

# Medical Administrative Assistants



#### **Acknowledgments**

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#### Introduction

To become a skilled medical administrator (medical office assistant), you first need to learn the vocabulary (language) of the medical administration profession. The sections in this booklet introduce you to some of the basic terms you will need. Once you understand the language of medical office assistants, you will be prepared to interpret and communicate information accurately.

This guide mainly focuses on some of the essential terms in the medical administration profession. Self-tests and answer keys have been included in this guide. The activities are designed to be completed *after* you have studied the corresponding unit. After you have read and understood the material you can try the tests yourself. If you score below 80% on the self-tests, it is recommended that you go back and review those areas.

If you would like to study more in depth, there is a list of references at the back of this package.



#### The Health Office Professional

**Allied health care** - Any duty or profession that supports primary health-care professionals, such as physicians, in delivering health-care services.

**Client -** A person seeking or receiving health care; synonymous with patient, but suggests a more active role.

**Clinic** - A facility providing medical care on an outpatient basis. Many clinics have a specialty such as ongoing care for diabetes or cancer.

**Core competency -** The basic or essential skills that one needs to succeed in a particular profession. (For example, a health office professional needs computer skills.)

**Externship** - A co-operative or workplace experience or period of training for a student that is provided by the student's educational facility.

Internship - A period of time spent doing a job as part of becoming qualified to do it. For example, "Jane has a summer internship at a local hospital."

**Licensure -** A legal document, obtained after passing written and clinical examinations that is required for health-care practitioners in regulated fields.

**Medical Assistant -** A person who is trained to assist a physician with various clinical tests, examinations and procedures.

**Medical Office Assistant** - A person who primarily handles administrative but also some clinical duties in a health office.

**Regulated Profession -** A profession that is legally restricted to practitioners with a specific professional qualification and/or provincial registration.

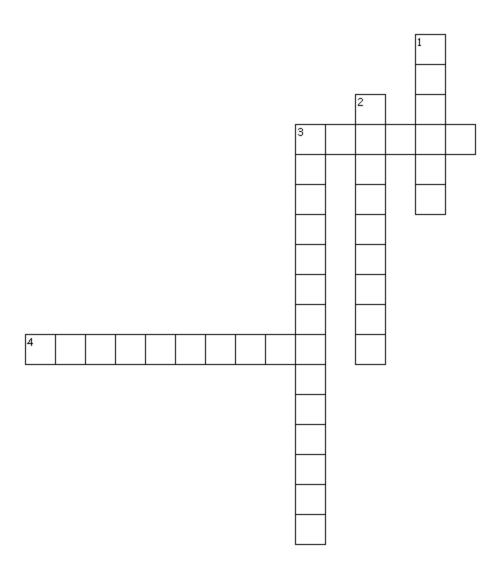


# **Tools: Equipment and Technology**

Due to the diversity of roles for Medical Administrative Assistants (hospital admitting, Winnipeg Regional Health Authority and doctors' offices), various machines and computer programs are used. These include Transcription, Microsoft Office, GroupWise, Max Gold or other scheduling software, computers with admitting, transfer and discharge (ADT) functions.



## The Health Office Professional: Crossword



#### **Across**

- 3. A person receiving health care
- 4. A co-operative or workplace experience

#### Down

- 1. A facility providing medical care
- 2. Obtained after passing written and clinical examinations
- 3. Essential skills



# **Commonly Ordered Tests**<sup>1</sup>

ABGs	arterial blood gases	LDH	lactic dehydrogenase
AFB	acid-fast bacilli	LDL	low-density lipoprotein
APTT	activated partial thromboplastin time	LP	lumbar puncture
BE	barium enema	LS	X-ray of the lumbosacral spine
BUN	blood urea nitrogen	MCH	mean corpuscular hemoglobin
C&S	culture and sensitivity	мснс	mean corpuscular hemoglobin concentration
C&T	crossmatch and type (for compatible blood; see T&S)	MCV	mean corpuscular volume
CBC	complete blood count	Mg	magnesium
CK	creatine kinase	MRI	magnetic resonance imaging
CO <sub>2</sub>	carbon dioxide	Na	sodium
CRP	C-reactive protein	0&P	ova and parasites (often in stool specimens)
CSF	cerebrospinal fluid	ОВ	occult blood
CT	computed tomography	Р	phosphorus
CXR	chest X-ray (PA, posterior-to-anterior; Lat., lateral)	Pap	Pap smear
ECG/EKG	electrocardiogram	PCO <sub>2</sub>	partial pressure of carbon dioxide
ELISA	enzyme-linked immunosorbent assay	PFT	pulmonary function test
ERCP	endoscopic retrograde cholangiopancreatography	PSA	prostate-specific antigen
EMG	electromyography	PT	prothrombin time
ESR	erythrocyte sedimentation rate	PTT	partial thromboplastin time
FBS	fasting blood sugar	RBC	red blood cell
GB/GBS	gallbladder series	S&A	sugar and acetone
GTT	glucose tolerance test	SBF	small bowel follow-through
HbAic	glycoslated hemoglobin	SGOT	serum glutamic-oxaloacetic transaminase
Hb, Hgb	hemoglobin	SGPT	serum glutamic-pyruvic transaminase
HBV	hepatitis B virus	$T_3$	triiodothyroxine
Hct	hematocrit	$T_4$	thyroxine
HDL	high-density lipoprotein	T&S	type and screen (for compatible blood; see C&T
HIV	human immunodeficiency virus	TSH	thyroid stimulating hormone
INR	international normalization ratio	UGI	upper gastrointestinal series
IV-GTT	intravenous glucose tolerance test	US	ultrasound
IVP	intravenous pyelogram	VDRL	venereal disease research laboratory
K	potassium	VMA	vanilylimandelic acid (usually a 24-hr urine test
KUB	X-ray of the kidney, ureter, and bladder	WBC	white blood cell count

<sup>&</sup>lt;sup>1</sup> Thompson, D.V. (2005). <u>Administrative and Clinical Procedures for the Health Office Professional.</u> (*p.141*) Toronto, Ontario: Pearson Prentice Hall.



