Lesson 40

Introduction to Medical Transcription

Step 1 Learning Objectives for Lesson 40

- When you have completed the instruction in this lesson, you will be trained to do the following:
  - Explain the formatting guidelines.
  - Identify and describe the Problem Oriented Medical Record method to organize Chart Notes.
  - Identify and describe the headings used in History and Physical Examination reports.
  - Differentiate between the History and Physical Examination and Chart Note and their headings.
  - Apply formatting rules and transcribe a sample History and Physical Examination report.

Step 2 Lesson Preview

- Can you believe you made it to the final course in your Healthcare Documentation Program? Look how far you've come! You started out in Course One by learning about medical insurance and medical terminology. Then, in Course Two, you discovered the basics of anatomy and physiology. You also learned how to create claims with medical billing software, while navigating the ins and outs of the claims process. In Course Three, you studied the organization and concepts of ICD-9-CM coding and the foundation of diagnostic coding. You expanded on your coding knowledge in Course Four by applying procedure codes. Now, you are ready to complete your studies in the Healthcare Documentation Program by exploring medical transcription and editing. You're probably ready to get started, so what are you waiting for? Let's go!

This course rounds out your healthcare document specialist knowledge with some hands-on practice in medical transcription and editing. Recall that a medical transcriptionist listens to the doctor's dictation and types what she hears. By using transcriptionists, doctors save time by speaking their notes. Some medical transcriptionists also serve as medical editors. Medical editors listen to the doctors' spoken notes while editing rough reports that a speech recognition program produced based on the doctors' dictation. Before you dive into Course Five, you'll review medical reports. You've seen a variety of examples of medical reports throughout your program, but now you'll take a closer look at the headings, subheadings and information within each report.

> The headings you will be using in Course Five will vary a little bit from some that were used in the previous lessons. For the reports you transcribe in Course Five, use the formatting guidelines and headings that are presented in this lesson.

Before you begin this lesson, let's clarify the standards you will learn in this course. You'll see report formats and rules throughout your lessons to help keep your reports consistent, but these are not standardized in the field. Formatting and style guidelines vary at each medical office. Your client or employer will provide formatting and style guidelines. When you are working, you'll have report templates and example reports that show you how reports should look. Formats and rules will vary, so you'll need to be flexible to meet your employer or client's needs. For the purposes of this course, we are providing you with a *Transcription Reference Guide*. This guide offers helpful information, including the list of rules that you'll use to format your reports for the course.

> Be sure to locate your *Transcription Reference Guide*, which is included in this course. It is a valuable tool for you to use as you are learning how to transcribe medical reports. The *Transcription Reference Guide* includes samples of the report formats you will be using in this course as well as a list of all the rules you will learn, a list of common laboratory values and other references that will be helpful to you. Take a few minutes to look through the *Transcription Reference Guide* now to become familiar with the information that is included. Make sure to keep it on hand to refer to as you complete the Practice Exercises and Quizzes and as you transcribe your reports.

In this course, you'll be introduced to the different types of medical reports, such as Chart Notes, History and Physical Examination, Consultation Report, Discharge Summary and Operative Report. To begin learning about these medical records, you will study report headings and some of the format specifics. Other specifics will be taught as you move through the course. In this lesson, you'll discover the type of information included in the Chart Notes and the History and Physical Examination. The lesson will conclude with information on terminology, and you'll practice transcribing a History and Physical Examination report.

Before learning about the guidelines, let's talk about the types of reports you'll encounter in this course.

🕮 Step 3 Types of Reports

- In general, you'll see five reports commonly used: *Chart Notes, History and Physical Examination, Consultation Report, Discharge Summary* and *Operative Reports*. In this program, the last four reports are known as the **Basic Four** or **Big Four**.

  - **Chart Notes**, also referred to as the Problem Oriented Medical Record or SOAP note, are the notes made in the medical record during ongoing medical care. It is the most straightforward method of transcription.

  - **History and Physical Examination**, or **H&P**, is the more traditional type of report consisting of section titles, headings and subheadings.

  - A **Consultation Report** is a report from a specialist to the patient's primary care provider that includes a recommendation for course of action.

  - A **Discharge Summary** is a report that documents what occurred during the course of a patient's hospital stay, and the doctor's recommendations for follow-up after the patient leaves the hospital.

  - An **Operative Report** is a detailed description of why a surgery was done, how it was performed, what was found during surgery and what the final diagnosis was, based on the surgical findings.

  You already know a lot about reports. In Course Three, you discovered where to look on the report to find the final diagnosis. You found that if the preoperative and postoperative diagnoses are different, you'll code to the postoperative diagnosis. In addition, Course Four taught you to categorize elements for key components when determining the level of service for evaluation and management codes.

  You have a good understanding of the format when it comes to coding. Now, you'll learn how these concepts apply to medical transcription and editing. First, you'll look at the general guidelines for the course. Keep in mind, most of the information provided in this section can also be found in the *Transcription Reference Guide.* It's a good idea to keep the *Guide* handy and refer to it often. Then, you'll learn the specifics of Chart Notes and the History and Physical Examination. You'll learn about the other Big Four reports in other lessons.

🕮 Step 4 Format Guidelines

- The way the headings and text are laid out in medical reports is called the format. The format may differ from hospital to hospital and from doctor to doctor, but each facility will want you to use its own format for all of its reports.

  For this course, follow the format guide that we provide. It is based on AHDI and *ASTM* guidelines. **American Society for Testing and Materials International** (**ASTM**) is an organization that establishes standards for a variety of products, including medical records. The ASTM established standards for electronic medical records and defines authentication methods if you need to correct or amend medical records.

Paragraph Styles

There are several different ways the text of a medical report can be arranged. These are called paragraph styles. Medical reports can be composed of only one paragraph style which is used for all headings, or different paragraph styles may be used for different headings.

Let's look at the paragraph styles used in our program:

Full block or flush left style

In this style, all lines of a report would begin flush left. Headings are on their own line with the text beginning on the next line. The following is an example of the full block style. This is the style you will use most often in this course.

HEADING
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADING
SUBHEADING: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Run-on style

The text in this style begins on the same line as the headings, following the colon. Continuing sentences are flush left.

HEADING: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXX
HEADING: Subheading: XXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXX. Subheading: XXXXXXXXXXXXXXXXX

Now that you understand the paragraph styles, let's look at the format specifics for reports.

Format Specifics

This next section introduces you to the format specifics for all reports in this program. This is only an introduction. You can see each of these specifics in action as you learn about each report. In addition, you'll have plenty of hands-on practice using the format specifics in this course.

Paper: For the most professional look, use white paper, and type on one side of the page only.

Margins: In healthcare documentation, you'll use one-half inch to one inch margins, top and bottom and on either side. Do not use right justification to make your right margin even. **In this program, use 1-inch margins all around the page for reports.**

Identifying information block: Appears at the top of each page on the first line after the top margin for the Big Four reports or a Chart Note. Your client may have specifications for a tab.

	At Left Margin
Big Four reports:	Name: (Patient name) #(Patient number) Dr (Doctor's name) NAME OF REPORT Page # (for pages 2 and above)
Chart note:	Name: (Patient name) #(Patient number) Page # (for pages 2 and above) PROBLEM #(number) (first page only)

Section titles: At left margin and in all capitals.

Headings: At left margin and in all capitals.

Subheadings: At left margin and use initial capitals on the first word only.

Colon: Only after headings and subheadings when the information continues on the same line.

Double space: Before each new heading. (Single space before subheadings.) (When you "double space," there is a blank line before the next line of text.) Single space the headings from GENERAL through NEUROLOGIC in the PHYSICAL EXAMINATION section.

Text: May begin on the same line as the heading or on the line following, depending on the format used. Text begins on the same line as a subheading and is single-spaced. There is no blank line between a heading and its first line of text.

Rule 60 Use only one space following a period, comma, colon and semicolon.

Exception: When the colon is used as a symbol for ratio, omit the space. (Example: 1:5)

Exception: Omit the space after the colon when used for the doctor's and transcriptionist's initials. (Example: MD:MT).

End of report: Include a 3-inch signature line above the doctor's name, 4 lines below the last line of text, flush left. Double space after the doctor's name. At the left margin, list the dictation date, D: (date), and the transcription date, T: (date). Include the doctor's initials and your initials. Both sets of initials should either be in upper case or lower case letters and separated with a colon or a virgule (/). For the rest of this program, unless dictated otherwise, use the current date for the transcription date and the day before for the dictation date.

