Medical Office Terminology

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

Table 6.1 | Abbreviations for Commonly Ordered Laboratory and Diagnostic Tests

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABGs</td>
<td>arterial blood gases</td>
</tr>
<tr>
<td>AFB</td>
<td>acid-fast bacilli</td>
</tr>
<tr>
<td>APTT</td>
<td>activated partial thromboplastin time</td>
</tr>
<tr>
<td>BE</td>
<td>barium enema</td>
</tr>
<tr>
<td>BUN</td>
<td>blood urea nitrogen</td>
</tr>
<tr>
<td>C&amp;S</td>
<td>culture and sensitivity</td>
</tr>
<tr>
<td>C&amp;T</td>
<td>crossmatch and type (for compatible blood; see T&amp;S)</td>
</tr>
<tr>
<td>CBC</td>
<td>complete blood count</td>
</tr>
<tr>
<td>CK</td>
<td>creatine kinase</td>
</tr>
<tr>
<td>CO₂</td>
<td>carbon dioxide</td>
</tr>
<tr>
<td>CRP</td>
<td>C-reactive protein</td>
</tr>
<tr>
<td>CSF</td>
<td>cerebrospinal fluid</td>
</tr>
<tr>
<td>CT</td>
<td>computed tomography</td>
</tr>
<tr>
<td>CXR</td>
<td>chest X-ray (PA, posterior-to-anterior; Lat., lateral)</td>
</tr>
<tr>
<td>ECG/EKG</td>
<td>electrocardiogram</td>
</tr>
<tr>
<td>ELISA</td>
<td>enzyme-linked immunosorbent assay</td>
</tr>
<tr>
<td>ERCP</td>
<td>endoscopic retrograde cholangiopancreatography</td>
</tr>
<tr>
<td>EMG</td>
<td>electromyography</td>
</tr>
<tr>
<td>ESR</td>
<td>erythrocyte sedimentation rate</td>
</tr>
<tr>
<td>FBS</td>
<td>fasting blood sugar</td>
</tr>
<tr>
<td>GB/GBS</td>
<td>gallbladder series</td>
</tr>
<tr>
<td>GTT</td>
<td>glucose tolerance test</td>
</tr>
<tr>
<td>HbA1c</td>
<td>glycosylated hemoglobin</td>
</tr>
<tr>
<td>Hb, Hgb</td>
<td>hemoglobin</td>
</tr>
<tr>
<td>HBV</td>
<td>hepatitis B virus</td>
</tr>
<tr>
<td>Hct</td>
<td>hematocrit</td>
</tr>
<tr>
<td>HDL</td>
<td>high-density lipoprotein</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>INR</td>
<td>international normalization ratio</td>
</tr>
<tr>
<td>IV-GTT</td>
<td>intravenous glucose tolerance test</td>
</tr>
<tr>
<td>IPV</td>
<td>intravenous pyelogram</td>
</tr>
<tr>
<td>K</td>
<td>potassium</td>
</tr>
<tr>
<td>KUB</td>
<td>X-ray of the kidney, ureter, and bladder</td>
</tr>
<tr>
<td>LDH</td>
<td>lactic dehydrogenase</td>
</tr>
<tr>
<td>LDL</td>
<td>low-density lipoprotein</td>
</tr>
<tr>
<td>LP</td>
<td>lumber puncture</td>
</tr>
<tr>
<td>LS</td>
<td>X-ray of the lumbosacral spine</td>
</tr>
<tr>
<td>MCH</td>
<td>mean corpuscular hemoglobin</td>
</tr>
</tbody>
</table>
| MCHC         | mean corpuscular hemoglobin
| MCV          | mean corpuscular volume            |
| Mg           | magnesium                           |
| MRI          | magnetic resonance imaging         |
| Na           | sodium                              |
| O&P          | ova and parasites (often in stool specimens) |
| OB           | occult blood                       |
| P            | phosphorus                          |
| Pap          | Pap smear                           |
| PCO₂         | partial pressure of carbon dioxide |
| PFT          | pulmonary function test            |
| PSA          | prostate-specific antigen          |
| PT           | prothrombin time                    |
| PTT          | partial thromboplastin time        |
| RBC          | red blood cell                     |
| S&A          | sugar and acetone                  |
| SBF          | small bowel follow-through         |
| SGOT         | serum glutamic-oxaloacetic transaminase |
| SGPT         | serum glutamic-pyruvic transaminase |
| T₃           | triiodothyroxine                    |
| T₄           | thyroxine                           |
| T&S          | type and screen (for compatible blood; see C&T) |
| TSH          | thyroid stimulating hormone         |
| UGI          | upper gastrointestinal series       |
| US           | ultrasound                          |
| VDRL         | venereal disease research laboratory |
| VMA          | vanillylamandelic acid (usually a 24-hr urine test) |
| WBC          | white blood cell count              |

