have a Focused H&P documented in the Medical Record.

FOCUSED H&P

The Focused H&P should provide an account of the chief complaint, the present illness, including any assessment of contributing factors, relevant past medical history, an appropriate review of the body systems, an impression and a proposed initial plan of evaluation and treatment. The focused H&P should in all cases be documented in sufficient detail to give a practitioner all the information needed for the formulation of a reasonable picture of the patient’s clinical status.
If your service has an H&P template in Epic, please use. If you are not using a template be sure and include (at a minimum) all of these sections in your H&P:

- **Patient Chief Complaint (CC)** - why the patient is seeking medical care in their own words

- **History of Present Illness (HPI)** - describe the status of the symptoms or clinical problems from time of onset to encounter with the physician. The following eight elements may be used to characterize the patient's specific complaint/illness.
  
  a. Location  
  b. Quality  
  c. Severity  
  d. Duration  
  e. Timing  
  f. Context  
  g. Modifying Factors  
  h. Associated Signs and Symptoms

- **Review of System (ROS)** - an inventory of the specific body systems performed by the physician in the process of taking a history from the patient. The ROS is designed to bring out clinical symptoms which the patient may have overlooked or forgotten.

  The following body systems should be included in the ROS even if only noted as being normal or with complaint.

  1. Constitutional (e.g., fever, weight loss)  
  2. Eyes  
  3. Ears, Nose, Mouth, Throat  
  4. Cardiovascular  
  5. Respiratory  
  6. Gastrointestinal  
  7. Genitourinary  
  8. Musculoskeletal  
  9. Integumentary (skin and/or breast)  
  10. Neurological  
  11. Psychiatric  
  12. Endocrine  
  13. Hematologic/Lymphatic  
  14. Allergic/Immunologic

- **Past Medical, Family & Social History**
  
  - **Past Medical History** - review of past illnesses, operations or injuries, which may include:
    1. Prior illnesses or injuries  
    2. Prior operations  
    3. Prior hospitalizations  
    4. Current medications  
    5. Allergies  
    6. Age appropriate immunization status  
    7. Age appropriate feeding/dietary status

  - **Family History** - A review of medical events in the patient's family which may include information about:
    1. The health status or cause of death of parents, siblings and children
2. Specific diseases related to problems identified in the Chief Compliant, HPI, or ROS
3. Diseases of family members which may be hereditary or place the patient at risk

- Social History - An age appropriate review of the patient’s past and current activities which may include significant information about:
  1. Marital status and/or living arrangements
  2. Current employment
  3. Occupational history
  4. Use of drugs, alcohol or tobacco
  5. Level of education
  6. Sexual history
  7. Other relevant social factors

- Physical Examination-Objective findings from direct examination of the patient in the following format:
  1. General observation/appearance
  2. Vital signs: Blood pressure, pulse, temperature, respiratory rate
  3. HEENT- head eyes ears nose and throat
  4. Neck
  5. Lymph nodes
  6. Breasts
  7. Chest
  8. Lungs
  9. Abdomen
  10. Musculoskeletal
  11. Extremities
  12. Pelvic/ genital
  13. Rectal
  14. Neurological
  15. Height & Weight

- Diagnosis & Plan for Treatment- statement on the conclusions or impression drawn from the initial patient assessment. Include a diagnostic statement and intended treatment or clinical work-up for EACH condition, illness, problem or complaint that will be addressed during this admission. This includes chronic conditions/illness that will require continuation of home meds or other therapy while the patient is hospitalized.
  1. Remember, any condition that will be Clinically Evaluated, Therapeutically Treated, Extends the Length of Stay or Increases nursing care and/ or Monitoring should be documented.
  2. Diagnoses that relate to an earlier admission and have NO bearing on the current admission should NOT be included.

Refer to **IHOP 9.13.9** and **9.13.8** for more information.
PROGRESS NOTES

Progress notes are intended to provide a chronological record of the patient’s encounter. A daily progress note should be written by a physician, dentist or designated person.

An Admit Note is required and should contain sufficient information to guide the health care team in caring for the patient until the complete history and physical examination is recorded. It must contain the admitting and provisional diagnosis.

Necessity for Admission: Physicians have a critical role in assuring that the hospital is paid for all of the care rendered. It is you who create the record, and it is the record alone that will determine whether or not the hospital is paid. Necessity for admission and elements of quality care are two important areas to consider when documenting in the record. Always explicitly answer this question in your admission note: Why must this patient be admitted? The key word is must.

Progress Notes should include the following:
- All conditions being treated, investigated and/or monitored as well as the current treatment plan for each
- Any change in the patient’s conditions including response to treatment; increase or decrease in acuity or severity and additional conditions that subsequently develop after admission
- Results of any treatment including medications, procedures or other therapies
- Significant clinical laboratory, radiologic or other diagnostics test results; any diagnostic implication, change in treatment based on this findings should also be documented
- Clinical information and medical decision making to support all diagnoses and treatments

Procedure Progress Notes for bedside and other non-OR procedures must be entered into the patient record immediately following the procedure and should include the following:
- What procedure was performed and the indication for that procedure
- Who performed the procedure
- Type of anesthesia used, if any
- Procedural approach - Endoscopic, Laparoscopic, Open, Percutaneous, Endovascular or other
- Any radiologic guidance or robotic assistance
- Size & depth of excisions; Type of closure or grafts (homo/hetero)
- Any devices, implants, grafts, etc. used
- Any complications or unexpected events
- Brief narrative of the procedure
- Findings at the time of the procedure
- Patient’s response and condition at the end of the procedure
- Time out documentation