# Fill in the Blank 1: Acronyms for Commonly Ordered Tests

Directions: Read page 8. Study the acronyms that are used for commonly ordered tests. Write down what the acronyms stand for in the blanks. (Try to fill this in without looking back at page 8.)

Example	: C&S= <u>Culture and Sensitivity</u>
1.)	WCB:
2.)	CT:
3.)	IVP:
4.)	US:
5.)	CXR:
6.)	ECG/EKG:
7.)	HBV:
8.)	MRI:
9.)	RBC:
10.)	Pap:



#### **Medical Records and Reports**

#### **Medical Chart Notes and Progress Notes**

When a patient comes into the office or specialty clinic for the first visit, a **chart** is prepared. There are different kinds of charts that are used, as you will see in this booklet. It is important to be neat, accurate, complete and timely when recording charts. This should be done as soon as possible after the patient is seen.

A social data sheet is a form with the patients' personal information, such as their medical health number, address, date of birth, other insurance information, etc.

Chart notes (also called progress notes) are the formal or informal notes taken by the physician when he or she meets with or examines a patient in the office, clinic or hospital.<sup>2</sup>

#### **Complete Documentation**

- 1.) The patient records must be complete and easy to read.
- 2.) Each meeting with a patient should include:
  - Date
  - Reason for the visit
  - History, physical examination, prior diagnostic test results
  - Diagnosis (assessment, impression)
  - Plan for care
  - Name of the observer
- 3.) Reason for ordering diagnostic or other services should be written down.
- 4.) Health risk factors e.g., smoking, heart condition, diabetes, etc., should be identified.
- 5.) Progress, response to treatment, changes in treatment and revision of diagnosis should be written down. <sup>3</sup>

<sup>&</sup>lt;sup>2</sup> Diehl, M.O. (2002). <u>Medical Transcription: Techniques and Procedures</u>. 5<sup>th</sup> Edition. (p .262). St. Louis, Missouri: Saunders.

# 纂

#### **Patient's History**

The history includes the chief complaint (**CC**), the history of the present illness (**HPI**), the review of systems (**ROS**), and past history, family and/or social history (**PFSH**).

The **chief complaint** (CC) describes the symptom, problem or condition that is the reason for the encounter and must be clearly described in the record.

The **history of the present illness** (HPI) is the description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present.

A **review of symptoms** (ROS) inquires about the system directly related to the problems identified in the HPI.

#### **Abbreviations/Acronyms**

Many facilities now are trying to encourage doctors to discontinue the use of abbreviations and slang, but that will take some time. Below are 20 common abbreviations. (Specific abbreviations may be different in different clinics and hospitals.)

abd for abdomen

**afib** for atrial fibrillation

consult for consultation

**C-section** for caesarian section

**diff** for differential(lab)

dig for digitalis (heart drug)

<sup>&</sup>lt;sup>3</sup> Diehl, M.O. (2002). <u>Medical Transcription: Techniques and Procedures</u>. 5<sup>th</sup> Edition. (p. 263) St. Louis, Missouri: Saunders.



**Dob** = Date of Birth

**DX** = Diagnosis, impression (IMP)

echo for echocardiogram

**H&H** for hemoglobin and Hematocrit (lab)

hep lock for heparin lock

*lab* for laboratory

Lytes for electrolytes (lab)

pap test for papanicolaou test

path for pathology

**PE** (or **PX**) = Physical examination

post-op for postoperative (after the operation)

**pre-op** for preoperative (before the operation)

prepped for to prepare

**RX** = Prescription

**Rx** for prescription

tach for ventricular tachycardia

tachy for rapid or fast

vitals or VS for vital signs (Temp, BP)



## Abbreviations Used in Scheduling

V/S	vital signs check	Can	cancellation	Ref	referral
CPx	physical examination	NS	no show	ECG	electrocardiogram
A/CPx	annual physical	FUp	follow-up	Lab/w	lab work-up
AHE	annual health	RS	reschedule	US	ultrasound
1 1 1	examination	A/S	allergy shot	WB	well baby
PN	prenatal	lmm	immunization	Pap	Pap smear
PP	postpartum check	F/S	flu shot	Con	consult
NP ~	new patient	Inj	injection	BP	blood pressure
NC	new client				



# Fill In the Blank 2: Abbreviations/Acronyms

Directions: After you study the acronyms on page 11, complete the questions below.

1.)	Rx:
2.)	Afib:
3.)	post-op:
4.)	tachy:
5.)	V/S:
6.)	NP:
7.)	BP:
8.)	Can:
9.)	PE:
10.)	lnj:



#### **Preparation of a History and Physical:**

#### Full Block Format Report Style<sup>4</sup>

de Mars, Verna Marie 76-83-06

Cortland M. Struthers, MD

HISTORY

CHIEF COMPLAINT:

Prolapse and bleeding after each bowel movement for the past 3-4 months.

PRESENT ILLNESS:

This 68-year-old white female says she usually has three bowel movements a day in small amounts, and there has been a recent change in the frequency, size and type of bowel movement she has been having. She is also having some pain and irritation in this area. She has had no previous anorectal surgery or rectal infection. She denies any blood in the stool itself.