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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= Culture and Sensitivity

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.2

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.3

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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)

---

**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

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V/S</td>
<td>vital signs check</td>
<td>Can</td>
<td>cancellation</td>
</tr>
<tr>
<td>CPx</td>
<td>physical examination</td>
<td>NS</td>
<td>no show</td>
</tr>
<tr>
<td>A/CPx</td>
<td>annual physical</td>
<td>FUp</td>
<td>follow-up</td>
</tr>
<tr>
<td>AHE</td>
<td>annual health examination</td>
<td>RS</td>
<td>reschedule</td>
</tr>
<tr>
<td>PN</td>
<td>prenatal</td>
<td>A/S</td>
<td>allergy shot</td>
</tr>
<tr>
<td>PP</td>
<td>postpartum check</td>
<td>Imm</td>
<td>immunization</td>
</tr>
<tr>
<td>NP</td>
<td>new patient</td>
<td>F/S</td>
<td>flu shot</td>
</tr>
<tr>
<td>NC</td>
<td>new client</td>
<td>Inj</td>
<td>injection</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ref</td>
<td>referral</td>
<td>ECG</td>
<td>electrocardiogram</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lab/w</td>
<td>lab work-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>US</td>
<td>ultrasound</td>
</tr>
<tr>
<td></td>
<td></td>
<td>WB</td>
<td>well baby</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pap</td>
<td>Pap smear</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Con</td>
<td>consult</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BP</td>
<td>blood pressure</td>
</tr>
</tbody>
</table>
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.) Inj: ______________________
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.

4 Ibid, 291
GI: Weight is stable. See Present Illness.


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 ¾” is okay.)

Close: Typed line for signature. Dictator’s typed name. Transcriptionist’s initials. Date of dictation (D). Date of transcription (T).

---

5 Ibid, 290.
Modified Block Format Report

de Mars, Verna Marie
Cortland M. Struthers, MD

Hospital Number: 76-03-06

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

EXTREMITIES: No edema.

NEUROLOGIC: Unremarkable.

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

Cortland M. Struthers, MD

6 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 ¾" is ok.)

Close: Typed line for signature. Dictator’s typed name. Transcriptionist’s initials. Date of dictation (D). Date of transcription (T).\(^7\)

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

\(^7\) Ibid, 290.
Indented Format Report Style

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

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

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8 Ibid, 295.
Run-On Format Report Style⁹

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.

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: 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

---

⁹ 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

---

**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.


**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.

**RECOMMENDATION:** Tonsillectomy and adenoidectomy.

---

¹⁰ Ibid, 315.
**Interval History**\(^{11}\)

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**

09-74-12

**March 17, 200X**

**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 gastrojejunostomy.

**PAST HISTORY:** Regional family, see old chart.

**PHYSICAL EXAMINATION:** Well-developed, well-nourished, but nervous white female in no acute distress.


**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.

---

\(^{11}\) Ibid, 316.
Miscellaneous Medical Reports

Discharge Summaries

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

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

Evans, Cornelia Elizabeth
87-32-11
July 15, 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 102.5°, 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 25.5, 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 cefazolin 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°F in the evening. Repeat CBC showed Hgb 7.8, Hct 23.5.
The pregnancy test was negative. On the second night following admission, she spiked to 104°F. The patient was started on anti-tuberculosis 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.