Post Operative Progress Notes for all operations or high-risk procedures must be entered into the patient’s record immediately following the procedure (unless a full operative report is immediately entered into Epic – see section on Operative Reports below) and should include the following:
• Pre and Post Op diagnosis
• Names of the primary surgeon(s) and his/her assistant(s)
• Procedure performed
• Description of each procedure finding
• Estimated blood loss; if any
• Specimens removed; if any
• Any complications or unexpected events
• Condition of patient following the surgery

Anesthesia Pre-op Note must be entered into the patient’s record by the anesthesiologist (or other credentialed staff) prior to any administration of anesthesia and within 48 hours prior to the procedure. The note should include:
• Results of physical exam performed
• Assessment of patient’s anesthesia risk
• Plan for anesthesia

Another pre-op assessment should be documented immediately prior to the patient’s transfer to the operating suite and the administration of any pre-operative medications. In certain emergent cases, such as gross hemorrhage, trauma or imminent obstetric delivery, this note may be deferred and entered after the emergency is over or as part of the post anesthesia note.

Anesthesia Post-op Note: The postoperative status of the patient is assessed by the anesthesia provider on admission to the Post Anesthesia Care Unit (PACU), during PACU stay if indicated, and upon discharge from the PACU. This assessment data is documented on the anesthesia record. The post anesthesia evaluation is performed and documented by someone qualified to administer anesthesia. The post anesthesia evaluation should not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation. While the evaluation should begin in the designated recovery area, it may be completed after the patient has moved to another location. This post anesthesia evaluation must be completed within 48 hours. For those patients who are unable to participate in the post anesthesia evaluation, an evaluation should be completed and documented within 48 hours with notation that the patient was unable to participate and why. For those patients whose regional anesthetic effects are expected to continue beyond the 48 hour time frame, a post anesthesia evaluation must be completed within 48 hours, with notation that full recovery has not occurred and is not expected within the stipulated timeframe, but that the patient was otherwise able to participate in the evaluation. For deep sedation cases, the post anesthesia note may be documented by an LIP who is privileged in deep sedation. A post anesthesia note is not required for moderate sedation cases.

On-Service and Off-Service Progress Notes must be entered into the patient’s record when a patient transfers to another clinical service. Both the service making the transfer and the service receiving the transfer must enter a note. This note should include:
• A summary of the patient’s hospital course up to the time of transfer
• Sufficient detail to provide effective continuity of care
• All diagnostic and therapeutic procedures and treatments including medications and the patient’s response to each
• All of the conditions currently being treated as well as those already treated & resolved
• The reason for the transfer to another service

**Death Note** progress note must be entered into the patient’s record at the time of death and should include the following:

• Exact date and time of death
• Clinical assessment of the immediate and underlying cause of death
• Major problem list along with a clinical assessment of each problem
• Information concerning permission for autopsy

**PHYSICIAN’S ORDERS**

All orders for treatment shall be written and signed by the physician, dentist, Advanced Nurse Practitioner (APN) or Physician Assistant (PA), with the exception of emergency situations that may require the provider to issue an order verbally or by telephone so that patient treatment can begin immediately.

All providers writing orders in areas with the Epic EMR system access should enter the orders into Epic or find another physician to enter them. For the areas not using Epic, form #5350, Physician’s Order Sheet, must be used.

**Verbal or telephone orders** may only be given by a physician, dentist, APN or PA.

When verbal or telephone orders are issued, they must be read back to the provider.

Only certain health care professionals may accept telephone or verbal orders (see the *Rules and Regulations of the Medical Staff*, page 79).

All verbal and telephone orders must be signed, dated, and authenticated in Epic by the ordering provider within 96 hours.

In the absence of the ordering provider, the inpatient attending physician or another physician on the same service can sign/authenticate the order.

No physician will be required to sign/authenticate an order he/she feels is inappropriate.

Verbal and telephone orders may only be accepted by specified health care workers.

**Standing orders** may be used on a limited basis in situations where treatment initiatives are an essential part of effective management.

Orders written by non-licensed personnel shall not be acted on until countersigned by a licensed physician, dentist, APN or PA.

All orders shall include the month, day, year, and time of day the orders are written. Military time shall be used.

Only symbols and abbreviations found in the UTMB abbreviations guide are recommended for use. The list of prohibited abbreviations shall be adhered to when documenting.

When entering/writing admission orders, be sure and include the names of the attending and resident physicians.
To implement an oral or written directive or Directive to Physician or Out-of-Hospital DNR Order, a physician will write an appropriate order. For additional information about resuscitation and life support documentation, refer to the policies 9.15.5, 9.15.6, and 9.15.8.

See IHOP policy # 9.11.5, Physician Orders, for more information.

CONSULTATION REPORT
Consultation requests should be directed to a specific physician or service in general. The request and the report shall be typed in Epic or dictated and shall become a permanent part of the medical record. Consultation requests may also be directed to allied health professionals including, but not limited to Physical Therapy, Pulmonary Care Service, Nutrition, Speech Therapy, Therapeutic Recreation, Music Therapy, and Social Work.

A request for consultation entered/signed by the physician requesting the consultation shall include a brief statement of information regarding the patient including:

- Diagnosis;
- Special conditions affecting the report of the consultation; and
- Specific information that is expected from the consultant.