PAST HISTORY:

ILLNESSES: The patient had polio at age 8 from which she has made a remarkable recovery. Apparently, she was paralysed in both lower extremities and now has adequate use of these. She has no other serious illnesses.

ALLERGIES: ALLERGIC TO PENICILLIN. She denies any other drug or food allergies. MEDICATIONS: None.

OPERATIONS: Herniorrhaphy, 25 years ago.

SOCIAL: She does not smoke or drink. She lives with her husband who is an invalid and for whom she cares. She is a retired former municipal court judge.

**FAMILY HISTORY:** 

One brother died of cancer of the throat; another has cancer of the kidney.

**REVIEW OF SYSTEMS**:

SKIN: No rashes or jaundice.

HEENT: Unremarkable.

CR: No history of chest pain, shortness of breath, or pedal edema. She has had some mild hypertension in the past but is not under any medical supervision nor is she taking any medication for this.

<sup>&</sup>lt;sup>4</sup> Ibid, 291



GI: Weight is stable. See Present Illness.

OB-GYN: Gravida 11 Para 11. Climacteric at age 46, no sequelae. EXTREMITIES: No edema.

NEUROLOGIC: Unremarkable.

j rt

D:5-17-0X

T: 5-20-0X

#### **Full Block Format: Category Explanations**

Statistical Data: This is decided by the medical facility. In some cases, the entire statistical heading is printed for the medical transcriptionist to include the patient's name, identification number, physician, date, etc.

Title: History or Personal History centered on the page. Typed in all capital letters.

Main Topics: Typed in all capitals, followed by a colon and underlined, on a line by itself. Begun on edge of left border.

Subtopics: Capitalized, followed by a colon.

Data: Begun on the *same* line as subtopic. Single-spaced. All lines return to the left margin. Double-spaced between the last line of one heading and the next heading.

Margins: Narrow (1/2" to 3/4" is okay.)

Close: Typed line for signature. Dictator's typed name. Transcriptionist's initials. Date of dictation (D). Date of transcription (T).<sup>5</sup>

<sup>&</sup>lt;sup>5</sup> Ibid, 290.



#### Modified Block Format Report<sup>6</sup>

de Mars, Verna Marie

Cortland M. Struthers, MD

Hospital Number: 76-83-06

HISTORY

CHIEF COMPLAINT:

Prolapse and bleeding after each bowel movement for the past

PRESENT ILLNESS:

This 68-year-old white female says she usually has three bowel movements a day in small amounts, and there has been a recent change in frequency, size and type of bowel movement she has been having. She is also having some pain and irritation in this area. She has had no previous anorectal surgery or rectal infection. She denies any blood in the stool itself.

PAST HISTORY:

ILLNESSES:

The patient had polio at age 8 from which she has made a remarkable recovery. Apparently, she was paralyzed in both lower extremities and now has adequate use of these. She has no other

serious illnesses.

ALLERGIES:

ALLERGIC TO PENICILLIN. She denies any other drug or food allergies.

MEDICATIONS:

None.

OPERATIONS:

Herniorrhaphy, 25 years ago.

SOCIAL:

She does not smoke or drink. She lives with her husband who is an invalid and for whom she cares. She is a retired former

municipal court judge.

FAMILY HISTORY:

One brother died of cancer of the throat, another has cancer

of the kidney.

REVIEW OF SYSTEMS:

SKIN:

No rashes or jaundice.

HEENT:

Unremarkable.

CR:

No history of chest pain, shortness of breath, or pedal edema. She has had some mild hypertension in the past but is not under any medical supervision nor is she taking any medication for this.

GI:

Weight is stable. See Present Illness.

OB-GYN: EXTREMITIES: Gravida II Para II. Climacteric at age 46, no sequelae.

No edema.

NEUROLOGIC:

Unremarkable.

D: 5-17-0X

5-20-0X

Cortland M. Struthers, MD

<sup>&</sup>lt;sup>6</sup> Ibid, 293.



#### **Modified Block Format Report: Category Explanations**

Statistical Data: This is decided by the medical facility.

Title: History or Personal History centered on the page. Typed in all capital letters.

Main Topics: Typed in all capitals, followed by a colon and underlined; on a line by itself. Begun on edge of left border.

Subtopics: Indented on tab stop under main topics. Typed in full capitals, followed by a colon.

Data: Begun on the *same* line as the topic or subtopic. Data input begun two tab stops after the heading. Single-spaced. Double-spaced between the last line of one heading and the next heading.

Margins: Narrow (1/2" to 3/4" is ok.)

Close: Typed line for signature. Dictator's typed name. Transcriptionist's initials. Date of dictation (D). Date of transcription (T).<sup>7</sup>

What is the major difference between Full Block Report Format and Modified Block Format Report? (See Answers on page 32)

-

<sup>&</sup>lt;sup>7</sup> Ibid, 290.



#### Indented Format Report Style<sup>8</sup>

de Mars, Verna Marie

This style is popular because it is clean and easy to read

76-83-06 Cortland M. Struthers, MD HISTORY CHIEF COMPLAINT: Prolapse and bleeding after each bowel movement for the past 3-4 PRESENT ILLNESS: This 68-year-old white female says she usually has three bowel movements a day in small amounts, and there has been a recent change in the frequency, size and type of bowel movement she has been having. She is also having some pain and irritation in this area. She has had no previous anorectal surgery or rectal infection. She denies any blood in the stool itself. PAST HISTORY: ILLNESSES: The patient had polio at age 8 from which she has made a remarkable recovery. Apparently, she was paralyzed in both lower extremities and now has adequate use of these. She has had no other serious illnesses. ALLERGIES: ALLERGIC TO PENICILLIN. She denies any other drug or food allergies. MEDICATIONS: None. OPERATIONS: Herniorrhaphy, 25 years ago. SOCIAL: She does not smoke or drink. She lives with her husband who is an invalid and for whom she cares. She is a retired former municipal court judge. One brother died of cancer of the throat, another has cancer of FAMILY HISTORY: the kidney.