A signature line looks like this:

_____
Jess Kydding, MD

or this:

_____
Jess Kydding, MD
Chief of Neurosurgery

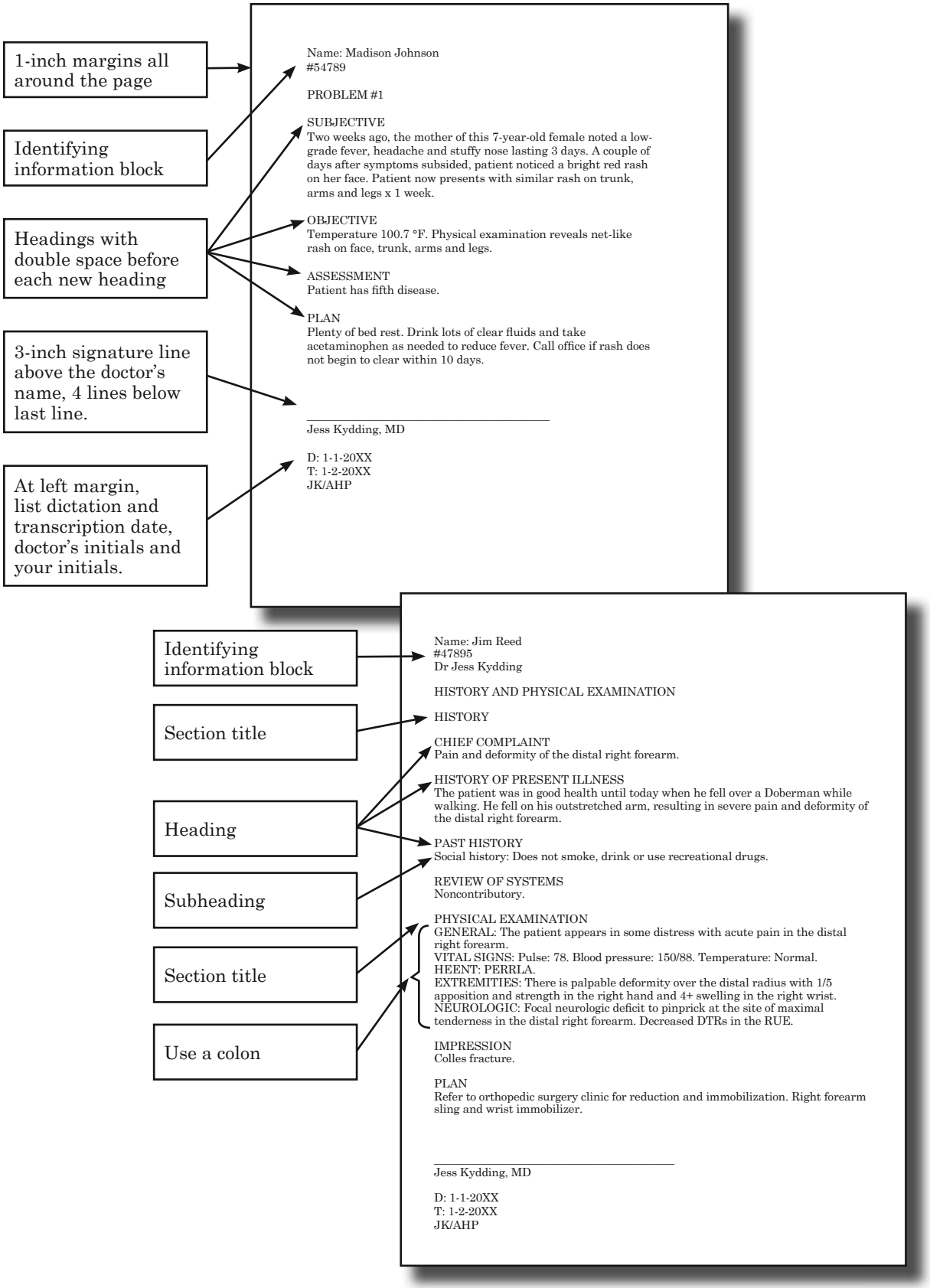
Page breaks: Let's look at two rules that will help you when you are coming to the end of a page in a report.

Rule 57 **CONTINUED is required on all pages where another page follows. Place this flush left at the left 1-inch margin, at the bottom 1-inch margin.**

Exception: In ChartScript, CONTINUED will not be used.

Rule 54 **Do not leave a heading alone on a page without any of its text. If a heading appears on the last line of a page, move it to the next page to accompany its text.**

Look at the following examples to see how these format specifics apply.


1-inch margins all around the page
Identifying information block
Headings with double space before each new heading
3-inch signature line above the doctor's name, 4 lines below last line.
At left margin, list dictation and transcription date, doctor's initials and your initials.
Name: Madison Johnson
#54789
PROBLEM #1
SUBJECTIVE
Two weeks ago, the mother of this 7-year-old female noted a low-grade fever, headache and stuffy nose lasting 3 days. A couple of days after symptoms subsided, patient noticed a bright red rash on her face. Patient now presents with similar rash on trunk, arms and legs x 1 week.
OBJECTIVE
Temperature 100.7 °F. Physical examination reveals net-like rash on face, trunk, arms and legs.
ASSESSMENT
Patient has fifth disease.
PLAN
Plenty of bed rest. Drink lots of clear fluids and take acetaminophen as needed to reduce fever. Call office if rash does not begin to clear within 10 days.
Jess Kydding, MD
D: 1-1-20XX
T: 1-2-20XX
JK/AHP
Identifying information block
Section title
Heading
Subheading
Section title
Use a colon
Name: Jim Reed
#47895
Dr Jess Kydding
HISTORY AND PHYSICAL EXAMINATION
HISTORY
CHIEF COMPLAINT
Pain and deformity of the distal right forearm.
HISTORY OF PRESENT ILLNESS
The patient was in good health until today when he fell over a Doberman while walking. He fell on his outstretched arm, resulting in severe pain and deformity of the distal right forearm.
PAST HISTORY
Social history: Does not smoke, drink or use recreational drugs.
REVIEW OF SYSTEMS
Noncontributory.
PHYSICAL EXAMINATION
GENERAL: The patient appears in some distress with acute pain in the distal right forearm.
VITAL SIGNS: Pulse: 78. Blood pressure: 150/88. Temperature: Normal.
HEENT: PERRLA.
EXTREMITIES: There is palpable deformity over the distal radius with 1/5 apposition and strength in the right hand and 4+ swelling in the right wrist.
NEUROLOGIC: Focal neurologic deficit to pinprick at the site of maximal tenderness in the distal right forearm. Decreased DTRs in the RUE.
IMPRESSION
Colles fracture.
PLAN
Refer to orthopedic surgery clinic for reduction and immobilization. Right forearm sling and wrist immobilizer.
Jess Kydding, MD
D: 1-1-20XX
T: 1-2-20XX
JK/AHP

Remember, this is only an introduction to the format specifics. This course contains many opportunities for you to practice formats. You are encouraged to take that opportunity each and every time to polish your transcription skills.

As you continue your studies in this course, you will refer to the format specifics often. Be sure to mark this section in your materials or in the *Transcription Reference Guide* for quick access to the format specifics. Now, let's talk briefly about computer settings.

Software Tips

The information that follows includes hints on how to set up format when using a computer.

When in need, your computer's *Help* function can help you insert symbols, add tabs or alter text.

Word Processing Software

Any computer with a word processing program can be used to complete your healthcare documentation program. When working, most medical transcriptionist services require PC-compatible computers with Microsoft Word software.

Font Styles and Sizes

Times New Roman font in size 12 should be used for this course. Do not use italics, script, handwriting, bold or a fancy font. Times New Roman is considered the most readable font.

Subscript/Superscript

To type subscripts (H_2O) or superscripts (10^3), research these features in your software manual or on-screen help menus. Often you can find superscript and subscript in your "format" menu and "font" submenu. Avoid changing the font size within a report to get subscript or superscript.

Symbols

To insert symbols like a degree sign (°), research "symbols" in your software manual or on-screen help menus. You can usually find what you need by accessing the "insert" menu and looking in the "symbols" submenu. Your system may have a Character Map in the accessories menu in your Windows "start" function (usually located in the bottom left-hand corner of your screen). The map has many more choices. Avoid using a superscript letter "O" for a degree symbol. If you cannot insert this symbol, write out degrees and the temperature scale name. For example, 98 degrees Fahrenheit.

Step 5 Chart Notes

- As you have learned, Chart Notes are the notes made in the medical record during ongoing medical care. It is the most straightforward method of transcription. Chart Notes may also be referred to as the Problem Oriented Medical Record or as a SOAP Note.

  Problem Oriented Medical Records list the problems. In the Problem Oriented Medical Record each symptom or diagnosis is called a "problem" and is listed in a problem list at the front of the patient's chart. You won't see the problem list, but you will see the numbers. Each Chart Note is numbered to match a problem in the problem list.

  For instance, Fran has been seeing Dr Richards for a number of years. The front cover of her medical chart has a master list of the problems: high blood pressure, diabetes and depression. Today, Fran visits Dr Richards to discuss changing her high blood pressure medication. The master list indicates that is problem #1, so it's listed as such in the Chart Note.

Chart notes are made during medical care.