A satisfactory consultation shall contain a written opinion by the consultant that reflects:

- Patient’s name
- Unit history number
- Date and time of consultation
- Examination of the patient
- Review of the medical record
- Written report of the:
  - findings
  - diagnosis
  - recommendations

The report shall be entered into the EMR (Epic) or dictated.

Each consultation should be acknowledged in writing within a reasonable length of time, and documented in the record. The consultation requested from a specific physician, by name, is to be answered by the individual member of the staff specified in the request or a designee from the medical staff.

When an operative procedure is involved, the consultation report shall be recorded prior to the operation, except in an emergency.

Should the findings, diagnosis, and recommendations be recorded on a special form (i.e. therapy, bronchoscopy, etc.), reference should be made to the special report on which the information is recorded.

OPERATIVE REPORTS
Operative report must be entered into the EMR or dictated upon completion of the operation or other high-risk procedure and before the patient is transferred to the next level of care.
(see attachment J). The exception to this requirement occurs when an operative or other high-risk procedure progress note (see Post Operative Progress Notes in the Progress Note section above) is written or typed immediately after the procedure, in which case the full report can be typed or dictated within 24 hours. If the provider 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.

Whether dictated or direct entry the operative report should include the following:

- Procedure Date
- Preoperative and Postoperative diagnosis
- Name of procedure performed, in full text, please do not abbreviate
- Description of the procedure
- Description of findings
- Specimens removed; if any
- Name of primary surgeon and any assistants
- Condition of patient after surgery
- Any complications or unexpected events
- Estimated blood loss; if any

**Diagnostic and Therapeutic Procedures**

All diagnostic and therapeutic procedures must be recorded and authenticated in the medical record. It is important to acknowledge abnormal findings and to document plans for follow-up, or rationale for not following-up. Be sure to document the full name of the procedures.

**DISCHARGE DOCUMENTATION**

**FINAL DISCHARGE NOTE**

For Short Stays (<48 hours) a Final Discharge Note (FDN) should be completed in Epic at the time of discharge by the physician, the resident, and/or by the attending physician. The following must be recorded in the FDN:

- **Principal Diagnosis**: The condition which, after study, occasioned admission to the hospital.
- **Complications** (if present): The conditions which developed after admission that may have extended the length of stay and required use of additional resources, e.g., infections of any type including urinary tract, septicemia, or complications of medical or surgical treatment.
- **Comorbidities** (if existing): The conditions that was present prior to admission that could extend the length of stay or require additional resources, e.g. anemia, insulin dependent diabetes mellitus, heart or pulmonary conditions.
- **Principal Procedure**: The definite/therapeutic procedure most closely related to the principal diagnosis.
All other diagnoses and procedures must be listed on the Final Discharge Note and must correspond with the results of any tests performed as listed on the Operative/Procedure Report and the Discharge Summary (if required).

The discharge plan must be documented, and the availability of appropriate services to meet the patient’s needs after hospitalization must be addressed.

If the Final Discharge Note form is used current conditions and complications affecting the current hospital admission and significant past diagnoses/ procedures must be listed.

Any revisions to the diagnoses or procedures on a paper Final Discharge Note must be initialed and dated by the attending physician.

**DISCHARGE SUMMARY**

If a Discharge Summary is required, it must be entered into Epic or dictated as soon as possible when the patient is discharged. The Discharge Summary must contain the following:

- Attending physician at the time of discharge
- Date of admission and Date of discharge
- Reason(s) for hospitalization
- The care, treatment, and services provided
- Patient hospital course including ALL conditions diagnosed and/or treated; treatments rendered and patient response to treatments
- Information provided to the patient and family
- Provision for follow-up care.
- Disposition of patient including transfers to other facilities, discharge instructions and medications; and provisions for follow-up care, including Home Health
- Patient’s condition at discharge

The physician should read, approve, and sign the Discharge Summary as soon as it is ready for review. If dictated/typed by a resident, it may be signed by the resident; however, it must always be authenticated by the attending physician.

**EMERGENCY ROOM RECORD**

An Emergency Department Record should be completed for all patients who receive care in this setting. Documentation will be done in Epic and should contain the following:

- Time and means of arrival
- Adequate patient identification, or the reason why not obtainable
- Pertinent history of the illness or injury, including details related to the first aid or emergency care given to the patient prior to his/her arrival at the hospital
- Indication that the patient left against medical advice (if applicable)
- Conclusions reached at the termination of care, treatment, and services, including the patient’s final disposition, condition, and instructions given for follow-up care, treatment, and services
- A copy of any information made available to the practitioner or medical organization providing follow-up care, treatment, or services
If a patient leaves the hospital against medical advice, that fact should be documented. Each patient’s medical record should be authenticated by the practitioner who is responsible for its clinical accuracy.

**OBSERVATION RECORD**

Observation is an outpatient status, primarily intended for short-term diagnostic testing and monitoring which are reasonable and necessary to evaluate a patient’s condition in order to determine the need for admission to the hospital.

Observation status is appropriate for:

- Patients with presenting symptoms that are questionable and require testing and/or evaluation to determine their medical condition and to determine whether they should be admitted.
- Patients with diagnosis that are expected to respond quickly to therapeutic interventions, thus preventing unnecessary admission (e.g., chest pain, non-emergent cardioversions, and asthmatics).
- Post-operative ambulatory surgical cases when the patient requires care beyond that usually found in the standard of practice for the procedures.