REVIEW OF SYSTEMS:

SKIN:

No rashes or jaundice.

HEENT:

Unremarkable.

CR:

No history of chest pain, shortness of breath, or pedal edema. She has had some mild hypertension in the past but is not under any

medical supervision nor is she taking any medication for this.

GI:

Weight is stable. See Present Illness.

OB-GYN:

Gravida II Para II. Climacteric at age 46, no sequelae.

EXTREMITIES:

No edema.

NEUROLOGIC:

Unremarkable.

jrt

D: 5-17-0X T: 5-20-0X Cortland M. Struthers, MD

Figure 12-3. Example of a history done in indented format.

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<sup>8</sup> Ibid, 295.



#### Run-On Format Report Style<sup>9</sup>

Run-on format uses much less space on the paper and takes less time to prepare. This format is the most popular one used by the institutions. The history is not typed separately but continues on into the physical. It closely resembles a chart note.

de Mars, Verna Marie 76-83-06 Cortland M. Struthers, MD

HISTORY

CHIEF COMPLAINT: Prolapse and bleeding after each bowel movement for the past 3-4 months.

PRESENT ILLNESS: This 68-year-old white female says she usually has three bowel movements a day in small amounts, and there has been a recent change in the frequency, size and type of bowel movement she has been having. She is also having some pain and irritation in this area. She has had no previous anorectal surgery or rectal infection. She denies any blood in the stool itself.

PAST HISTORY: Illnesses: The patient had polio at age 8 from which she has made a remarkable recovery. Apparently, she was paralyzed in both lower extremities and now has adequate use of these. She has had no other serious illnesses. Allergies: ALLERGIC TO PENICILLIN. She denies any other drug or food allergies. Medications: None. Operations: Herniorrhaphy, 25 years ago. Social: She does not smoke or drink. She lives with her husband who is an invalid and for whom she cares. She is a retired former municipal court judge.

 $\begin{tabular}{ll} FAMILY \ HISTORY: \ One \ brother \ died \ of \ cancer \ of \ the \ throat, \ another \ has \ cancer \ of \ the \ kidney. \end{tabular}$ 

REVIEW OF SYSTEMS: Skin: No rashes or jaundice. HEENT: Unremarkable. CR: No history of chest pain, shortness of breath, or pedal edema. She has had some mild hypertension in the past but is not under any medical supervision nor is she taking any medication for this. GI: Weight is stable. See Present Illness. OB-GYN: Gravida II Para II. Climacteric at age 46, no sequelae. Extremities: No edema. Nuerologic: Unremarkable.

irt

D: 5-17-0X T: 5-20-0X

Cortland M. Struthers, MD

20

<sup>&</sup>lt;sup>9</sup> Ibid, 296



#### **Short-Stay Record**

When a patient is being sent to an outpatient or surgical or diagnostic centre, a shortened form of the History and Physical (H&P) is okay. This form is good for many diagnostic procedures and minor operative procedures. The statistical data would be the same as those required on the longer forms, but the description of the patient's condition and the history would be a lot shorter. 10

> Roland, Jamie T. 543098

Copy: Robert R. Shoemaker, MD

SHORT-STAY RECORD

HISTORY:

Patient is a 6-year-old male complaining of frequent episodes of tonsillitis. He has

missed several weeks of school this spring because of infections. He is a constant mouth breather. He snores loudly at night. He has constant nasal obstruction. There is no history of

earaches.

PAST HISTORY:

There are no allergies. Bleeding history: None. Operations: None. Illnesses: None Medications: Vitamins, iron. Has been on Penicillin for resolution of symptoms. Family History: Noncontributory.

PHYSICAL EXAMINATION:

Skin: No rashes. EENT: Ears: TM and canals appeared normal. Nose: Congested posteriorly but not anteriorly. Very large cryptic tonsils meeting in the Neck: Numerous palpable nodes.

CHEST:

Lungs: Clear to percussion and auscultation. Heart: Not enlarged, normal sinus rhythm,

no murmurs.

ABDOMEN:

Soft, nontender.

EXTREMITIES:

Full range of motion.

NEUROLOGICAL:

Completely normal.

IMPRESSION:

Chronic hypertrophic tonsils and adenoids with recurrent infections.  $% \left( 1\right) =\left( 1\right) \left( 1\right$ 

RECOMMENDATION:

Tonsillectomy and adenoidectomy.

6-8-0X D: Т: 6-8-0X

Peter Anthony Nelson, MD

<sup>&</sup>lt;sup>10</sup> Ibid, 315.



#### Interval History<sup>11</sup>

If the patient returns to the hospital within a month of being discharged and has the same complaint, a complete H&P does not have to be written on the patient. However, an interval history (or interval note) is completed to describe what has happened to the patient since the **discharge.** The complete statistical data are used, but the medical information is shorter. The history would include any new findings since the last examination.

Benita L. Martinez

March 17, 200X

09-74-12

William B. Dixon, MD

INTERVAL HISTORY

PRESENT COMPLAINT:

This is a 45-year-old female who the first of March had a Roux-en-Y gastrojejunostomy done for a reflux bile gastritis. Postoperatively, she did moderately well; however, she began to evidence signs of anastomotic obstruction which got persistently worse. Upper GI series was done 4 days ago which showed an almost complete obstruction of the anastomosis. Patient is now being admitted for decompression of her stomach and revision of the gastro-

jejunostomy.