SURGICAL PROCEDURES
Biopsy of omentum for frozen section; culture specimens.

DISCHARGE DIAGNOSIS
Genital tuberculosis.

amd
D:7/15/200X
T:7/16/200X

Harold B. Cooper, MD

12 Ibid, 323.
Operative Reports

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.

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**OPERATIVE REPORT**

**FREOPERATIVE DIAGNOSIS:**

1. Menorrhagia.
2. Chronic pelvic inflammatory disease.
3. Perineal relaxation.

**POSTOPERATIVE DIAGNOSIS:**

1. Menorrhagia.
2. Chronic pelvic inflammatory disease.
3. Perineal relaxation.

**OPERATION:**

1. Total abdominal hysterectomy.
2. Lysis of pelvic adhesions.
4. Appendectomy.
5. Posterior colpoplasty.

**PROCEDURE:**

Under general anesthesia, the patient was prepared and draped for abdominal operation. The abdomen was opened through a Pfannenstiel incision, and examination of the upper abdomen was entirely normal. Examination of the pelvis revealed an enlarged uterus. The uterus was three degrees deviated 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 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 urovesical 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. Parametrial 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 nutured into the lateral angles of the vagina by means of interrupted sutures; the vagina was then closed with continuous over-and-over stitch. The parietal peritoneum was sutured with interrupted figure-of-eight suture; the lateral suture incorporated the stumps of the uterine arteries; the pelvis was then reconstituted with continuous length of O/2-0 chromic suture. Appendix was identified and appendectomy was done in the usual manner. The appendicular stump was cauterized with phenol and neutralized with alcohol. Re-examination at this time of the pelvis revealed no bleeding well controlled. The abdominal wall was then closed in layers, and the skin was approximated with catgut and 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 suture 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.

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Harold B. Cooper, MD

College Park Hospital
321 College Park circle
Winns Creek, XX 98786

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13 Ibid, 326-327.
Pathology Reports\textsuperscript{14}

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

\textit{Pathology - The scientific study of disease.}\textsuperscript{15}

\begin{center}
\begin{tabular}{|l|l|}
\hline
College Hospital & \\
2345 College Hospital Boulevard & \\
Wood Creek, XX 98765 & \\
\hline
Date: & June 20, 200X \\
Patient: & Elaine J. Silverman \\
Physician: & Harold B. Cooper, MD \\
Pathology No. & 430211 \\
Room No. & 1308 \\
\hline
\end{tabular}
\end{center}

SPECIMEN SUBMITTED:

Tumor, right axilla

GROSS DESCRIPTION

Specimen A consists of an oval mass of yellow fibroadipose tissue measuring 4 x 3 x 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 x 2.5 x 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.

\begin{flushright}
Stanley T. Nason, MD
\end{flushright}

\textsuperscript{14} Ibid, 330.
\textsuperscript{15} Retrieved March 21, 2008 from \url{www.dictionary.cambridge.org}.\textsuperscript{15}
Radiology and Imaging Reports

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)

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16 Ibid, 333. Note: This radiology report is in modified block format.
Consultation Reports

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

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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

Psychiatric Reports

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.

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18 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

PSYCHIATRIC LIFE HISTOLOGY:

1. This 17-year-old, single, Hispanic male patient was admitted to Greenvale Hospital on 9-8-00 on a tentative commitment 5333 from Pinmat County. His birth date is 0-24-xx. There is no religious reference. His mother is Mary Sanchez. Her address is 300 East Dea Street, Woodland Hills, NY 12345, (013) 599-9999.