Observation should *not* be used for:

- Patient holding because of social factors.
- Patient or physician convenience for testing or examination.
- Routine preparation for and recovery from diagnostic testing.
- Substitute for appropriate inpatient admission.
- Routine outpatient blood administration.

Content of observation records include:

- **Physician’s order** to assign to observation status;
- **History and physical** examination, to include: chief complaint, presenting symptoms, duration of symptoms, and lab results, if available;
- **Treatment plan** (proposed intervention)
- Ongoing documentation in **Progress Notes**, including interim evaluation of intervention (at least every six hours)
- **Discharge Summary** including final diagnosis, medications and follow-up care.

If it is determined that the patient in Observation status meets full admission criteria, a physician must document in the progress notes what has changed in the patient’s condition to warrant the change in bed status (conditions that have been ruled in, deterioration in the patient’s condition despite treatments, or new findings that cannot be treated in the outpatient setting). No admission order should be placed without appropriate documentation to coincide with the admission order date and time.

**DAY SURGERY UNIT RECORD** (Also applies to Same Day Admits)

The following documentation is required on all Day Surgery patient records.
- Signed informed consent;
- Complete history and physical examination;
- Documentation of discharge criteria;
- Lab, x-ray, path report, and other tests performed, if appropriate;
- Operative report; and
- Final Discharge Note including final diagnosis, medications, and follow-up care.

**OUTPATIENT CLINIC NOTE**

Medical record information is created for each patient receiving outpatient services and is immediately incorporated into the patient’s permanent medical record (either in Epic or other approved electronic form, or in a paper medical record for the clinics that have not converted to Epic).

Outpatient clinic notes may include:

- Patient identification;
- Relevant history of the illness or injury;
- Physical findings including vital signs;
- Diagnostic and therapeutic orders;
- Clinical observations including results of treatment;
- Reports of procedures, tests, and results;
- Diagnosis;
- Patient disposition and any pertinent instructions given to the patient and/or family for follow-up care;
- Immunization record;
- Allergy history;
- Growth chart for pediatric patients;
- Referral information to and from outside agencies; and
- Signature of physician or appropriate health care provider
- Any current medications, over-the-counter medications, and herbal preparations

A summary list must be documented and updated at the time of the clinic visit with the patient’s provider, including:

- Any significant medical diagnoses and conditions
- Any significant operative and invasive procedures
- Any adverse or allergic drug reactions
- Any current medications, over-the-counter medications, and herbal preparations

**ORGAN TRANSPLANTATION**

**Live donor and organ recipient:** The medical record of both the live donor and the organ recipient shall fulfill the requirements for any surgical inpatient record.

**Deceased donor:** The donor record shall include the following:

1. The donor’s name and unit history number where applicable or other means of identification.
2. Date and time for determination of legal death as defined in Texas Health and Safety Code Chapter 671.

3. Identification of and documentation by the licensed primary physician who pronounced legal death, who, thereafter, shall not participate in organ recovery and/or transplantation of donor organs or parts.

4. When the basis for the authorization is from a legally recognized donor, a copy of the donation document serves as the consent form. If the donor status is unclear or the decedent is deemed unsuitable and the family/next-of-kin objects, the Consent for Organ/Tissue Donation form is completed, indicating that the family does not wish to donate. A copy of the decedent’s donation document or the original completed Consent for Organ/Tissue Donation will be filed in the decedent’s medical record.

5. For all Medical Examiner cases, there must be documentation in the progress notes stating that permission from the Medical Examiner for organ donation was obtained.

6. The physician performing the organ recovery procedure shall document a detailed note including the description of the technique used to remove and prepare or preserve the donated organs, and noting especially the abnormal or other appropriate findings in the event a postmortem autopsy is required (Texas Health and Safety Code Chapter 671).

See policies 9.15.2, 9.15.3, 9.15.9 and 9.15.10 for additional information.

**MEDICAL RECORD INTEGRITY**

A medical record can fail to document the essential elements of good care, even though good care was rendered if any of the following occurs:

1. No preoperative evaluations.
2. Lack of documented pre-discharge training and/or planning.
3. No acknowledgement of abnormal findings on diagnostic testing in physician notes.
4. Lack of documentation of pending test results at the time of discharge with specific statements about communication of these results to the patients.

All medical records must accurately and completely document all orders, test results, evaluations, care plans, treatments, interventions, care provided and the patient’s response to those treatments, interventions and care.

When authenticating an entry into a medical record the author must verify that the entry being authenticated is his/her entry or that he/she is responsible for the entry, and that the entry is accurate.

**Documentation red flags include:**

- A medical record with obvious or nearly identical documentation
- Extensive, repetitious unnecessary documentation
  - unrelated to the presenting problem
  - “blown in” records
  - documentation by “exception”
• Records lack individualization
  ◦ “cloned” notes
  ◦ templates
• Documentation inconsistencies
  ◦ within the provider’s own records
  ◦ compared to records of other providers

Certain risks are inherent in the use of the COPY AND PASTE functionality. This tool if used inappropriately can negatively affect documentation integrity, adversely impact patient care, and damage the trustworthiness of the record for medico-legal purposes.

Copied information may be appropriate when copied information is:
  • based on external and independent verifiable sources, such as basic demographic information that is stable over time.
  • clearly and easily distinguished from original information
  • not actually rendered as part of the record until after a re-authentication process

Whenever the copy function is used a double check is critical to ensure you have documented in the correct patient’s record, that all information has been updated, unnecessary redundant information has not been copied, and that you are satisfied with the quality and accuracy of the new entry. To use the copy function without using extreme caution can lead to contradictory information and may endanger the future care of your patient and your reimbursement.