PAST HISTORY:

Regional family, see old chart.

PHYSICAL EXAMINATION:

Well-developed, well-nourished, but nervous

white female in no acute distress.

HEENT:

Eyes: React to L&A. Ears: Canals and membranes normal. Nose: Negative. Neck: Supple with no masses, no enlargement of glands.

Thyroid: Not palpable.

LUNGS:

Clear to percussion and auscultation.

HEART:

Rhythm and rate normal. No murmurs. No

enlargements.

ABDOMEN:

Recent bilateral, subcostal incision, well-

healed. No other abdominal masses.

PELVIC:

Not done.

EXTREMITIES:

Negative.

IMPRESSION:

Gastrojejunal anastomotic obstruction.

ADVICE:

1. Decompression by Levin tube.

2. Re-resection and anastomose tomorrow.

William B. Dixon, MD

mlo

D: 3/17/0X T: 3/17/0X

<sup>&</sup>lt;sup>11</sup> Ibid, 316.



#### Miscellaneous Medical Reports

#### Discharge Summaries<sup>12</sup>

A discharge summary is a clinical resume or final progress note.

Discharge: To leave the hospital with permission from the doctor.

Evans, Cornelia Elizabeth July 16, 200X

DISCHARGE SUMMARY

ADMISSION DATE: June 14, 200X

DISCHARGE DATE: July 15, 200X

#### HISTORY OF PRESENT ILLNESS

This 19-year-old black female, nulligravida, was admitted to the hospital on June 14, 200X, with fever of 102°, left lower quadrant pain, vaginal discharge, constipation, and a tender left adnexal mass. Her past history and family history were unremarkable. Present pain had started two to three weeks prior to admission. Her periods were irregular, with the latest period starting on May 30, 200X, and lasting for six days. She had taken contraceptive pills in the past, but had stopped because she was not sexually active.

#### PHYSICAL EXAMINATION

She appeared well developed, and well nourished, and in mild distress. The only positive physical findings were limited to the abdomen and pelvis. Her abdomen was mildly distended, and it was tender especially in the left lower quadrant. At pelvic examination, the cervix was tender on motion, and the uterus was of normal size, retroverted, and somewhat fixed. There was a tender cystic mass about 4-5 cm in the left adnexa. Rectal examination was negative.

#### ADMITTING DIAGNOSES

- 1. Probable pelvic inflammatory disease (PID).
- 2. Rule out ectopic pregnancy.

#### LABORATORY DATA ON ADMISSION

Hgb 8.8, Hct 26.5, WBC 8,100 with 80 segs and 18 lymphs. Sedimentation rate 100 mm in one hour. Sickle cell prep + (turned out to be a trait). Urinalysis normal. Electrolytes normal. SMA-12 normal. Chest x-ray negative, 2-hour UCG negative.

#### HOSPITAL COURSE AND TREATMENT

Initially, she was given cephalothin 2 gm IV q.6h. and kanamycin 0.5 gm IM b.i.d. Over the next 2 days, the patient's condition improved. Her pain decreased and her temperature came down to normal in the morning and spiked to 101° in the evening. Repeat CBC showed Hb 7.8, Hct 23.5. The pregnancy test was negative. On the second night following admission, she spiked to 104°. The patient was started on antituberculosis treatment, consisting of isoniazid 300 mg/day, ethambutol 600 mg b.i.d., and rifampin 600 mg daily. She became afebrile on the sixth postoperative day and was discharged on July 15, 200X, in good condition. She will be seen in the office in one week.

SUNGICAL PROCEDURES	

Biopsy of omentum for frozen section; culture specimens.

DISCHARGE DIAGNOSIS Genital tuberculosis.	
	Harold B. Cooper, MD
amd	
D:7/15/200X	
T:7/16/200X	
12 lbid, 323.	



#### Operative Reports<sup>13</sup>

Whenever a surgical procedure is done in the hospital, an outpatient surgical centre, or a clinic, an operative report should be dictated or written in the medical record soon after surgery.

Below is a sample of an operative report. Notice that the first paragraph is one long paragraph. This is how many surgeons dictate their operative records. Some hospitals require that surgeons separate the report into subheadings, such as anesthesia, incision, findings, procedure, closure, and so on.

Patient: Elaine J. Silverman

June 20, 200X Date:

Room No.: 1308 Hospital No.: 84-32-11

OPERATIVE REPORT

Menorrhagia.

Chronic pelvic inflammatory disease. Perineal relaxation.

POSTOPERATIVE DIAGNOSIS:

PREOPERATIVE DIAGNOSIS:

Menorrhagia.
 Chronic pelvic inflammatory disease.
 Perineal relaxation.

OPERATION:

Total abdominal hysterectomy. Lysis of pelvic adhesions. Bilateral salpingo-oophorectomy.

Appendectomy.

Posterior colpoplasty.

