HISTORY & PHYSICAL EXAM FORMAT

NAME OF DICTATING MD, PA, OR NP/
SUPERVISING MD (REQUIRED)
PATIENT NAME
MEDICAL RECORD NUMBER
ADMIT DATE
PRIMARY CARE MD / ADDRESS / PHONE#
CHIEF COMPLAINT
HISTORY OF PRESENT ILLNESS

- Location
- Quality
- Severity
- Timing
- Duration
- Context
- Modifying Factors
- Associated Signs & Symptoms

CURRENT MEDICATIONS (Include Dosage)
PAST MEDICAL HISTORY
PRIOR MAJOR ILLNESSES/INJURIES
PRIOR OPERATIONS/HOSPITALIZATIONS
ALLERGIES
PAIN ASSESSMENT
AGE APPROPRIATE IMMUNIZATION STATUS
FAMILY HISTORY
(Mother / Father / Siblings with significant problems)
SOCIAL HISTORY
Psychosocial Needs (Incl. support mechanism and patient compliance with prior instructions)
Marital status &/or living arrangements
Current Employment
Occupational History
Use of drugs, alcohol, & tobacco (Specify quantity)
Extent of education

REVIEW OF SYSTEMS

- General
- HEENT
- Cardiovascular
- Gastrointestinal
- Musculoskeletal
- Neurological
- Endocrine
- Allergic/Immunologic
- Male/Female Genitalia
- Gynecologic
- Obstetrical
- Respiratory
- Genitourinary
- Integumentary
- Psych
- Hematologic/Lymphatic

PHYSICAL EXAM
Constitutional (General appearance, vital signs)
Eyes
Ears, Nose, Mouth, Throat
Cardiovascular
Respiratory
Gastrointestinal
Genitourinary
Musculoskeletal
Skin
Neurologic
Psych
Hematologic/Lymph/Immunologic

ASSESSMENT / PLAN

1. List all diagnoses and for each specify the following:
   - Discuss clinical impressions or diagnosis
   - Clarify initiation of or changes in treatments
2. Amt. &/or complexity of data to be reviewed
   - Diagnostic service ordered, planned, scheduled or performed
   - Review and results of lab, radiology, or other diagnostic tests
   - Review of old records or additional history from family or other source & relevant finding(s)
3. Risk of Significant Complications, Morbidity &/or Mortality
   - Comorbidities / underlying diseases
   - Surgical or invasive diagnostic procedures ordered, planned, scheduled or performed

An H&P must be performed and documented no greater than 30 days prior to admission and no later than 24 hours after admission. If the patient is admitted for the same or related problem, and H&P performed within 30 days of admission is acceptable, as long as it is updated with an interval note. This note must be done at admission, but no longer than 24 hours after admission and in all cases prior to surgery.

DISCHARGE SUMMARY FORMAT
COMPLETE THE DAY OF DISCHARGE

NAME OF DICTATING MD, PA, OR NP/
SUPERVISING MD (REQUIRED)
PATIENT NAME
MEDICAL RECORD NUMBER
ADMIT DATE
DISCHARGE DATE
PRIMARY CARE MD / ADDRESS / PHONE#
CHIEF COMPLAINT
FINAL DIAGNOSIS
REASONS FOR ADMISSION
HOSPITAL COURSE
Consults / Findings
Operations / Dates of Surgery
Treatment rendered and response
PERTINENT Diagnostic Findings
Complications and Comorbidities

CONDITION AT DISCHARGE
DISCHARGE INSTRUCTIONS
Medications exactly as given to patient
Diet & Activity
Follow-up Care Instructions
Self-Care Instructions