For more detailed information regarding Copy & Paste see IHOP Policy 06.03.01 Use of Cloned Documentation in the Electronic Health Record.

FORMS

Approval of Forms: Contact the HIM Department at ext. 73497 for assistance when designing a medical record form and for information regarding the approval process. For additional information regarding Medical Records Forms Management, please refer to the Institutional Handbook of Operative Procedures, Policy #9.2.8. All reports originating in this hospital and comprising the medical record of a patient will be original documents. If a copy has been approved for inclusion in the record, it must be clearly marked as an “Original” or “medical record copy.” Note: all informed consent forms must be approved by the Risk Management Department and Legal Affairs.

ADDITIONAL DOCUMENTATION GUIDELINES & CODING

Coding is transforming the verbal description of disease, injuries and procedures into numerical codes. Every patient encounter will be assigned these numerical codes based on the review of the provider’s documentation. Therefore, all diagnostic or procedural statements should be accurate, specific, complete and descriptive of the patient’s condition. Accurate documentation results in accurate coding which is essential to reflect the severity of illness, complexity of care provided and consumption of resources.
These codes are utilized and reported both internally and externally. Codes and the data generated from coding are used internally for reimbursement, strategic and fiscal planning, clinical research, assessment of quality, physician profiling and other clinical and administrative purposes.

These same codes and data generated from coding are reported externally to various public and private agencies, such as Medicare/ Medicaid, Texas Medical Foundation, Census Bureau, State and Local Health Departments as well as many national ranking or benchmarking institutions including but not limited to Leap Frog Group, Vizient, Hospital Compare, Healthgrades and others.

All codes are assigned by highly skilled and trained individuals nationally certified to perform Coding. Code assignment is dictated by the Rules and Guidelines established and updated annually by the Federal Government. Not adhering to these guidelines for documentation and coding constitutes fraud and is subject to prosecution.

A few of these guidelines/definitions that are important for you to be familiar with are listed below:

**All Diagnoses** that affect the current patient encounter must be documented and coded. This requirement includes conditions that coexist at the time of admission or develop subsequently and affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier admission, but which have no bearing on the current admission are to be excluded from coding. Diagnoses that are suspected and are treated empirically or cannot be ruled-out are to be included as diagnostic statements in the patient’s record and coded accordingly. Signs, symptoms and observations should be documented as a diagnosis whenever possible to provide adequate substantiation of coding for severity of illness and risk of mortality.

All diagnostic statements should be accurate, specific, complete and descriptive of the patient’s condition.

- **Principal Diagnosis**: The condition which, after study, was the reason for the admission to the hospital. This term applies to inpatients only.
- **Secondary Diagnosis**: Any conditions that affect patient care in terms of requiring: Clinical Evaluation, Therapeutic Treatment, Diagnostic Procedures, Extended the Length of Stay or increased nursing care and/ or Monitoring should be documented and coded.

**Significant Procedure**: A significant procedure is one that carries an operative or anesthetic risk or requires highly trained personnel or special equipment. All significant procedures are to be documented in the patient record. (See Procedure Progress Notes and Operative Reports sections above).

**DRGs**
Codes are sequenced into Medicare Severity Diagnoses Related Groups (or MSDRGs) to determine reimbursement from third party payers. MSDRGs are determined by the principal procedure, or the principal diagnosis if no procedure exists, and the presence of other
MSDRGs group patients with similar resource consumption, severity of illness and length of stay into payment groups.

MSDRGs are used for determining reimbursement and as an indicator for other types of reporting such as budgeting, physician profiling, clinical outcomes, case mix calculation and clinical research.

**Post Discharge Physician Query**

Coders will submit a post discharge query in the event that clarification is needed to support the completeness and accuracy of the final diagnosis and/or procedures. A query will be sent to the resident’s in-basket and a copy to the attending. An addendum to the discharge summary is needed within two (2) days. The physician has the option to respond or disagree with the query. If a response is not received in the allotted time the coder will complete the chart as documented.

**PHYSICIAN QUERY**

The **Clinical Data Management Department** provides concurrent review of the inpatient medical record to facilitate improvement of the overall quality, completeness and accuracy of the medical record documentation. The purpose of concurrent reviews is to obtain and promote appropriate clinical documentation through interaction with and education of physicians, other members of the patient care team and coding staff. Clinical Data Management works to ensure that clinical documentation accurately and completely reflects the level of service and severity of illness used for measuring and reporting physician and institutional clinical outcomes.

**PHYSICIAN QUERY & CLINICAL DATA MANAGEMENT**

- Clinical Documentation Specialists will conduct concurrent reviews of the inpatient record.
- The Clinical Documentation Specialists will review the record for documentation opportunities using CMS Documentation Guidelines and AHA ICD-9 Coding Guidelines.
- Physicians will be asked to clarify and/or provide additional documentation in the record.
- The Physician Queries (questions or requests for clarification) will be sent directly to the resident and attending’s In-Box as an Epic EMR chart deficiency. Physicians have 48 hours to respond to the query. If not response, it will be escalated to the Department Vice Chair, CMO and Chief Physician Executive.
- The Clinical Documentation Specialist will interact directly with physicians as well as use Epic’s In-Basket to query providers to achieve complete, accurate and quality medical record documentation prior to the patient’s discharge.