Under general anesthesia, the patient was prepared and draped for PROCEDURE: abdominal operation. The abdomen was opened through a Pfannenstiel incision, and examination of the upper abdomma operation. The abdomen was opened through a Frannenstiel incision, and examination of the upper abdomen was entirely normal. Examination of the pelvis revealed an enlarged uterus. The uterus was three degrees retroverted and adhered to the cul-de-sac. Both tubes and ovaries were involved in an inflammatory mass, with extensive adhesions to the lateral pelvic wall on both sides. The tubes revealed evidence of chronic pelvic inflammatory disease. The omentum was also attached to the fundus and to the left adnexa. The omentum was dissected by means of blunt and sharp dissection; the dissection was carried to each adnexa, freeing both was dissected by means of blunt and sharp dissection; the dissection was carried to each admexa, freeing both tubes and ovaries by means of blunt and sharp dissection. The uterus was found to be approximately two times enlarged, after freeing all the adhesions. The uterovesical fold of peritoneum was then incised in an elliptical manner, bladder was dissected off the lower uterine segment. The round ligament, infundibulopelvic ligament on each side was identified, clamped, cut, and ligated. The uterine artery on each side was clamped, cut and doubly ligated. Paracervical fascia was developed. Heaney clamps were placed on the cardinal ligaments, the cardinal ligaments cut, and pedicles ligated. The vagina was circumscribed; the uterus, both tubes and ovaries were removed from the operative field. The cardinal ligaments were then sutured into the lateral angles of the vagina by means of interrupted sutures; the vagina was then closed with continuous over-and-over stitch. The paracervical feating and the continuous over-and-over stitch. The paracervical feating and the continuous over-and-over stitch. The paracervical feating and the continuous over-and-over stitch. fascia was sutured into place with interrupted figure-of-eight suture; the lateral suture incorporated the stumps of the uterine arteries; the pelvis was then reperitonealized with continuous length of GI 2-0 atraumatic suture. Appendix was identified and appendectomy was done in the usual manner. The appendiceal stump was cauterized with phenol and neutralized with alcohol. Re-examination at this time of the pelvis revealed all bleeding well controlled. The abdominal wall was then closed in layers, and the skin was approximated with camelback clips. During the procedure, the patient received one unit of blood. Patient was then prepared for vaginal surgery.

Patient was placed in lithotomy position, prepared and draped. Posterior colpoplasty was begun, for repair of rectocele and perineal relaxation. The posterior vaginal mucosa was dissected from the perirectal fascia; the excess posterior vaginal mucosa was excised and perirectal fascia was brought together with continuous interlocking sturre of 0 chromic. The posterior vaginal mucosa was closed with continuous interlocking suture of 0 chromic. Perineal body was closed with subcutaneous, subcuticular stitch. There was a correct sponge count. The patient withstood the operation well. Patient left the operating room in good condition.

Harold B. Cooper, MD

ftr D: 6-20-0X T: 6-22-0X

> College Park Hospital 321 College Park Circle Woods Creek, XX 98765

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<sup>&</sup>lt;sup>13</sup> Ibid, 326-327.



#### Pathology Reports<sup>14</sup>

As a medical transcriptionist, you can specialize by typing pathology or radiology reports. Pathology transcriptionists work in laboratories, hospital medical laboratories and coroners' offices.

Pathology - The scientific study of disease. 15

#### College Hospital 2345 College Hospital Boulevard Wood Creek, XX 98765

#### PATHOLOGY REPORT

Date:

June 20, 200X

Elaine J. Silverman

Pathology No. 430211 Room No. 1308

Physician:

Harold B. Cooper, MD

SPECIMEN SUBMITTED:

Tumor, right axilla

GROSS DESCRIPTION

Specimen A consists of an oval mass of yellow fibroadipose tissue measuring  $4 \times 3 \times 2$  cm. On cut section, there are some small, soft, pliable areas of gray apparent lymph node alternating with adipose tissue. A frozen section consultation at time of surgery was delivered as NO EVIDENCE OF MALIGNANCY on frozen section, to await permanent section for final diagnosis. Majority of the specimen will be submitted for microscopic examination.

Specimen B consists of an oval mass of yellow soft tissue measuring  $2.5 \times 2.5 \times 1.5$  cm. On cut section, there is a thin rim of pink to tan-brown lymphatic tissue and the mid portion appears to be adipose tissue. A pathological consultation at time of surgery was delivered as no suspicious areas noted and to await permanent sections for final diagnosis. The entire specimen will be submitted for microscopic examination.

RTW:wfr

MICROSCOPIC DESCRIPTION

Specimen A sections show fibroadipose tissue and nine fragments of lymph nodes. The lymph nodes show areas with prominent germinal centers and moderate sinus histiocytosis. There appears to be some increased vascularity and reactive endothelial cells seen. There is no evidence of malignancy.

Specimen B sections show adipose tissue and 5 lymph node fragments. These 5 portions of lymph nodes show reactive changes including sinus histiocytosis. There is no evidence of malignancy.

DIAGNOSIS

A & B: TUMOR, RIGHT AXILLA: SHOWING 14 LYMPH NODE FRAGMENTS WITH REACTIVE CHANGES AND NO EVIDENCE OF MALIGNANCY.

Stanley T. Nason, MD

STN:wfr D: 6-18-0X T: 6-18-0X

<sup>14</sup> Ibid, 330.

<sup>&</sup>lt;sup>15</sup> Retrieved March 21, 2008 from <a href="https://www.dictionary.cambridge.org">www.dictionary.cambridge.org</a>.



#### Radiology and Imaging Reports<sup>16</sup>

**Radiology** - The scientific study of the medical use of radiation especially X-rays.

**Radiation** - A form of energy that comes from a nuclear reaction.

Common Radiology and Imaging Reports are as follows:

- X-ray
- CT scanning (Computed Tomography)
- MRI (Magnetic Resonance Imaging)
- NMR (Nuclear Magnetic Resonance)

XYZ Magnetic Imaging Center 4500 College Road Woodland Hills, XY 12345 (013) 647-0980

INTERPRETATION

PATIENT: Jeffrey Clauson NUMBER: 4309x

AGE: 27 DATE: August 30, 200X

MAGNETIC RESONANCE IMAGING, CERVICAL SPINE

Cervical radiculopathy

HISTORY: TECHNIQUE:

Sag. G.E. 600/30/23. M.R., 43 Nex, 5 mm., C.C. Sag. S.E. 500/24, M.R., 4 Nex, 5mm., C.C. Ax. S.E. 1000/30, H.R., 2 Nex, 5 mm., C.C.