If a Chart Note requires more than one page, "CONTINUED" is typed at the bottom of the page to indicate that more text follows on the next page. The identifying information is typed at the top of the second page exactly as done on the first page. "Page 2" is typed below the patient number. The problem number, if dictated, is included only on the first page.

Let's look at the parts of a Chart Note and then identify sections in an example.

Identifying Information

As you learned in the format specifics, the patient's name and chart number are included here. The doctor's name is not included on the top of the report since the report will go directly into the doctor's office file.

Problem Number

Remember, the problem list is found at the front of the patient's chart. You won't see the problem list, but you will see the numbers. Each chart note is numbered to match a problem in the problem list. If the problem number is missing, you'll flag it for the doctor.

SOAP Headings

Chart Notes are typed in full-block style paragraphs and use only four headings: SUBJECTIVE, OBJECTIVE, ASSESSMENT and PLAN. The acronym for the headings is SOAP, which is why it's also known as a SOAP Note.

- SUBJECTIVE
  You'll recall studying the history component in your evaluation and management lesson. The history component is the information the patient tells the provider based on the patient's knowledge. In the SOAP format, the history component is found under SUBJECTIVE. These are observations that the patient or the old medical records tell the doctor; the doctor has not observed the findings directly.

- OBJECTIVE
  The descriptive findings from the physician's examination of the patient are found under OBJECTIVE. These observations are made directly by the physician dictating the note. Objective observations include information from the physical examination, x-ray films and laboratory tests.

- ASSESSMENT
  The ASSESSMENT is the physician's diagnosis based on clinical findings, such as laboratory and imaging results.

- PLAN
  PLAN refers to the doctor's order, which may consist of prescription management, recommendation for additional work up or a follow-up visit.

For a Chart Note, all headings are required and should be flagged if details are missing.

End of Report

A signature line with the doctor's name, the doctor's and transcriptionist's initials, and the dates of dictation and transcription are included at the end of the report.

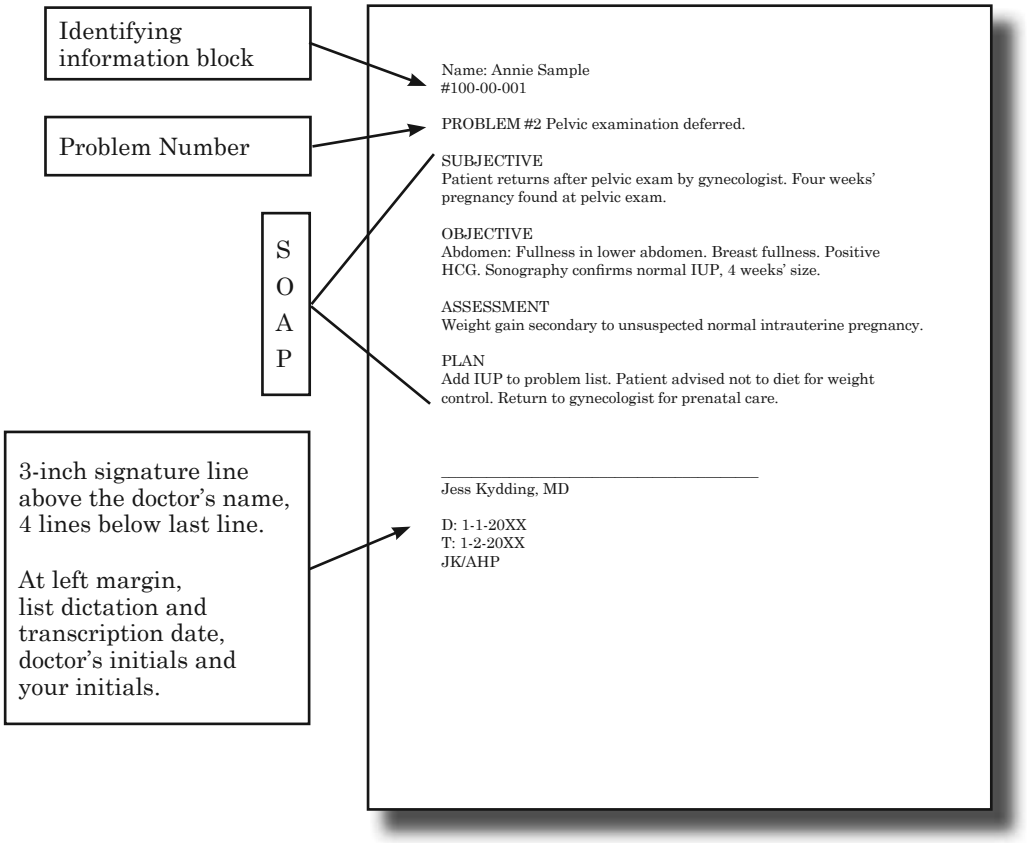
- Signature line with name of the person dictating. The name of the person dictating is typed underneath a blank line for the signature. A typical signature line is 3 inches long. The doctor's name is typed using formal format here. For example, Anne Jones, MD. The formal format is used here to denote the doctor's official professional degree and to show that the report is an official document once signed.

- Date dictated (D:), date transcribed (T:). Historically dates were transcribed with two digits to indicate the year. For example, 98 was used for the year 1998. Although most medical forms and reports use four digits to denote the year, you may see it done both ways in the program.

- The initials of the person dictating and the initials of the transcriptionist. The doctor's initials are always listed first, followed by the transcriptionist's. Either both initials should be in upper case letters, or both initials should be lower case letters. The initials should be separated by either a colon or a virgule (/). For example RB:AHP or rb/ahp.

Chart Note Example

Review the following example of a Chart Note, and then you're ready to complete a Practice Exercise to reinforce what you've learned.



✍ Step 6 Practice Exercise 40-1

❑ Determine if each statement is True or False.

1. _____ **For the most professional look, use white paper and type on both sides of the page.**

2. _____ **The identifying information block appears at the top of each page on the first line after the top margin for Chart Notes.**

3. _____ **Use 1-inch margins all around the pages for reports in this program.**

4. _____ **Headings are at the left margin with initial caps on the first word only.**

5. _____ **The entire Chart Note should be double spaced.**

6. _____ **Use italics and fancy font to create a Chart Note.**

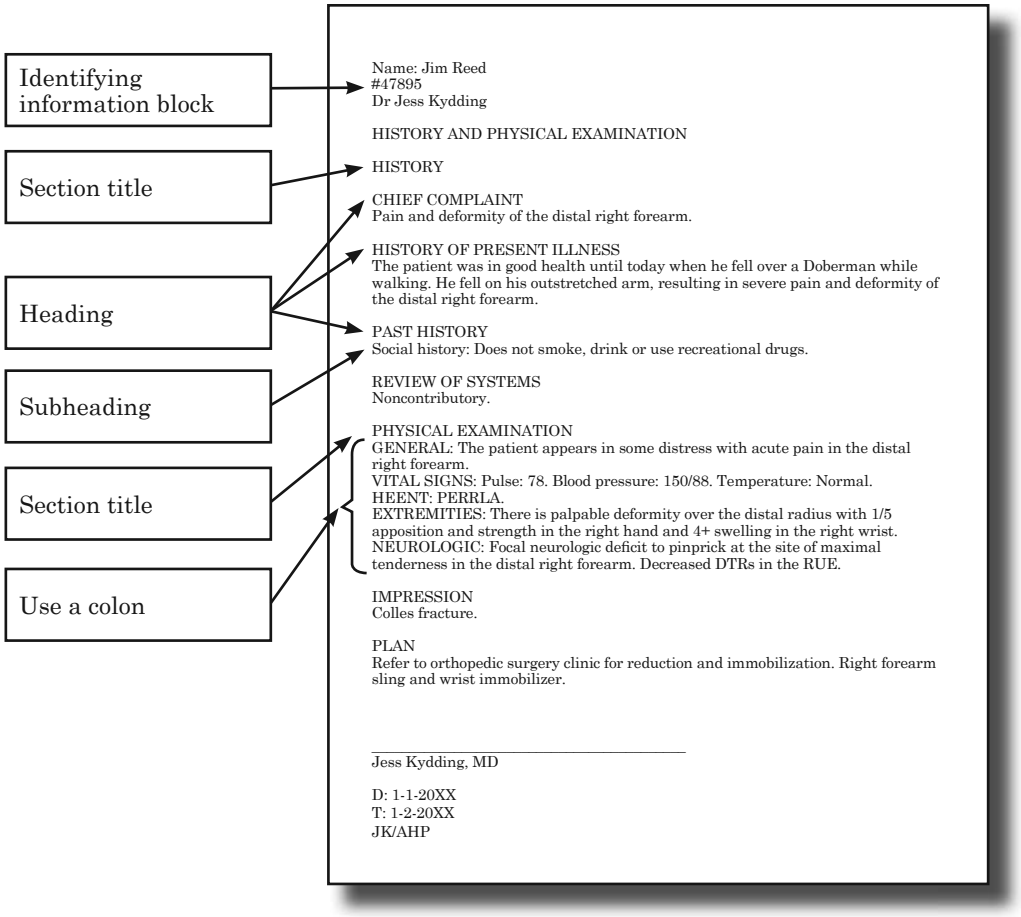
7. _____ **Subjective refers to the physician's observations.**

🗝 Step 7 Review Practice Exercise 40-1

❑ Check your answer with the Answer Key included with this course. Correct any mistakes you may have made.