Results from the concurrent reviews as well as performance metrics for Case Mix Index, Risk of Mortality and Severity of Illness based on the coded record are reported institutionally to Leadership, as well as department and physician specific metrics reported to Clinical Department Chairs.
The benefits of this program include:

- Appropriate and accurate reimbursement for inpatient care given.
- A robust clinical database that provides accurate detailed information for measuring and reporting clinical outcomes, physician profiles, and institutional performance.
- Legally compliant medical records that satisfy Medicare and Joint Commission requirements for properly documented patient care.
- Continuous quality improvement cycle that audits and educates physicians on appropriate documentation needs.
- Information on practice patterns, patient populations and reimbursement trends that aid in financial and strategic decision making.
CHARTING DO’S (The following recommendations are for documenting in the paper record and/or in the EMR)

DO Correctly document retroactive entries. If a correction is made at a later time, the entry must reflect the date and time of documentation, the correct information entered, and the reason for the corrected entry noted. If any entry is made retrospectively to the time of the event, it must reflect the date and time of documentation, note the reason for the last entry, and be signed (with a full signature) or authenticated.

DO Be complete, relevant, objective and informative, but concise.

DO Document missed appointments and any other factual instances of non-compliance by the patient.

DO Acknowledge abnormal or pending lab results and plan of action.

DO Give a specific date when stating that follow-up will be provided in the future.

DO Document all contacts with the patient. Include all telephone calls and services rendered. Document all prescription refills.

DO Chart all information immediately (delays lead to inaccuracies).

DO Record an emergency contact mechanism for patient and next of kin.

DO Describe clearly in each record entry:
- Mode of contact (i.e., telephone call, visit, etc.)
- Reason for contact
- Procedures done or information/advice given
- Outcome of contact
- Plan for future care/follow-up

DO Document direct statements from the patient. Write them out and place in quotes.

DO Fill in every blank when editing transcribed documents. Record negatives as well as positives.

DO Use only standard abbreviations (See UTMB’s list of prohibited abbreviations in the back of this book).

DO Note the date for referral or return visits.

DO Document thought processes during the decision-making. This takes care of the “Why” questions that patients and possibly plaintiffs ask.

DO Read nurses’ notes. Make sure they don’t contain incorrect information or something not called to your attention.

DO Proof read verbal and telephone orders before signing them.

DO Use the most specific description possible in assessment and plan.

DO Write “Acute,” “Chronic,” or “Acute on Chronic” for diagnoses.

DO Document etiology: congenital, idiopathic, diabetic, hypertensive, post-operative, due or associated with another disease process.
Do Document size, anatomical location, duration, and acuity.

Do Document Provisional or Differential diagnosis: Include “likely,” “probable.” Consider “multifactorial.”

Do Link diagnosis to presenting symptom.

Do Document specific organ failure, rather than “multisystem organ failure.”

Do Address and reinforce the specific diagnostic impression of the consult service or diagnostic study/evaluation in your progress note.

Do Document in progress notes any diagnoses from abnormal lab, radiology, diagnostic studies, pathology, nursing/ancillary notes and indicate the clinical significance for each diagnosis or finding.

Do Write “resolved” to show that the condition has been fully treated.

Do Identify if Palliative / Comfort care is initiated.

Do Make sure each problem is updated daily when charting your daily progress note.

Do Document the corresponding diagnosis for all medications, treatments, and diagnostic studies to reflect the severity of illness and risk of mortality.

Do Document All Surgical, Medical and Other Complications of Care, even if minor, readily treated or resolved. Complications cannot be coded as such unless the physician documents that the condition is associated with, or due to, the surgery, procedure or other treatment.

Do Use your Documentation Specialist as a resource

CALL: 747-1526, 747-1527, or 747-1525

CHARTING DO’S FOR PAPER RECORDS

Do Write legibly. Physician’s signatures must be legible and will include first name or initial, last name, and M.D.; initials alone will not be acceptable. Write your Dictation/Doctor number after each signature on Procedure Notes to insure proper credit for doing procedures. Alternatively, initials may be used only if they are accompanied by a rubber stamp, or printed/typewritten full name, as defined above (See Policy 9.2.15).

Do Date and time all entries. Military time preferred.

Do Document your doctor number after every signature in the record.

Do Document the complete date (day, month, and year – “MM/DD/YYYY”) on each medical record entry.

Do Sign each entry with your name and credentials/title/position.

Do Use black ink. It is best for copying and imaging purposes.

Do Correct any error or mistake in charting by drawing a single line through the incorrect portion, add the correct information, state the reason for the corrected entry, and initial and date the correction.
DO If an entry is made in the paper record retrospectively, it must reflect the date and time the entry is actually made. Note the reason for the late entry, and sign with a full signature.

DO Review, initial, and date all lab and radiology reports.

CHARTING DO’S FOR THE EMR

DO Use the copy/paste function sparingly and only from your own notes.

DO Follow Epic procedures to correctly make corrections/amendments to data entries.

CHARTING DON’TS (The following recommendations are for documenting in the paper record and/or in the EMR)

DON’T Document that you don’t believe that the patient should be in the hospital.

DON’T Document feelings about financial reimbursements or that the patient is being discharged because of federal requirements.

DON’T Document statements such as “Patient awaiting weather change for discharge, or “Patient to be discharged tomorrow because he doesn’t have a ride.”

DON’T Chart subjective comments about the patient, i.e., “Patient is crazy;” DO quote the patient’s words, “I’m Napoleon Bonaparte,” which will describe the behavior instead. Try to avoid adjectives and judgmental statements.