FINDINGS

The sagittal sequences cover from the lower posterior fossa to approximately T4-5. The axial sequence covered from the upper odontoid process through mid T1.

There is mild reversal of the normal lordotic curve of the cervical spine.

The C2-3 and C3-4 interspaces are normal.

There is posterior osteophyte formation projecting broadly across the anterior aspect of the spinal canal at C4-5 level. On the sagittal sequences this appears to contact the cord. There is no deformity identified with the cord to indicate compression. The foramina are patent.

The C5-6 level is unremarkable aside from some narrowing of the anterior subarachnoid space, probably a result of mild spurring and the effect of the reversal of the normal lordotic curve.

At C6-7 there are degenerative disk changes with disk space narrowing and osteophyte formation. There is no cord compression, although there is moderate left foraminal stenosis.

The C7-T1 level demonstrates moderate left foraminal stenosis.

There is either spur or disk bulge at the T1-2 level. This was only seen on the sagittal sequences. The abnormality appears to contact the cord but does not appear to cause any compression. There are no additional extradural abnormalities. There are no intradural extramedullary lesions. The cord is normal without abnormal intensity to indicate the presence of infarction or mass, and there is no evidence of a syrinx. This is mentioned in that the cerebellar tonsils project somewhat below the foramen magnum indicating the possibility of a Chiari II malformation.

IMPRESSION: CEREBRAL SPONDYLOSIS AS DESCRIBED ABOVE.

PROBABLE CHIARI II MALFORMATION. NO CORD SYRINX.

Jason B. Iverson, MD

rmt

<sup>&</sup>lt;sup>16</sup> Ibid, 333. Note: This radiology report is in modified block format.



#### Consultation Reports<sup>17</sup>

Consult: Seek advice from someone, e.g., one doctor asking another doctor.

HAROLD B. COOPER, MD

6000 MAIN STREET

VENTURA, CALIFORNIA 93003

June 15, 200X

John F. Millstone, MD

5302 Main Street

Ventura, CA 93003

Dear Dr. Millstone:

RE: Elaine J. Silverman

This 19-year-old woman was seen at your request. The patient was admitted to the hospital yesterday because of chills, fever, and abdominal and back pain.

The history has been reviewed. A prominent feature of the history is the presence of intermittent, severe, shaking chills for four days with associated left lower back pain, left lower quadrant abdominal pain and fever to as high as 103 or 104 degrees. The patient has had hypertension for a number of years and had been managed quite well with Aldomet 250mg twice a day.

On examination her temperature at this time is 100.6 degrees. The pulse is 110 and regular. Blood pressure is 190/100. The patient had partial bilateral iridectomies, the result of previous cataract surgery. Otherwise, the head and neck are not remarkable. Lung fields are clear throughout. The heart reveals a regular tachycardia; heart sounds are good quality. No murmurs heard and there is no gallop rhythm present. The abdomen is soft. There is no spasm or guarding. A well-healed surgical scar is

<sup>&</sup>lt;sup>17</sup> Diehl, M.O. (2002). <u>Medical Transcription: Techniques and Procedures</u>. 5<sup>th</sup> Edition. (p.336) St. Louis, Missouri: Saunders.

present in the right flank area. There is considerable tenderness in the left lower quadrant of the left mid abdomen, but as noted, there is no spasm or guarding present. Bowel sounds are present. Peristaltic rushes are noted and the bowel sounds are slightly high pitched in character. The extremities are unremarkable.

Diagnosis: I believe the patient has acute diverticulitis. She may have some irritation of the left ureter in view of the findings on the urinalyses. She appears to be responding to therapy at this time in that her temperature is coming down and also there has been a slight reduction in the leukocytosis from yesterday.

I agree with the present program of therapy and the only suggestion would be to possibly increase the dose of gentamicin to 60 mg every eight hours, rather than the 40 mgq8h which she is now receiving.

Thank you for asking me to see this patient in consultation.

Sincerely,

Harlod. B. Cooper, MD

mtf

#### Psychiatric Reports<sup>18</sup>

Psychiatry is one of the specialties of clinical medicine. It is a varied field, and the language involves abnormal psychology, human behaviour and treatment terminology. Patients are referred to as "clients." In a hospital setting, clients include the mentally deficient (MD) and developmentally disabled (DD).

A report by a clinical psychologist would not necessarily contain a physical examination of the body systems or a list of the medications. The main heading might be "Psychologic Evaluation," and subheadings might be given as follows: Purpose of the Report; Psychosocial History; Results of the Psychologic Assessment; Mental Status Examination; Test Results; Impressions; Diagnosis, and Recommendations.

**Psychiatry**: The part of medicine that studies mental illness.

<sup>&</sup>lt;sup>18</sup> Ibid, 346.



**Psychologist**: Someone who studies the human mind and human emotions and behaviour, and how different situations have an effect on them.

Below is a sample psychiatric evaluation in full block format on the next page.

