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MEDICAL STAFF MEDICAL RECORD POLICY

ADULT AND PEDIATRIC H&Ps

Please refer to CaroMont Regional Medical Center Medical Staff Bylaws 12.E

History and Physical examination reports should include at a minimum, the following items: Chief Complaint/History of Present Illness, Past History, Review of Systems Physical Examination, Impression or Diagnosis, and Plan.

Short History and Physical forms may be used as approved by the appropriate Service Lines.

NEWBORN INFANTS

An admission physical examination shall be completed and recorded within twenty-four (24) hours after birth and the infant shall be examined daily during hospitalization. An infant may be discharged as long as he or she has been examined on that day and the discharge order is written. It is not necessary for the discharge summary to be complete if another note already exists on that day.

DOCUMENTATION FOR OUTPATIENT BLOOD TRANSFUSIONS AND IV MEDICATION INFUSIONS

For therapeutic outpatient blood transfusions and IV medication administration, the physician must provide an order for the treatment and the reason (diagnosis) for treatment.

OBSTETRICAL TRIAGE DOCUMENTATION

Patients seen in the Obstetrics Triage area with a stay less than 4 hours do not require a complete history and physical examination.

REQUIRED COMPONENTS OF THE MEDICAL RECORD

The medical record shall include information to support the patient's diagnosis and condition, justify the patient's care, treatment and services, and document the course and result of the patient's care, and services to promote continuity of care among providers. The components may consist of the following: identification data, history and physical examination, consultations, clinical laboratory findings, radiology reports,

Medical Records Policy And Procedure Manual

**Kathleen A. Waters, Gretchen
Frederick Murphy**



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Table of Contents Medical Records Policy And Procedure Manual

1. Understanding the eBook Medical Records Policy And Procedure Manual
 - The Rise of Digital Reading Medical Records Policy And Procedure Manual
 - Advantages of eBooks Over Traditional Books
2. Identifying Medical Records Policy And Procedure Manual
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Medical Records Policy And Procedure Manual
 - User-Friendly Interface
4. Exploring eBook Recommendations from Medical Records Policy And Procedure Manual
 - Personalized Recommendations
 - Medical Records Policy And Procedure Manual User Reviews and Ratings
 - Medical Records Policy And Procedure Manual and Bestseller Lists
5. Accessing Medical Records Policy And Procedure Manual Free and Paid eBooks
 - Medical Records Policy And Procedure Manual Public Domain eBooks
 - Medical Records Policy And Procedure Manual eBook Subscription Services
 - Medical Records Policy And Procedure Manual Budget-Friendly Options
6. Navigating Medical Records Policy And Procedure Manual eBook Formats

- ePub, PDF, MOBI, and More
 - Medical Records Policy And Procedure Manual Compatibility with Devices
 - Medical Records Policy And Procedure Manual Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Medical Records Policy And Procedure Manual
 - Highlighting and Note-Taking Medical Records Policy And Procedure Manual
 - Interactive Elements Medical Records Policy And Procedure Manual
 8. Staying Engaged with Medical Records Policy And Procedure Manual
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Medical Records Policy And Procedure Manual
 9. Balancing eBooks and Physical Books Medical Records Policy And Procedure Manual
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Medical Records Policy And Procedure Manual
 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
 11. Cultivating a Reading Routine Medical Records Policy And Procedure Manual
 - Setting Reading Goals Medical Records Policy And Procedure Manual
 - Carving Out Dedicated Reading Time
 12. Sourcing Reliable Information of Medical Records Policy And Procedure Manual
 - Fact-Checking eBook Content of Medical Records Policy And Procedure Manual
 - Distinguishing Credible Sources
 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
 14. Embracing eBook Trends
 - Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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