

**MEDICAL UNIVERSITY OF SOUTH CAROLINA
CHARLESTON MEMORIAL HOSPITAL
ASHLEY RIVER TOWER**

TO DICTATE:

1. **DIAL**
Inside/Outside Hospital **843-792-7007**.
2. **WHEN PROMPTED**
Enter 5 digit beeper no. followed by # key
3. **WHEN PROMPTED**
Enter [1] to dictate
4. **WHEN PROMPTED**
Enter work type followed by the # key:
History & Physical Reports..... [1]
Consults..... [2]
Operative Reports..... [3]
Discharge Summaries..... [4]
STATS..... [8]
CMH ER Note..... [6]
CMH Discharge Summaries..... [7]
Psychiatric Discharge Summaries.... [12]

- MUSC ER Notes.....[15]
Procedure Notes.....[16]
5. **WHEN PROMPTED**
Enter the MRN, followed by the # key.
 6. **WHEN PROMPTED**
STATE THE FOLLOWING:
 1. Patient Name
 2. Medical Record Number
 3. Patcom Number
 4. Date of Procedure
Or
Admission & Discharge Date
 5. Attending Physician
Press [2] to begin dictation
Press [5] to disconnect or
Press [8] to dictate another report

After pressing [5] or [8] wait momentarily for your job number and document this number for future reference.

KEYPAD INSTRUCTIONS

Keypad function:	Key:	Description:
Dictate	[2]	Begin Dictating.
Edit	[2] [2]	Pressing the [2] key while dictating will STOP the dictation, pressing the [2] key will START the recording
Hold	[1]	Places dictation on hold for up to 4 minutes, Press [2] to continue
Review	[3]	Reviews last 4 seconds of dictation; press repeatedly to review further, press [2] to continue dictation.
Dictate Another Report	[8]	Ends dictation, prompts for work type and Medical Record Number of next patient.
Disconnect	[5]	Press before hanging up. Wait momentarily for your job number.
Rewind to Beginning	[7] [7]	Rewinds to beginning of dictation.
Fast Forward to End	[4] [4]	Forwards to last dictated word.

TO LISTEN / REVIEW:

- i. After prompt press [3].
- ii. To select by job number, enter the job number followed by the # key.
- iii. To select by patient press [**]. Enter the work type followed by the # key.

For assistance call the following:
Medical University of South Carolina 843-792-1284

**MEDICAL UNIVERSITY OF SOUTH CAROLINA
MEDICAL RECORD GUIDELINES**

History & Physical Report:

1. Must be dictated/written within 24 hours of admission.
2. If a complete History has been obtained within 7 days prior to admission, a durable, legible copy may be used, provided there has been no subsequent change or the changes have been recorded at the time of admission.
3. When a patient is readmitted within 30 days for same or related problem, an interval H&P reflecting any changes may be used.
4. The medical record must reflect a dictated/written ***Physical exam prior to surgery.***
5. ***The History and Physical Report should contain the following information:***
 - * Date of History and Physical
 - * Chief complaint-(use patient's own words)
 - * History of Present Illness
 - * Acute & Chronic Conditions
 - * Past Medical History
 - * Past Surgical History
 - * Allergies
 - * Social History
 - * Current Medications
 - * Family History
 - * Review of Systems
 - * Physical Examination
 - * Pertinent normal and abnormal findings
 - * Conclusion and a planned course of action

Consultation Report:

1. Date of consultation
2. Should be dictated /written (when written, use consultation report and request form) immediately after the consultation.
3. **The Consultation Report should contain the following information:**
 - a. Physician requesting consultation
 - b. Reason for consultation
 - c. Written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record
 - d. Recommendations
 - e. Signature

Operative Report:

All operative reports should be dictated immediately following surgery

1. **IDENTIFICATION INFORMATION**
 - Patient's full name and spelling
 - MUH Number
 - MUH PATCOM Number
 - **Date of Procedure**
 - Resident's Name "dictating for" Attending Name
2. Indication For Procedure
3. Pre-Operative Diagnosis
4. Post-Operative Diagnosis
5. Operation (Technical Procedure Used)
6. Anesthesia
7. Description of Findings
8. Description of Procedure
9. Estimated Blood Loss
10. Complications
11. Specimens Removed
12. Patient's Condition at the End of the Procedure
13. Indicate The Level Of Participation Of The Attending (i.e., "Dr. _____ was present for key elements of the procedure which were, and immediately available in the OR area for the remainder." or "Dr. _____ was present and scrubbed for the entire procedure.")

Discharge Summaries

All discharge summaries should be dictated on the day of discharge.

1. IDENTIFICATION INFORMATION

- * Patient's full name and spelling
- * MUH Number
- * MUH PATCOM Number
- * Date of Admission
- * Date of Discharge
- * List chief complaint
- * Attending Physician's name and spelling
- * Person dictating (spelling)
- * Service
- * Admitting diagnosis
- * Brief HPI, pertinent ROS
- * Past Medical History
- * Past Surgical History
- * Allergies
- * Social History/Family History (pertinent)
- * PE & diagnostics tests (pertinent +/- findings)
- * List procedures, studies and results
- * List consults obtained

2. HOSPITAL COURSE (briefly describe pertinent course including: consults, diagnostic procedures, lab procedures, therapy initiated & changes in patient's status-improved)

3. D/C DIAGNOSIS (list primary and 9 secondary diagnoses)

4. CANCER STAGING (if applicable)

T ____ N ____ M ____ = Stage

5. D/C MEDICATIONS (list meds, dose, length of prescription, etc.)

6. PATIENT'S DISPOSITION (home, home health, nursing home, etc.)

7. D/C PLANS (with whom d/c follow-up appt, follow-up date & studies / tests, d/c diet)

8. REFERRING MD (spell name & indicate location)*

9. CARBON COPY (spell name & indicate location)*

*** If you do not know Referring MD or location, please ask Attending MD.**

Revised 9/05; 3/06; 4/08



Charleston Memorial Hospital
Ashley River Tower

Health Information Services