#### How would a report from a psychiatrist and a psychologist be different?

(See Answers on page 33)

#### **Psychiatric Report**

S	tate	of California — Health and	Welfare Agency		Departme	ent of Mental Healti
		GUIDELINES	Date of Report: Dictated: Transcribed:	11-09-0X	PSYCHIATRIC EVALUATION	Unit 9
В	1 2 3 3 4 4 5 5 6 6 7. 8 9. 10. ME 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. SU	SYCHIATRIC HISTORY Identification data Source of information Chief complaint History of present illness (focus on recent illness, and include emotional behavior) History of past psychiatric episodes Relevant medical/ surgical/trauma/ medication history Developmental history (if applicable) Educational/vocational Relevant family history Relevant social history NTAL STATUS EXAM Attitude/Cooperation General appearance (include speech) Motor activity Orientation Mood and affect Mental content Memory Fund of general knowledge Cognition and comprehension Abstraction ability Counting and calculating Judgement Insight régarding illness Patient strengths Suicide, homicide, dangérousness MMARY OF YCHIATRIC	PSYCHIATRIC  1. This 1' Greenv from P referen Street,' 2. Informaccompolly Sy His inf  3. "I don't  4. Pedro to because days pr smoked in the shocks, sleepin the hos positive Spanish motor i and disto Gree stated to He prespaintin to eat of in his in He lauguake strone occ Medica difficul	HISTORY: 7-year-old, ale Hospital Itman Count ce. His moth Woodland H ation obtaine anying pape banish. The bornation is know why was admitted of bizarre b ior to admis coraine. He treets, sticki crawling ur g. He laughe pital. The dr e cocaine an n revealed hi ntegration d charged to h invale Medic hat after disc sented bizarr g the walls, or sleep, wall oom, attemp thed and crie eet drugs an assion he we t for him to		dmitted to rship 5353 or religious East Date  wing the speaks terpreter.  st 26, 200X, report five CP. He also running nude ceiving electric e-was not restraint in K, showed a abody test in test of visual ed with Haldol readmitted b. His mother and childish. articles, les, refusing piles of objects in the did not owever, on the Greenvale teed. It was tee. He was
	27. 28.	Narrative summary (including Risk Potential) Diagnosis (DSM III R) Preliminary Treatment Plan	He also 10 mg	banged the t.i.d. A long	al restraints many times because of assa walls and screamed. He was treated with term hospitalization was  J. 999999-9 U.99	h Haldol
		Prognosis Signature and Title				☐ Continued
MH	H 57	EVALUATIO PSYCHI Confidential Client/F See W & I Code 02 (Revised 7/87) Reference 2410	ATRIC Patient Information			



# **Multiple Choice Test**

1.)	•	s prepared.		
a) report c) history				
	b)	chart	d) indented report	format
2.)	Each meetir	ng with a patie	nt should include:	
	a)	diagnostic te	·	ory, physical examination, prior is (assessment, impression); Plan rver.
	b)	Date; Reaso	on for the test; Diag	nosis
	c)	History; Diag	gnosis	
	d)	None of the	above	
3.) The describes the symptom, problem or condition the reason for the encounter and must be clearly described in the record			•	
	a)	History of Pr	esent Illness (HPI)	
	b)	Review of S	ymptoms (ROS)	
	c)	Past history,	family and/or socia	al history (PFSH)
	d)	Chief compla	aint (CC)	
4.)	the same co	mplaint, a cor	-	nonth of being discharged and has not have to be written on the s completed.
	a)	Short stay hi	istory	c) Interval note
	b)	Review of S	ymptoms (ROS)	d) All of the above



5.)	Whenever a surgical procedure is done, a(n) report should be				
dictated or written in the medical record soon after surgery.					
	a)	Pathology	c) Radiology		
	b)	Operative	d) Psychiatric		
6.) format uses much less space on the paper and takes les					
prepare. It closely resembles a chart note.			oles a chart note.		
	a)	Full-block	c) Run-on		
	b)	Modified	d) Indented		



# **Answer Key**

#### The Health Office Professionals Crossword (page 7)

Across		Down	
3. Client		1. Clinic	
4. Ext	ternship	2. Licensure	
		3. Co	re competencies
Fill in	the Blank 1: Acronyms for Commonly	y Orde	red Tests (page 9)
1.) W	CB: White Blood Cell Count	6.) E0	CG/EKG: Electrocardiogram
2.) C	Γ: Computed Tomography	7.) HBV: Hepatitis B Virus	
3.) IVP: Intravenous Pyelogram		8.) MRI: Magnetic Resonance Imaging	
4.) US: Ultrasound		9.) RBC: Red Blood Cell Count	
5.) C	XR: Chest X-Ray	10.) Pap: Pap smear	
Fill in	the Blank 2: Abbreviations/Acronyms	s (page	14)
1.)	Rx for prescription	6.)	NP new patient
2.)	afib for atrial fibrillation	7.)	BP blood pressure
3.)	post-op after the operation	8.)	Can cancellation
4.)	tachy for rapid or fast	9.)	PE Physical Examination

#### Page 18 question:

**V/S** vital signs

5.)

What is the major difference between Full Block Report Format and Modified Block Format Report? In a modified Block Format Report, the subtopics are indented on tab stop under main topics, and are typed in full capitals, followed by a colon.

10.)

Inj Injection

#### Page 29 question:



How would a report from a psychiatrist and a psychologist be different? A report from a psychiatrist may include a prescription for medication. A psychologist cannot write prescriptions.

#### Multiple Choice Test (page 30)

- 1.) B. Chart.
- 2.) A. Date; Reason for the visit; History, physical examination, prior diagnostic test results; Diagnosis (assessment, impression); Plan for care, and Name of the *observer*.
- 3.) E. Chief complaint (CC)
- 4.) E. Interval note
- 5.) B. Operative
- 6.) C. Run-on

#### References

Diehl, M.O. <u>Medical Transcription: Techniques and Procedures</u>, 5<sup>th</sup> Edition. St. Louis, Missouri: Saunders, 2002.

Thompson, D.V. <u>Administrative and Clinical Procedures for the Health Office</u>

<u>Professional</u>. Toronto, Ontario: Pearson Prentice Hall, 2005.

Updated: April 2008