📖 Step 8 History and Physical Examination

❑ Now that you've studies Chart Notes, let's look at the first of the Big Four reports—History and Physical Examination. H&P is the more traditional type of report consisting of identifying information, report title, section titles, headings and subheadings. For all of the Big Four reports, you'll include the title, or the name of the report just under the identifying information.



The **format** of a report is the way the headings are organized on a page, how they are capitalized and how the text is typed. As you can see, the main sections of an H&P are identified by the **section titles**, HISTORY, PHYSICAL EXAMINATION, IMPRESSION and PLAN. Section titles must always be included in the report, and they are typed in all capital letters. The HISTORY and PHYSICAL EXAMINATION sections of the report are further divided into main headings. These main headings are typed beginning at the left margin in capital letters. These headings may be further divided into subheadings. Subheadings are typed with an initial capital only. For example—Social history. All the information dictated by the doctor is organized under these various headings.

Rule 52 Do not include a heading or subheading if no information is dictated for it.

For example, if the provider does not dictate any information for REVIEW OF SYSTEMS, then that heading is not used in the report. Please note that Rule 52 does not apply to Chart Notes.

When reviewing a medical report, the reader will be looking for certain types of information to be included under the appropriate headings. Although not all headings or subheadings will be included in a report, you cannot have text without a heading or text under the wrong heading. If the provider neglects to dictate a heading but dictates the information for that heading, you will need to add the heading.

There are a number of different format styles and headings that medical facilities use. For your program, you will transcribe all of your dictations using the headings and formats that you learn in this lesson and the remainder of the program. Now, let's look at the details of the H&P report.

Identifying Information

Identifying information indicates the transcription for the medical record. The information varies from facility to facility, but most reports include the following items:

By consistently including identifying information on medical reports, you ensure that the medical information is filed with the correct patient.

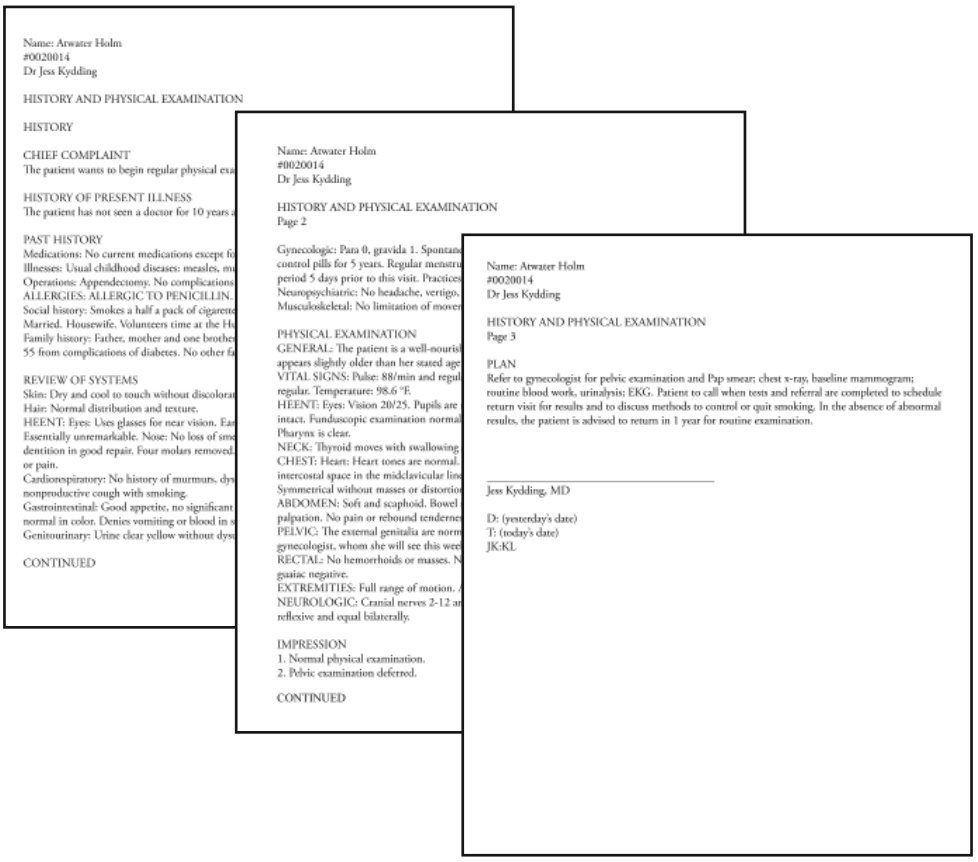
- Patient's name, identifying number, and doctor's name. This information should be on every page of the report. The doctor's name is typed using informal format. For example, Dr Anne Jones. Use the informal format when talking to or about the doctor.
- Page number, if there is more than one page.
- Signature line with name of the person dictating. The name of the person dictating is typed underneath a blank line for the signature. A typical signature line is 3 inches long. The doctor's name is typed using formal format here. For example, Anne Jones, MD. The formal format is used here to denote the doctor's official professional degree and to show that the report is an official document once signed.
- Date dictated (D:), date transcribed (T:). Historically dates were transcribed with two digits to indicate the year. For example, 98 was used for the year 1998. Although most medical forms and reports use four digits to denote the year, you may see it done both ways.
- The initials of the person dictating and the initials of the transcriptionist. The doctor's initials are always listed first, followed by the transcriptionist's. Either both initials should be in upper case letters, or both initials should be lower case letters. The initials should be separated by either a colon or a virgule (/). For example RB:TB or rb/tb.
- The name of the report is also considered identifying information. This information appears on every page of the report, typed in all capital letters.

Other information may be required by a hospital or provider, such as the patient's age and date of birth, the name of a referring physician, the admission date, name of persons receiving a copy of the report or hospital room number.

Rule 56 Identifying information is required on all pages of a report. Refer to the format guides provided in the lessons for instructions on correctly formatting this information on the different types of reports.

Exception: In ChartScript, identifying information is used on the first page of the report only. ChartScript is a software program that you will use to create reports later in this program.

Identifying information is usually typed at the top and/or the bottom of the report. Note that CONTINUED is typed at the bottom of the page of a report to indicate that more text follows on the next page. In addition, the patient's name, medical record number, doctor's name, page number and name of the report are included on each continuation page.


Name: Arwater Holm
#0020014
Dr Jess Kydding

HISTORY AND PHYSICAL EXAMINATION

HISTORY

CHIEF COMPLAINT
The patient wants to begin regular physical exa

HISTORY OF PRESENT ILLNESS
The patient has not seen a doctor for 10 years

PAST HISTORY
Medications: No current medications except fo
Illnesses: Usual childhood diseases: measles, mu
Operations: Appendectomy. No complications
ALLERGIES: ALLERGIC TO PENICILLIN.
Social history: Smokes a half a pack of cigarette
Married. Housewife. Volunteers time at the Ho
Family history: Father, mother and one brother
55 from complications of diabetes. No other fa

REVIEW OF SYSTEMS
Skin: Dry and cool to touch without discolorat
Hair: Normal distribution and texture.
HEENT: Eyes: Uses glasses for near vision. Ear
Essentially unremarkable. Nose: No loss of sme
dentition in good repair. Four molars removed.
or pain.
Cardiorespiratory: No history of murmurs, dys
nonproductive cough with smoking.
Gastrointestinal: Good appetite, no significant
normal in color. Denies vomiting or blood in s
Genitourinary: Urine clear yellow without dysu

CONTINUED

Name: Arwater Holm
#0020014
Dr Jess Kydding

HISTORY AND PHYSICAL EXAMINATION
Page 2

Gynecologic: Para 0, gravida 1. Spontane
control pills for 5 years. Regular menstru
period 5 days prior to this visit. Practices
Neuropsychiatric: No headache, vertigo,
Musculoskeletal: No limitation of mover

PHYSICAL EXAMINATION
GENERAL: The patient is a well-nourish
appears slightly older than her stated age
VITAL SIGNS: Pulse: 88/min and regul
regular. Temperature: 98.6 °F.
HEENT: Eyes: Vision 20/25. Pupils are
intact. Funduscopic examination normal
Pharynx is clear.
NECK: Thyroid moves with swallowing.
CHEST: Heart: Heart tones are normal.
intercostal space in the midclavicular line
Symmetrical without masses or distortio
ABDOMEN: Soft and scaphoid. Bowel
palpation. No pain or rebound tenderne
PELVIC: The external genitalia are norm
gynecologist, whom she will see this wee
RECTAL: No hemorrhoids or masses. N
guaiac negative.
EXTREMITIES: Full range of motion.
NEUROLOGIC: Cranial nerves 2-12 ar
reflexive and equal bilaterally.