DON’T Chart names without describing their function in relation to the patient’s care. Do chart “Referred to Bob Jones, M.D. of UTMB for allergy testing.” NOT “Referred to Bob Jones.”

DON’T Use the medical record to malign colleagues or other care providers.

DON’T Make any changes to a medical record after being notified of a lawsuit. Contact the Legal Affairs department if you need to make changes to the medical record.

CHARTING DON’TS FOR PAPER MEDICAL RECORDS

DON’T Use liquid paper, white out, scribble over, cut off, or in any other way obliterate a record entry which has been made.

DON’T Remove any document from the paper medical record. Documents can only be removed by trained employees in the Health Information Management Department for these reasons: 1). The document was filed into the wrong patient’s record, 2). Is a duplicate of an original that is filed in the medical record, 3). Is not an approved medical record form (e.g. financial form).

CHARTING DON’TS FOR THE EMR

DON’T Put clip art in the electronic medical record.
Dictation
Information
UTMB DICTATION SYSTEM – M*MODAL DIGITAL VOICE, INC. (DVI)

UTMB is pleased to present the M*Modal digital dictation system for your convenience. The Record Processing Division of HIM offers hands-on training if desired. Call (409) 772-6890 if you wish to schedule training. The system will guide you with verbal prompts so one-on-one training is not mandatory.

Please dictate clearly and succinctly. Dictate less than 5 minutes, which results in approximately 1 to 2 typed pages.

DICTATION INSTRUCTIONS:

1. Dial x70000 (Galveston Campus) or 1-877-367-9237 from any location

2. Select Location code
   a. Galveston & League City = 4
   b. Angleton Danbury Campus = 3

3. Enter your dictator ID/doctor number and press #

4. Enter the Work Type followed by #
   a. 1 = Operative Report (all areas)
   b. 2 = Discharge Summary (ADC only)
   c. 3 = History & Physical (ADC only)
   d. 4 = Initial Consultation (ADC only)

5. Enter the 6 digit patient MRN# (i.e., 123456) minus the alpha character. You will dictate the alpha character (i.e., “P” or “Q”) along with the medical record number.

6. You will be given a job number. Record this job number for tracking purposes.

7. You will hear a beep, and then begin dictating.

Editing Controls

2 = Record On/Off
3 = Short Review
4 = Pause
5 = Disconnect
6 = Priority
8 = Next Report
44 = Fast Forward to End
77 = Full Rewind

Press 8 to start a new report without hanging up, repeating steps 4-7 for each report. To complete dictation(s) press 5 and hang up.

For assistance with dictation issues, please call extension 26890.
See specific dictation card for details.

NOTE: Residents and Fellows must dictate attending physician’s full name at the beginning of all dictations. Also, record job number for tracking purposes.

Only with your compliance and adherence to these instructions will we be able to serve you in the most efficient manner. Appropriate routing depends on your accuracy.

**DICTATING HINTS**

**ENTERING IDENTIFYING NUMBERS:** When dictating, each number should be pushed individually. If numbers are entered too fast, the numbers may be transposed or not registered by the system. This is extremely important in identifying reports for inquiries regarding dictation or transcription status.

**PATIENT AND PHYSICIAN IDENTIFICATION:** Identify yourself (spell your name). Dictate and spell patient’s name and MRN# at the beginning of each dictation. Include the alpha character on the MRN#.

**WARNING:** You cannot be cleared of record work you have completed, unless you include all report header information (patient’s MRN#, the attending’s ID# and name, date of operation) and the work type.

**OPERATIONS:** When dictating procedures, always dictate correct date of operation, patient name, MRN# number, and faculty surgeon’s name. This is necessary to clear you of delinquent operative reports. Operative reports must be dictated within 24 hours post surgery.

**MISSING DATA FROM REPORTS:** Include all required information as outlined in your handbook. If, for example, OPERATION is missing, that report is considered incomplete.

**INCOMPLETE DICTATION:** If for some reason you are not able to complete a dictation, make a note as to where you are in the report. Later, when you return to complete this dictation, re-enter all of your numbers in the system and state that you are completing dictation that you had previously started. Include the job number of the incomplete dictation. The two parts of the report will then be merged.
Dictation Do's and Don'ts

- Do be concise and speak distinctly
- Do dictate the full name of the physicians
- Do use appropriate headings and dictate in the appropriate order
- Do dictate less than 5 minutes, which is approximately 1 to 2 typed pages
- Do record the job number of your dictation
- Don't dictate from cell phones
- Don't dictate where there is background noise
- Don't use abbreviations for the name of the procedure performed – you must use full text.
- Don't use prohibited abbreviations – i.e. Use “q.daily” not q.d.