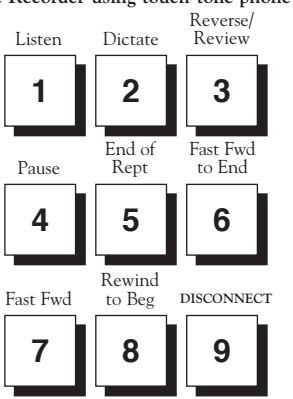
EMORY HEALTHCARE

EMORY UNIVERSITY HOSPITAL MIDTOWN /
EMORY UNIVERSITY HOSPITAL

TELEPHONE DICTATION INSTRUCTIONS

1. Dial the number where the patient received treatment
   - Emory University Hospital Midtown 404-686-2222 or 404-686-8255
   - Emory University Hospital 404-712-8255 or 404-712-4755
2. Hospital dictation ID number prompt:
   - Residents and midlevels-enter your NPI number
   - Supervising physicians-GA License number
   - Call Medical Records if you hear "INVALID Entry"
   - Press the # key to go to the next prompt
3. Enter the 1-digit report type:
   1 = Operative Report 6 = Consultation
   2 = Discharge Summary 7 = Procedure (Not done in OR)
   3 = H & P 8 = Letter
4. Enter the 7-digit patient Medical Record number. Begin 6 digit numbers with a leading 0.
5. Listen for ready tone/voice prompt, "You may begin dictation". Start dictation – recorder starts and stops by voice sensing.
6. Please identify yourself and spell your name, credentials, as appropriate:
7. **Do not use a cell phone to dictate.**
8. Press # key after dictation for job confirmation number. This number can be used to track dictation.
9. To continue dictating another report without hanging up press the "5" to begin the next dictation.
10. Press "9" to DISCONNECT when finished with dictation. (Be sure to get the job number first)

Control the Recorder using touch-tone phone as follows:



DOCUMENTATION TIPS

- Document diagnostic statements along with clinical statements. Clarification and specificity of conditions are key in order for coding, which is essential to reflect severity of illness and risk of mortality.
- Principal diagnosis is "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." **This includes final diagnoses determined once all pathology, radiology and lab results are finalized, including any results published after discharge.**
- Secondary diagnoses must be monitored, evaluated, treated, or increase care or length of stay.
- Any condition present on admission (POA) must be documented in the body of the medical record.
- Inpatient setting – coding rules permit a hospital to code "possible," "probable," "suspected," or "unable to rule out" diagnoses. Documentation should include medical decision making process and clinical information supporting the suspected condition.
- Document corresponding diagnoses for all medication, treatments and diagnostic studies.
- Document significance and corresponding diagnosis of any abnormal findings described on lab, x-ray or pathology reports. **This documentation is required for coding.**
- Avoid the use of general signs and symptoms or generic diagnoses if more specific qualified conditions are supported.
- Document the full extent of all procedures including bedside procedures

General documentation should reflect:

- Type of diabetes, all associated conditions, controlled or uncontrolled (not poorly)
- Specificity of pneumonia (list cause or type)
- Pressure ulcer type, site and stage
- Type of anemia (acute blood loss, chronic, macrocytic, aplastic, etc)
- Acute, chronic, or acute on chronic
- Specificity for CHF: acute, chronic, systolic, diastolic
- Bactermia vs septicemia
- Nutritional status to include BMI
- Diagnosis for AMS
- Sepsis d/t urinary cause (not urosepsis)
- Respiratory failure vs insufficiency

OPERATIVE REPORT FORMAT

NAME OF DICTATING MD
PATIENT NAME
MEDICAL RECORD NUMBER
PROCEDURE DATE
SURGEON
1ST ASSISTANT
2ND ASSISTANT
PRE-OPERATIVE DIAGNOSIS
POST-OPERATIVE DIAGNOSIS
PROCEDURE
ANESTHESIA
INDICATIONS FOR SURGERY
(if applicable, include EBL, complications, drains and fluids replaced)

DESCRIPTIONS OF FINDINGS
DETAILS OF PROCEDURE

Please be sure to include the following in your dictated operative report in order to assist with correct coding of physician services:

SPECIMENS REMOVED
CONDITION OF PATIENT POST-OP

- If a resident participates in a service performed in a teaching setting, the physician fee schedule payment is made only ***if the teaching physician is present during the key portion of the procedure.*** In these cases, be sure to clearly document this information. You must dictate in the operative note that "Dr. X was present during the key portion of the procedure."
- Fully describe every procedure listed at the top of operative note in the body of the report.
- Differentiate between two or more surgeons in a procedure. Be specific when identifying the procedures performed by each surgeon.
- Include the reason for complex procedures and if complications arise include length of time involved.

If you have any questions or problems while dictating, please call Medical Records at 712-2572 and speak to the transcription manager.

CONSULTATION FORMAT

NAME OF DICTATING MD, PA, OR NP/
SUPERVISING MD (REQUIRED)
PATIENT NAME
MEDICAL RECORD NUMBER
CONSULT DATE
CONSULTING MD
REQUESTING MD

REASON FOR CONSULT (Problem Specific)
SUMMARY WITH RECOMMENDATIONS
HISTORY OF PRESENT ILLNESS
Location
Quality
Severity
Timing
Duration
Context
Modifying Factors
Associated Signs & Symptoms
MEDICATIONS (Include Dosage)
ALLERGIES
PAST MEDICAL HISTORY
(Mother/Father/Siblings with significant problems)
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Endocrine	Psych
Allergic/Immunologic	Hematologic/Lymphatic

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Skin
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Hematologic/Lymph/Immunologic

DIAGNOSTIC STUDIES ASSESSMENT/PLAN