IMPRESSION
1. Normal physical examination.
2. Pelvic examination deferred.

CONTINUED

Name: Arwater Holm
#0020014
Dr Jess Kydding

HISTORY AND PHYSICAL EXAMINATION
Page 3

PLAN
Refer to gynecologist for pelvic examination and Pap smear; chest x-ray, baseline mammogram; routine blood work, urinalysis; EKG. Patient to call when tests and referral are completed to schedule return visit for results and to discuss methods to control or quit smoking. In the absence of abnormal results, the patient is advised to return in 1 year for routine examination.

Jess Kydding, MD

D: (yesterday's date)
T: (today's date)
JK:KL

Rule 55 The dictation and transcription dates must be typed separately, even if they are the same date. Use numeral format for these dates. They are indicated by the abbreviations "D:" for the date dictated and "T:" for the date transcribed. (Example: D: 01/01/XXXX)

Look at this example of a report that was dictated and transcribed on the same day.

D: 7-8-XXXX
T: 7-8-XXXX

This report was transcribed two days after it was dictated.

D: 7-8-XXXX
T: 7-10-XXXX

For this program, use yesterday's date for the day dictated and today's date for the day the report was transcribed, unless otherwise directed by the physician in the dictation.

Rule 53 The signature line comes at the end of the report. Use a simple 3-inch line, and do not use the signature function in your word processing program. There must be at least two lines of report text on a page before the signature line.

If the signature line is going to be on the last page all by itself, either make space for the signature line at the bottom of the previous page by using a smaller bottom margin or move the last two lines of report text to the top of the new page where the signature line will be.

HISTORY

The report name HISTORY AND PHYSICAL EXAMINATION is flush left and double-spaced below the doctor's name. The section of the report is HISTORY, and is also flush left in the report.

Rule 50 All information in a medical report is typed flush left at the 1-inch margin.

Rule 51 Use the standard format order as shown on the format samples. If headings are dictated out of order, edit the report to correct the format order.

Abbreviations and acronyms should not be used in headings. The one exception to this is the acronym HEENT, which is acceptable in both the REVIEW OF SYSTEMS and the PHYSICAL EXAMINATION sections of reports. Details of HEENT will be discussed shortly.

In the discussions concerning the information in each heading below, the abbreviation or acronym for the heading is listed in parentheses. You'll recall, the HISTORY OF PRESENT ILLNESS is often called the HPI.

CHIEF COMPLAINT (CC)

The chief complaint (CC) is the patient's description of the problem that the patient wants the provider to evaluate and treat.

It is customary for a physician to use the patient's own words in case they are needed for later reference. If the patient's own words are used, quotation marks are used, and slang is acceptable.

HISTORY OF PRESENT ILLNESS (HPI)

Under this heading, the provider will summarize the story of any symptoms, signs, previous medical evaluation and treatment for the problem addressed in the CHIEF COMPLAINT. The doctor may also include other related problems or normal findings from other headings that follow.

PAST HISTORY (PH)

Under this heading, the provider will list all prior diseases, accidents, surgeries or conditions. These are divided into the subheadings listed below. The information can be in narrative form or as subsections. You won't see all of these subheadings all the time. But it's important to be familiar with all possible subheadings, so that you can correct the format order if it's dictated out of order (Rule 51).

- Immunizations: Past immunizations are listed under this subheading.
- Education: If a patient mentions her education, it's listed under this subheading.
- Habits: This includes drugs, tobacco and alcohol. The amount used is usually listed.
- Medications: Medications the patient is currently taking are listed here.
- Illnesses or Medical history: Details of the patient's medical history are listed under this subheading.
- Operations: Prior surgeries and their outcomes are listed here. The dates of surgeries are also listed.

Past surgeries and their outcomes are included in a patient's PAST HISTORY.

- ALLERGIES: The patient's allergies are listed here. This subheading is typed in all capital letters. In a moment, the rule for this subheading will be discussed in more detail.
- Social history: This includes the patient's occupation, hobbies or recreation, foreign travel, marital status and environment. The purpose of this topic is to list the patient's exposure to etiologic agents, such as chemical toxins, infectious agents and risk factors for disease.

- Family history: Information in this heading includes the ages, state of health, diseases and death of family members. The purpose of this section is to look for hereditary etiologies and risk factors for disease. The incidence of diseases that run in families is recorded. This may include heart disease, diabetes, cancer, infectious diseases or mental illness.
- Psychiatric: Past mental-related conditions are listed here.
- Obstetrical/Gynecologic: If applicable, past obstetrical or gynecologic conditions or treatments are listed under this subheading.
- Dental/Oral: Details of the patient's dental or oral history are listed under this subheading.
- Alcohol and substance abuse: This information may be addressed in the habits section.
- Diet: The patient's past diet history is included here.
- Work history: If dictated, the patient's work history information is included under this subheading.

Allergies

There is a special rule for transcribing allergies.

Rule 13 Institutions have specific rules for allergy statements. For this program, type the allergy statement in all capital letters. Do not use all caps for sentences that further clarify the allergy statement.

Look at this example.

ALLERGIES: ALLERGIC TO PENICILLIN. The patient had a rash with oral penicillin.

Note that the second sentence explaining the allergy is not capitalized. Only statements that name the patient's allergies are given this special emphasis. This includes allergies to medications, food and chemicals.

In the ALLERGIES subheading, all allergies to medication, food and irritants are listed. The type of allergic reaction is often described.

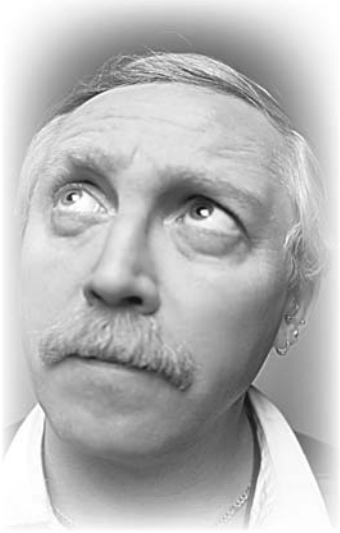
REVIEW OF SYSTEMS (ROS)

Here the physician records any signs or symptoms in the organ systems of the body. This will help to pick up any abnormality that was overlooked in the HPI. You'll recall from evaluation and management coding that the information in this section is from the patient's own description, not the doctor's hands-on physical examination. For example, the patient may report some difficulty breathing when exercising, which the doctor will record.

If there is no information for a system, the physician won't dictate a subheading. In fact, if there are no additional symptoms at all, the physician won't dictate any subheadings.

All possible subheadings for the ROS heading are listed below. Keep in mind that you'll rarely see all of these in every report, and if dictated out of order, edit the report to correct the format order (Rule 51).

- General
- Skin
- HEENT: This acronym stands for head, eyes, ears, nose and throat. It is an exception to the rule about not using acronyms in report headings. HEENT may include information about the head, eyes, ears, nose, sinuses, mouth and throat. If HEENT is not dictated and information is given for any of these categories, then HEENT should be added.
- Neck
- Breasts
- Cardiac
- Respiratory
- Cardiorespiratory
- Gastrointestinal
- Genitourinary
- Gynecologic
- Peripheral vascular
- Neurologic
- Hematologic
- Endocrine
- Psychiatric
- Neuropsychiatric
- Musculoskeletal



HEENT is an acronym for head, eyes, ears, nose and throat.

The rule for subheadings is the same as the rule for headings.

Rule 52 Do not include a heading or subheading if no information is dictated for it.

Look at this example.

REVIEW OF SYSTEMS
Skin: No rashes, discoloration present.
Neck: No jugular venous distention.

In the above example, the subheading HEENT was not used between skin and neck because there was no information dictated for it.

Remember, Rule 51 indicates that you will use the standard format order as shown on the format samples. If a doctor dictates headings or subheadings out of order, edit the report to the correct format order.

Let's pause for a moment to complete a Practice Exercise. Then you're ready to learn about the rest of the H&P report.

✍ Step 9 Practice Exercise 40-2

❑ Match each term with its description.

a. CHIEF COMPLAINT
b. HISTORY OF PRESENT ILLNESS
c. PAST HISTORY
d. Social history
e. Family history
f. REVIEW OF SYSTEMS
g. Identifying Information

1. _____ **Summarizes the story of signs, symptoms, diagnosis and treatment for the problem addressed in the CHIEF COMPLAINT.**

2. _____ **A category of information that identifies the transcription for the medical record.**

3. _____ **The patient's description of the problem that brought the patient to the doctor.**

4. _____ **Includes subheadings such as Cardiac, Genitourinary, Gynecologic and HEENT.**

5. _____ Previous operations and illnesses are listed here.

6. _____ Under this heading, the patient's allergies are typed in all capital letters.

