Dictation of Approved Note Types Tips

History and Physical: A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but always prior to surgery or a procedure requiring anesthesia. If the H&P was completed within 30 days prior to admission or registration, an updated medical record entry must be completed within 24 hours of admission or registration, but prior to surgery/procedure requiring anesthesia services, except when any significant delay in treatment could possibly jeopardize patient care, safety, or otherwise constitute a hazard to the patient.

When the H&P is conducted within 30 days before admission or registration by a physician who is not a member of the Medical Staff or does not have admitting privileges, or by a qualified licensed individual who does not practice at the hospital but is acting within the scope of his/her scope of practice under state law or regulation, an update must be completed and documented by a licensed practitioner who is credentialed and privileged by the hospital's medical staff to perform an H&P.

The contents of an H&P should include the following elements: chief complaint, history of present illness, past medical history, pertinent review of systems, current medications, allergies, pertinent social/family history, appropriate physical exam, impression, treatment plan and Admitting Diagnosis. An abbreviated H&P may be performed prior to newborn circumcision, which should include targeted family history related to clotting disorders and physical exam specific to genitalia.

Progress Notes:
Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of and/or transfer of care. Whenever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment.

Operative Reports:
An immediate post procedure note or progress note must be entered in the medical record immediately following the procedure and before the patient is transferred to the next level of care.

This postoperative note must include: the name of the primary surgeon and his/her assistants; postoperative diagnosis/findings; procedures performed and description of each procedure finding; specimens removed and disposition, if applicable; estimated blood loss; and patient condition.

Operative reports shall be dictated or written within 24 hours following surgery/procedure.

Operative reports shall include: the name of the primary surgeon and his/her assistants; postoperative diagnosis/findings, procedures performed and description of each procedure finding; specimens removed and disposition, if applicable; estimated blood loss; and patient condition.

Procedure/Operative Note:
Procedure/Operative Note shall include date of Procedure/Surgery, Pre and Post Procedure Diagnoses, Procedure/Operation Performed, Operative findings and Description of Procedure.

Consultation:
Consultation shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinions and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall be recorded prior to the operation except in emergency situations as documented in the record.

Discharge Summary:
Discharge summary (clinical resume) shall be entered on all medical records of patients hospitalized over 48 hours, except for normal obstetrical deliveries, normal newborn infants, and certain selected patients with problems of a minor nature. The latter exceptions shall be identified by the appropriate committee of the Medical Staff and for these, a final progress note shall be sufficient. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result.

The content of a discharge summary shall include the following: the reason for hospitalization, procedures performed, care, treatment, services provided, condition at discharge, information provided to the patient and family, and provisions for follow up care.

A discharge summary is not required when a patient is seen for minor problems or interventions as defined by the Medical Staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow up care.

For patient stays under 48 hours, the final progress note may serve as the discharge summary and must contain the outcome of hospitalization, provisions for follow up care, and disposition of the care including those cases where the patient expires. All summaries shall be authenticated by the responsible practitioner. In this particular circumstance, if the final progress note, which serves as the discharge summary, is completed by a PA or APN, the note must be countersigned by the sponsoring or other approved designated physician.

The patient's medical record shall be completed within 14 days of discharge, including progress notes, final diagnosis, and discharge summary.