2. Information obtained by interviewing the patient and reviewing the accompanying papers from Greenvale Center. The patient speaks only Spanish. The interview had to be done through an interpreter. His information is not very reliable.

3. "I don’t know why they sent me here."

4. Pedro was admitted to Greenvale Medical Center on August 26, 2000, because of bizarre behavior for five days. According to the report five days prior to admission, he smoked marijuana dipped in PCP. He also smoked cocaine. He demonstrated bizarre behavior such as running nude in the streets, picking up objects and putting them in his trousers, and making a electric shocks, crawling under a car and trying to set it on fire. He was not sleeping. He laughed and cried inappropriately. He broke a restraint in the hospital. The drug screening test 1 on August 26, 2000, showed positive cocaine and amphetamine for PCP and other drugs. Peezy, his mother in Spanish revealed she was about 75. Every development test of visual motor integration did not suggest organicity. He was treated with Haldol and discharged to his mother on 9-23-00. However, he was readmitted to Greenvale Medical Center on 9-24-00 and on 9-26-00. His mother stated that after discharge from the hospital he was fearful and childish. He presented bizarre behavior such as collecting household articles, painting the walls, attempting to play with medicate bottles, refusing to eat or sleep, walking around the house nude, collecting piles of objects in his room, attempting suicide by jumping off an apartment building. He laughed and cried inappropriately. His mother stated that he did not take street drugs and she took only Haldol and Cogentin. However, on one occasion he went to the store without supervision. At the Greenvale Medical Center he was confused, disoriented, and disoriented. It was difficult for him to attend to a conversation or to concentrate. He was not able to function in school. He needs close supervision and care. He had been in physical restraint many times because of assistive behavior. He also bunged the walls and screamed. He was treated with Haldol 10 mg q.i.d. A long-term hospitalization was...

SANchez, Pedro J. 999999-9 U.99
Multiple Choice Test

1.) When a patient comes into the office or specialty clinic for the first visit, a _______ is prepared.
   a) report  c) history  
   b) chart  d) indented report format

2.) Each meeting with a patient should include:
   a) Date; Reason for the visit; History, physical examination, prior diagnostic test results; Diagnosis (assessment, impression); Plan for care; and Name of the observer.
   b) Date; Reason for the test; Diagnosis
   c) History; Diagnosis
   d) None of the above

3.) The ____________ describes the symptom, problem or condition that is the reason for the encounter and must be clearly described in the record.
   a) History of Present Illness (HPI)
   b) Review of Symptoms (ROS)
   c) Past history, family and/or social history (PFSH)
   d) Chief complaint (CC)

4.) If the patient returns to the hospital within a month of being discharged and has the same complaint, a complete history does not have to be written on the patient. However, a(n) _________________ is completed.
   a) Short stay history  c) Interval note
   b) Review of Symptoms (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 less time to prepare. It closely resembles a chart note.

   a) Full-block       c) Run-on
   b) Modified        d) Indented
Answer Key

The Health Office Professionals Crossword (page 7)

Across
3. Client
4. Externship

Down
1. Clinic
2. Licensure
3. Core competencies

Fill in the Blank 1: Acronyms for Commonly Ordered Tests (page 9)

1.) WCB: White Blood Cell Count
2.) CT: Computed Tomography
3.) IVP: Intravenous Pyelogram
4.) US: Ultrasound
5.) CXR: Chest X-Ray
6.) ECG/EKG: Electrocardiogram
7.) HBV: Hepatitis B Virus
8.) MRI: Magnetic Resonance Imaging
9.) RBC: Red Blood Cell Count
10.) Pap: Pap smear

Fill in the Blank 2: Abbreviations/Acronyms (page 14)

1.) Rx for prescription
2.) afib for atrial fibrillation
3.) post-op after the operation
4.) tachy for rapid or fast
5.) V/S vital signs
6.) NP new patient
7.) BP blood pressure
8.) Can cancellation
9.) PE Physical Examination
10.) Inj Injection

Page 18 question:

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.
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**


Updated: April 2008