7. _____ Includes the following: _____
Anne Jones, MD

8 _____ You may use slang under this heading if it is the patient's own words.

9. _____ This subheading includes information about hereditary factors including heart disease, diabetes, cancer and ages of family members.

10. _____ This subheading includes occupation, travel, lifestyle, habits and hobbies that may expose a patient to unusual diseases.

11. _____ This heading comes before PH and after CC.

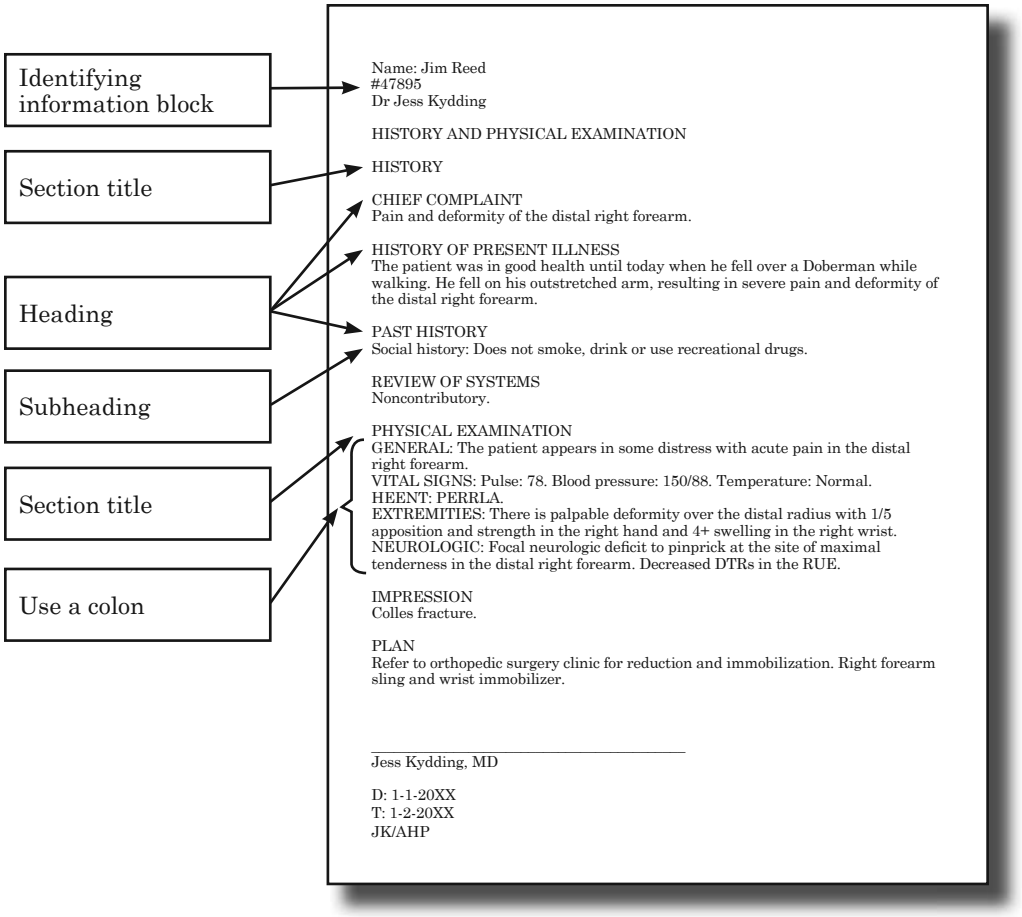
Step 10 Review Practice Exercise 40-2

- ❑ Check your answers with the Answer Key included with this course. Correct any mistakes you may have made.

Step 11 More about the H&P Report

- ❑ The H&P are identified by section titles. You've studied the headings and subheading for the HISTORY section title. Now, you are ready to learn about the second section title – PHYSICAL EXAMINATION. In addition, you'll study the IMPRESSION and PLAN sections to complete your introduction to the H&P report.

  Do you remember the section titles, headings and subheadings included in an H&P report? Here they are again so you can refer to them as you study.



PHYSICAL EXAMINATION (PE)

The information under PHYSICAL EXAMINATION, or PE, contains a description of the findings from the doctor's clinical examination of the patient. The information is usually organized under headings and subheadings. The headings under PHYSICAL EXAMINATION should be typed in all capitals, followed by a colon with the information continuing on the same line, and single spaced. This is one of the only sections in a report that uses the run-on style paragraph.

GENERAL

The information under this heading includes the age, race, general appearance and manner of the patient.

VITAL SIGNS

This heading is used when listing the most common measurements used to monitor health problems.

Information for vital signs includes the following: Blood pressure, pulse, respiratory rate (or respirations) and temperature.

Rule 59 **Vital signs may be separated by either commas or periods, depending on whether they are dictated as a list in a sentence or as subheadings. Aim for consistency. When periods are used to separate the vital signs, use a colon after the vital sign name.**

Look at the following examples:

VITAL SIGNS: Pulse: 80/min. Blood pressure: 110/77. Temperature: 99 °F.

OR

VITAL SIGNS: Pulse 80/min, blood pressure 110/77, temperature 99 °F.

Here's a special rule about transcribing temperatures:

Rule 11 **The degree symbol is used for expressions of temperature and for angles. If you are unable to insert the degree symbol into your document, write out the word "degrees" instead, and if reporting a temperature, write out the temperature scale name as well. (Example: 98.6 degrees Fahrenheit.) For the degree symbol, the keyboard command is Alt+0176 or Alt+248 if you use Microsoft® Word. You'll need to research keyboard commands if you use a different type of word processing program.**

The most accepted way to transcribe temperatures is to include the degree symbol when it is dictated. Include a space between the number and the degree symbol. There is no space between the degree symbol and the letters F or C. For example:

DICTATED: ninety nine point one degrees Fahrenheit

TRANSCRIBED: 99.1 °F.

Most word processing software programs have the ability to insert the degree symbol. For example, both Alt+0176 and Alt+248 are keyboard shortcuts for the degree symbol in Microsoft® Word. You will use the number key pad, not the numbers located above the letters. Investigate this feature in the *Help* option in your computer software program.

Use the number key pad for most keyboard shortcuts.

If your word processing program does not have the degree symbol (°) you may omit the symbol and type degrees followed by the temperature scale (Fahrenheit or Celsius).

99.1 degrees Fahrenheit.

SKIN

If the doctor examines the skin or sees any skin lesions, these findings are described here.

HEENT

Within HEENT, subheadings may be used for each area examined. Subheadings may include the following:

Head

Eyes

Ears

Nose

Sinuses

Mouth

Throat

NECK

If the doctor examines the thyroid or jugular veins, these findings are described here.

CHEST

The physician describes the external appearance of the chest. Examination of the breasts, when performed, and the sounds heard in the heart and lungs are listed here. Subheadings include the following:

Heart (or Cardiovascular if dictated)

Lungs

Breasts

Sometimes, the heading CHEST is omitted. In these cases, HEART (or CARDIOVASCULAR), LUNGS and BREASTS become individual headings instead of subheadings under CHEST.

ABDOMEN

This heading is used to describe the findings felt, seen and heard in the abdominopelvic cavity. Locations of some findings are described using the regions or quadrants of the abdomen you have studied. Under this heading, only findings from examination through the anterior abdominal wall are described. Findings in the pelvic cavity from a pelvic or rectal examination are described under separate headings.

PELVIC

The heading PELVIC is used for female patients only. It is unusual for this heading to be left out of the physical examination of an adult female patient. However, a pelvic examination is not always performed on female patients. If it is not, a statement that the examination was not performed is usually dictated.

ANORECTAL or RECTAL

In female patients, this is usually part of the pelvic examination. This category is not used if the rectal examination is part of the pelvic examination. It is unusual for this category to be left out of a physical examination of an adult male patient. However, if the rectal examination is not performed on a male patient, a statement that the examination was not performed may be dictated.

EXTREMITIES

This heading is used to describe musculoskeletal and skin findings in the upper and lower extremities. The nerve function of these extremities is described under NEUROLOGIC. The shoulder, arm, elbow, forearm, wrist and hand are the upper extremity. Can you name the parts of the lower extremity? That's right. The hip, thigh, knee, leg, ankle and foot.

The strength of peripheral pulses felt in the arteries of the arms and legs is often described under this heading. This is not the same as the patient's pulse rate that is listed under VITAL SIGNS.

The shoulder, arm, elbow, forearm, wrist and hand are the upper extremity.

NEUROLOGIC

Information in this heading describes the findings for different tests of the nervous system. Do you remember a doctor tapping on your knee for the knee-jerk reflex? That is a neurologic test called the **patellar reflex**.

IMPRESSION

You've covered the headings under PHYSICAL EXAMINATION. Next, let's review the items found under IMPRESSION, which is similar to ASSESSMENT in Chart Notes.

Under this heading, the doctor makes the preliminary diagnosis from the information dictated in the H&P. The list may be numbered or unnumbered. If the doctor dictates a number for any item on the list, number all the items on the list.