MMODAL DICTATION INSTRUCTIONS
DIAL: 1-877-367-9237
DIAL: 70000 (Galv. Campus)
- Select location code:
  3#  –  ADC
  4#  –  Galveston & LCC
- Key in your Dictator ID/Doctor Number and press #
- Key in selected work type and press #
- Key in patient’s medical record number (excluding alpha character) and press #
- Residents & fellows must dictate attending physician’s full name at the beginning of all dictations
- Record job number for tracking purposes later
- Press (2) to begin dictating or wait for tone
- Identify yourself (spell your name if unusual)
- Dictate patient’s medical record number (including the alpha character)
- Dictate and spell patient’s name
- Be sure dictate the surgery date
- Dictate attending/faculty physician’s name

- To end the dictation, Press (5) and hang up
- To dictate additional reports without hanging up, Press (8) then key in work type ID and press #
- Key in patient’s medical record number (excluding alpha character), press # and continue as before

WORK TYPE:
1  - Operative Report
2  – Discharge Summary (ADC only)
3  – History & Physical (ADC only)
4  – Initial Consult (ADC only)

Dictation Keypad functions
2  – Record ON/OFF
3  – Short Rewind
4  – Pause
5  – Disconnect
6  – Priority
8  – Next report
77 – Full Rewind
44 – Fast Forward

Headings and order to follow when dictating Operative Notes:
- Patient Name
- Medical Record Number
- Date of Surgery
- Faculty Surgeon’s full name
- Resident Surgeon’s full name
- Assistant(s) or Teaching Resident’s full name
- Co-Faculty Surgeon (if applicable) full name
- Preoperative Diagnosis
- Postoperative Diagnosis
- Title of Operation
- Indications/History/Findings (optional)
- Procedure

See The Medical Record and Health Information Management Services Handbook for additional document requirements
https://ispace.utmb.edu/xythoswfs/web/view/xy-2312058_1

eSignature URL
https://www.speechmachines.org

- Provider eSign ID
- Your password (not UTMB Users-M)
- Company ID = 53177
THE UNIVERSITY OF TEXAS MEDICAL BRANCH HOSPITALS

PLASTIC SURGERY

DOE, JOHN A

DATE OF OPERATION: 01/01/2012

U.H.#: 00-01-01-P

WARD:

FACULTY SURGEON: JAMES KILDARE, MD
RESIDENT SURGEON: MARCUS WELBY, MD (RES)
ASSISTANT OR TEACHING RESIDENT: JOE GANNON, MD (RES)

PREOPERATIVE DIAGNOSIS: Lipoma of upper back.

POSTOPERATIVE DIAGNOSIS: Lipoma of upper back.

OPERATION: Excision of lipoma of upper back 10cm X 8cm.

INDICATIONS: This is a 63-year-old male complaining that for the past year he has been having this mass growing on the right upper back. He states that for the past few months the size has increased. The primary care physician was worried; therefore, they consulted Plastic Surgery for excision. Due to the growing nature of the mass, it was decided to bring him back for excision of this mass in the right upper back suggestive of lipoma.

FINDINGS: Lipoma involving the fascia above and below the muscular layer.

After consent was obtained, the patient was brought back to the operating room and prepped and draped in sterile fashion. The lipoma was drawn out with a marking pen. Ten milliliters of local Marcaine with epinephrine was injected into the incision transversely through the mass. Once that occurred, a #15 blade was used to make an incision through the skin and subcutaneous tissues down to the fat. After incising through the fat layer, Bovie electrocautery was used to incise deeper. Unfortunately, no capsule was found surrounding the lipoma. This incision was taken all the way down to the muscular layer to the fascia. Once that occurred, the surrounding fat from under the skin was shelled out using Bovie electrocautery. After incising the superior half of the lipoma, in the inferior half it was noted that some of the lipoma was submuscular. Therefore, a muscular flap was formed to remove the lipoma from under the muscle. Once that was removed, it was noted that the lipoma involved not only the fascia, but also above the muscle and under the muscular layer. After full investigation of the wound, it was noted that the lipoma was entirely removed. The lipoma was removed in multiple pieces and sent to pathology for specimen for regular pathological examination. The patient had very
minimal bleeding. Bleeding was controlled by Bovie electrocautery. Copious irrigation was used. A total of 150 mL of irrigation was used to clean out the wound. No bleeding was noted; therefore, 4-0 Monocryl was used to close the deep dermal layer in an interrupted fashion, and then 5-0 Monocryl was used to close the skin in a running fashion. Dermabond was placed on top of the wound, 4x4s placed on top of that, with Op-Site on top of that. The patient tolerated the procedure well. He was extubated in the OR and sent to the PACU in stable condition.

MARCUS WELBY, MD (RES) Name of Faculty Surgeon

MW/MEDQ J#: 111111 D: 01/01/2010 08:40:31 T: 01/01/2010 16:45:53
UTMB
Abbreviations
Guide
# The Joint Commission Prohibited Abbreviations List

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U, u (unit)</td>
<td>Mistaken for “0” (zero), the Number “4” (four) or “cc”</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number 10 (ten)</td>
<td>Write “International Unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily)</td>
<td>Mistaken for each other</td>
<td>Write “daily”</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d., qod (every other day)</td>
<td>Period after the Q mistaken for “l” and the “O” mistaken for “l”</td>
<td>Write “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)*</td>
<td>Decimal point is missed</td>
<td>Write X mg</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg)</td>
<td></td>
<td>Write 0.X mg</td>
</tr>
<tr>
<td>MS</td>
<td>Can mean morphine sulfate or Magnesium sulfate</td>
<td>Write “morphine sulfate”</td>
</tr>
<tr>
<td>MSO₄ and MgSO₄</td>
<td>Confused for one another</td>
<td>Write “magnesium sulfate”</td>
</tr>
</tbody>
</table>

¹Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

**Exception:** A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

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The *Medical Abbreviations* book by Neil M. Davis can be purchased at the UTMB Bookstore and used as an abbreviations guide.

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Updated 11/22/2011

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The Abbreviations Guide is available via the web at https://www.utmb.edu/him under the “Physician Orientation” tab.