Rule 58 Use vertical numbered lists in full block paragraph style, where the heading is on one line and the text begins on the next line. Capitalize the first letter in each item in a vertical list. Use a period after the item number in a vertical numbered list and at the end of each list item.

Exception: Use horizontal numbered lists in run-on paragraphs, where the text immediately follows the subheading on the same line. Use parentheses with no period around the number in a horizontal numbered list.

Remember, with full block paragraph style, all lines of a report would begin flush left and headings are on their own line with the text beginning on the next line. With run-on paragraphs, on the other hand, the text in this style begins on the same line as the headings, following the colon and continuing sentences are flush left.

Let's look at the following example to see when you'd apply a numbered list or an unnumbered list.

If the doctor dictates a complete numbered list, or starts the numbered list, you use the numbered vertical list as shown.

IMPRESSION
1. Hepatic carcinoma.
2. Renal failure.
3. Venous metastasis.

If the doctor's dictation doesn't include numbering, you'll use an unnumbered list as shown.

IMPRESSION
Hepatic carcinoma. Renal failure. Venous metastasis.

PLAN

The final heading in the H&P is the PLAN. Under this heading, the doctor will list any diagnostic tests needed to rule out or confirm a diagnosis. The physician may also describe any treatment, medication or surgery that is planned. Usually the physician will indicate when the patient is to return for a follow-up visit.

Rule 58 also applies to numbered lists under the PLAN heading.

Look at these examples. In the first example, the physician did not dictate a numbered list. In the second example, the physician dictated a numbered list; therefore, you'll begin the text on the next line under the heading and capitalize the first letter in each item in the vertical list.

PLAN
Chest x-ray, CBC, electrolytes and pulmonary medicine consultation. Continue aspirin q.i.d. p.r.n. Return visit in 2 weeks after tests completed.

PLAN
1. Chest x-ray.
2. CBC, electrolytes.
3. Pulmonary medicine consultation.
4. Continue aspirin q.i.d. p.r.n.
5. Return visit in 2 weeks after tests completed.

Notice that in the horizontal series there are commas between tests but there are periods separating tests from medications and medications from return visits. This is done so that tests, medications and return visits can be seen more easily when the doctor refers to the report at a later date. Semicolons also may be used to separate different types of items listed under PLAN.

Starting on the next page is a list of the standard H&P headings that are typically used. These headings and subheadings are listed so that you may refer to them easily. Remember, you'll rarely see some of these subheadings, and your client may dictate new ones that aren't on this list.

Patient name
Patient number
Doctor's name (informal format)

HISTORY AND PHYSICAL EXAMINATION

HISTORY

CHIEF COMPLAINT

HISTORY OF PRESENT ILLNESS

PAST HISTORY
Immunizations
Education
Habits
Medications
Medical history or Illnesses
Surgical history or Operations
ALLERGIES
Social history
Family history
Psychiatric
Obstetrical/Gynecologic
Dental/Oral
Alcohol and Substance abuse
Diet
Work history

REVIEW OF SYSTEMS
General
Skin
HEENT (Head, Eyes, Ears, Nose, Sinuses, Mouth and Throat)
Neck
Cardiac or Cardiorespiratory
Respiratory
Breasts
Gastrointestinal
Genitourinary
Gynecologic
Peripheral vascular
Neurologic
Hematologic
Endocrine
Psychiatric
Neuropsychiatric
Musculoskeletal

Patient name
Patient number
Doctor's name (informal format)

HISTORY AND PHYSICAL EXAMINATION
Page 2

PHYSICAL EXAMINATION
GENERAL
VITAL SIGNS
SKIN
HEENT (Head, Eyes, Ears, Nose, Sinuses, Mouth and Throat)
NECK
CHEST (Heart or Cardiovascular, Lungs, Breasts)
ABDOMEN
PELVIC or GENITALIA
ANORECTAL or RECTAL
PERIPHERAL VASCULAR
MUSCULOSKELETAL
EXTREMITIES
NEUROLOGIC
MENTAL STATUS

If HEENT is not dictated, insert it, as its subheadings should not become headings. Subheadings are typed with an initial capital only.

If chest is not dictated, the subheadings of Heart (Cardiovascular), Lungs and Breasts become separate headings, typed in call capital letters.

IMPRESSION

PLAN

_____
Doctor's name (formal format)

D: XX-XX-XXXX
T: XX-XX-XXXX
XX:XX

To review what you've learned, complete the exercise that follows.

✍ Step 12 Practice Exercise 40-3

❑ Match the term(s) with the correct description.

a. GENERAL	e. CHEST	i. EXTREMITIES
b. VITAL SIGNS	f. ABDOMEN	j. NEUROLOGIC
c. HEENT	g. PELVIC	k. IMPRESSION
d. NECK	h. ANORECTAL	l. PLAN

1. _____ **Subheadings of this are Heart, Lungs, Breasts.**

2. _____ **Tests ordered to confirm a diagnosis are listed here.**

3. _____ **Subheadings include pulse, blood pressure, respiratory rate, temperature.**

4. _____ **Only includes anything found through the abdominal wall.**

5. _____ **Findings for the arms, legs, forearms, thighs, but not the nerves.**

6. _____ **Usually part of the pelvic exam in females; a separate category for males.**

7. _____ **Diagnoses are listed vertically under these headings if they**
_____ **are numbered. (Two headings will apply here.)**

8. _____ **Comes before IMPRESSION and after EXTREMITIES.**

9. _____ **Heading used only for female patients.**

Determine if the statement is True or False.

10. _____ **PHYSICAL EXAMINATION is a section title in the H&P.**

11. _____ **The items listed under IMPRESSION are listed horizontally in reports unless they are numbered.**

12. _____ **The items listed under PLAN are always listed vertically.**

Step 13 Review Practice Exercise 40-3

- ❑ Check your answers with the Answer Key included with this course. Correct any mistakes you may have made.

Step 14 Headings for the Reports

- ❑ Listed below are the headings for the History and Physical Examination and Chart Notes. We will build on this chart as you learn more about the Consultation Report, Discharge Summary and Operative Report in later lessons.

History and Physical Examination	Chart Note
(Identifying Information)	(Identifying Information)
CHIEF COMPLAINT	PROBLEM #
HISTORY OF PRESENT ILLNESS	SUBJECTIVE
PAST HISTORY	
REVIEW OF SYSTEMS	
PHYSICAL EXAMINATION	OBJECTIVE
IMPRESSION	ASSESSMENT
PLAN	PLAN

Step 15 Sample H&P Transcription

- This sample transcription uses the formatting guidelines set forth in this lesson. You will hear what the sample H&P sounds like by listening to the dictation as you read through it. Use the following steps.

  Please note: Up to this point, you have been able to access the audio for this program both online or on CD. However, beginning with this course, the only audio on CD will be the medical terms you study in the body-system lessons. All other audio and dictation *must* be accessed online. This will ensure that you have real-world practice in medical transcription and editing. Please see the Access Your Digital Audio insert included with this course for further instruction, and please don't hesitate to contact your instructor if you have questions.

Audio Exercise

Follow these steps:

a. Access the audio for Lesson 40 Sample History and Physical Examination.

b. As you listen, read the transcription beginning on the following page. You may pause the audio track as necessary while you read the report.

c. Look at the format, spelling, punctuation and grammar.

Note the following items about the sample report.

- Subheadings under HEENT in the HISTORY section of the report are listed in the text. In the PHYSICAL EXAMINATION section of the report, HEENT is a heading.

- Notice that the items in the IMPRESSION are listed in a vertical list. Items under PLAN are not numbered, so they are listed horizontally.

- Remember that if there are continuous sheets, you type CONTINUED at the left margin on the bottom 1-inch margin of the page. Use capital letters and at least one blank line after the last line of text.

Sample H&P Transcription with AHDI Format Guidelines

Name: Atwater Holm
#0020014
Dr Jess Kydding

HISTORY AND PHYSICAL EXAMINATION

HISTORY

CHIEF COMPLAINT
The patient wants to begin regular physical examinations as a part of routine health care.

HISTORY OF PRESENT ILLNESS
The patient has not seen a doctor for 10 years and wants to begin to take care of herself.

PAST HISTORY
Medications: No current medications except for daily multivitamins.
Illnesses: Usual childhood diseases: measles, mumps, chickenpox. She had no other serious illnesses.
Operations: Appendectomy. No complications or sequelae.
ALLERGIES: ALLERGIC TO PENICILLIN. History of rash with oral medication.
Social history: Smokes a half a pack of cigarettes per day. Denies alcohol or recreational drug use. Married. Housewife. Volunteers time at the Humane Society caring for sick animals.
Family history: Father, mother and one brother, living and well. Maternal grandmother died at age 55 from complications of diabetes. No other family history of heart or thyroid disease or cancer.

REVIEW OF SYSTEMS
Skin: Dry and cool to touch without discoloration. Well-healed appendectomy scar, RLQ, abdomen.
Hair: Normal distribution and texture.
HEENT: Eyes: Uses glasses for near vision. Ears: No history of hearing loss, tinnitus, dizziness. Essentially unremarkable. Nose: No loss of smell. No colds or bleeding. Mouth and throat: Normal dentition in good repair. Four molars removed. No difficulty swallowing, hoarseness, swollen glands or pain.
Cardiorespiratory: No history of murmurs, dyspnea, orthopnea, hemoptysis or chest pain. Mild nonproductive cough with smoking.
Gastrointestinal: Good appetite, no significant change in weight for 5 years. Stools formed and normal in color. Denies vomiting or blood in stools.
Genitourinary: Urine clear yellow without dysuria, nocturia, urgency or stress incontinence.
Gynecologic: Para 0, gravida 1. Spontaneous abortion, 6 weeks. No current contraception. Birth control pills for 5 years. Regular menstrual cycle of 28 days; 5 days' flow; last regular menstrual period 5 days prior to this visit. Practices monthly breast self-examination.
Neuropsychiatric: No headache, vertigo, convulsions. Able to cope with stresses of adult life.
Musculoskeletal: No limitation of movement, pain, fractures.

CONTINUED

Name: Atwater Holm
#0020014
Dr Jess Kydding

HISTORY AND PHYSICAL EXAMINATION
Page 2

PHYSICAL EXAMINATION
GENERAL: The patient is a well-nourished, well-developed white female in no acute distress who appears slightly older than her stated age of 42. The patient is oriented to time, place and person.
VITAL SIGNS: Pulse: 88/min and regular. Blood pressure: 120/77. Respiratory rate: 16 and regular. Temperature: 98.6 °F.
HEENT: Eyes: Vision 20/25. Pupils are normal and reactive to light and accommodation. EOMs intact. Funduscopic examination normal. Ears: Unremarkable. Nose: Unremarkable. Throat: Pharynx is clear.
NECK: Thyroid moves with swallowing and is not enlarged. No masses. No bruits.
CHEST: Heart: Heart tones are normal. No cardiomegaly, murmurs or bruits. PMI left 4th intercostal space in the midclavicular line. Lungs: Clear to auscultation and percussion. Breasts: Symmetrical without masses or distortion.
ABDOMEN: Soft and scaphoid. Bowel sounds are normal to auscultation. No organomegaly at palpation. No pain or rebound tenderness at palpation.
PELVIC: The external genitalia are normal. Pelvic examination was deferred to the patient's gynecologist, whom she will see this week.
RECTAL: No hemorrhoids or masses. No blood in the stool or on the examining finger. Stool guaiac negative.
EXTREMITIES: Full range of motion. All pulses are equal and full bilaterally.
NEUROLOGIC: Cranial nerves 2-12 are grossly intact. Deep tendon reflexes are normo-reflexive and equal bilaterally.

IMPRESSION
1. Normal physical examination.
2. Pelvic examination deferred.

PLAN
Refer to gynecologist for pelvic examination and Pap smear; chest x-ray, baseline mammogram; routine blood work, urinalysis; EKG. Patient to call when tests and referral are completed to schedule return visit for results and to discuss methods to control or quit smoking. In the absence of abnormal results, the patient is advised to return in 1 year for routine examination.

_____
Jess Kydding, MD

D: (yesterday's date)
T: (today's date)
JK:KL

Compare the format rules from this lesson to the report. When you are comfortable with the format, you will type while you listen to the sample transcription.

Audio Exercise

Follow these steps:

a. Access the audio for Lesson 40 Sample History and Physical Examination.

b. Listen to the dictation and transcribe the sample H&P you have just heard. Refer to the sample H&P as you transcribe it, if necessary.

c. Look up any terms you don't know. For any terms that you research, make a note for future reference.

Feel free to do this exercise more than once if you choose. The more comfortable you are with report formats now, the better.

Step 16 Practice Exercise 40-4

❑ Get ready for some fun! Now you have your first opportunity to try your hand at transcription. Before you start, keep in mind this is like riding a bike. When you first learn to ride a bike, you have training wheels. It seems like you have several things to focus on—pedaling, steering, watching for traffic, using the brakes, etc. After some practice, you are ready for the training wheels to go. You are a little wobbly, but eventually you are riding like a pro. Transcription is much the same. You will try to type while listening, trying to remember your formats, trying to find the right terminology, etc. With solid practice, you will soon be transcribing like a pro!

Transcribe four short reports.

Audio Exercise

Follow these steps:

a. Access the audio for Lesson 40 Practice Exercise 40-4.

b. Listen to Dictation Number 1 in its entirety. Then return to the beginning of the dictation and listen again as you transcribe the dictation.

c. No identifying information is needed at the top of the transcription for this exercise. You will include a signature line for Dr Anne Jones, dates and initials.

d. Practice format and use proper capitalization. Use the format guidelines you've learned in this lesson for H&P reports. Not all the headings for the H&P are used for these short reports. Use SOAP headings for Chart Notes.

e. Continue transcribing Dictations 2 through 4 in the same manner.

f. As you complete this exercise, use your medical dictionary, the alphabetized list of medical terms or the Internet to look up all medications and terms you don't know.

Step 17 Review Practice Exercise 40-4

- ❑ Check your answers with the Answer Key included with this course. Correct any mistakes you may have made.

  If you had difficulty with this exercise, do it again using the Answer Key for help until you feel comfortable. Then try it without looking at the Answer Key.

Step 18 Lesson Summary

- ❑ Lesson 40 introduced you to medical transcription, a useful skill for healthcare documentation. You discovered the Big Four reports consist of History and Physical Examination, Consultation Report, Operative Report and Discharge Summary.

  First, you discovered the guidelines to follow when transcribing reports. You studied paragraph styles and format specifics. The computer tips will assist you when creating reports.

  Next, you learned about the function of Chart Notes. You were introduced to the SOAP method for the organization of Chart Notes. Now you know how to correctly format Chart Notes and which headings include what information.

  Finally, you studied the information included in the History and Physical Examination. You're familiar with the types of headings included in the History and Physical Examination and are able to explain the information that is included under each heading.

  All in all, you've discovered a lot about the correct format for medical reports. You'll build upon this knowledge throughout the course, and will get plenty of practice using report formats. Practice will help you become comfortable with proper report formats.

  In the next lesson, you'll take a look at some of the terminology used in medical transcription.

just for fun

Why are references so important to the healthcare document specialist? Because it is impossible to remember every term you have learned before. Because it is not possible to know every term there is. Because new terms are being created every day. References serve a number of functions.

- Just like you don't keep all the books and papers you own on your desktop, you don't have to remember every term you have ever heard. References are where you keep terms you don't use every day.
- References can provide you with the information right now, when you need it. References store the memory of others so that you don't have to wait until the other person is available to use her memory.

When you choose a reference, it should meet two criteria:

- It should contain information that meets your needs.
- The information should be easy to find and in the form that you need.

It will do you no good to have a reference containing the information you want if you can't easily find the information.

For example, the phone book contains the name, address and telephone number of everyone in your area. A good reference. Suppose you wanted to call your neighbors four doors down because water was running out of their house. You know the address but not their name or phone number. You have knocked on the door, but they don't hear you. You could find the number in the phone book by reading through all the addresses. Would you really do that?

The information is there, but the time it takes to find it tells you this isn't the right reference. Thank goodness the telephone book is free. However, there is a reference listing phone numbers by address. Would you buy it? Probably not. It is too expensive for your needs unless you use it frequently.

By now you're probably wondering what happened with all the water at the neighbors' house. Nothing. That was just an example that we made up. It is called a hypothetical situation. A hypothesis means below or less than a real or proved fact. The point is: Don't buy a reference unless it meets your needs. Make sure the reference gives you the information easily in the form you need.

Now let's go shopping. Just for fun—make a short list of a few medications you have seen so far in the program. Take the list to your local drugstore. Ask the pharmacist for the "product inserts" for those medications. They're free. That's a good price for a published reference. Make friends with your pharmacist. Your pharmacist is not only a colleague of yours, but the person who will know the names of new drugs that doctors use and how to pronounce and spell them. Your pharmacist will also have product inserts for these new drugs.

Another place to shop for free is a medical supplies store. Look at the names of the different products at an actual or online store. What a great place to find the names of supplies and equipment. Talk to the salesperson. He may have free folders or catalogues for some of the products available.

Now take a break. Go to the park, the beach or your favorite place to relax. Look at the new references you have.

What information do these references contain? Do you need it? Is it easy to find? Is some of the information helpful?

Whenever you buy medicines, learn to save the product inserts, especially for nonprescription medicines. They are great references. Whenever you have a prescription filled, be sure to ask the pharmacist for the product insert.

Great start to Course Five!

This is the last step toward your new career.

Terminology awaits!

You'll soon develop a better understanding of terminology specific to medical transcription.

Continue to the next lesson.