Designation: E 2184 – 02

An American National Standard

Standard Specification for Healthcare Document Formats[1]

This standard is issued under the fixed designation E 2184; the number immediately following the designation indicates the year of original adoption or, in the case of revision, the year of last revision. A number in parentheses indicates the year of last reapproval. A superscript epsilon (ε) indicates an editorial change since the last revision or reapproval.

1. Scope

1.1 This specification addresses requirements for the headings, arrangement, and appearance of sections and subsections when used within an individual's healthcare documents. This specification will facilitate identification and retrieval of health information in a manner that will enhance the quality and efficiency of health services. Use of this specification in conjunction with XML DTDs (extensible markup language document type definitions) and the EHR (electronic health records) would further enhance efficiency in time and cost. This specification applies across multiple healthcare settings in which healthcare documents are generated, such as hospitals, clinics, skilled nursing facilities, ambulatory care facilities, outpatient surgery centers, and private healthcare providers' offices.

1.2 This specification addresses the headings, arrangement, and appearance of sections and subsections of healthcare documents, however generated (dictation/transcription, speech recognition, touch-screen entry, and so forth) and whether displayed electronically or on paper. It does not address the titles of healthcare documents or the content of sections and subsections.

1.2.1 The author of a healthcare document may choose to summarize subsection information within a general section rather than creating subsections.

1.3 The format and content of patient-identifying data are addressed in Guide E 1384.

1.4 Issues of confidentiality and security are addressed in Guide E 1869, Guide E 1902, Guide E 1762, Guide E 1985, Guide E 1986, Guide E 1987, Guide E 1988, Specification E 2084, Guide E 2085, and Guide E 2086, as well as in Specification E 2147.

1.5 Issues of XML DTDs are addressed in Specification E 2182 and Guide E 2183.

2. Referenced Documents

2.1 *ASTM Standards:*

E 1384 Guide for Content and Structure of the Electronic Health Record (EHR)[2]

E 1762 Guide for Electronic Authentication of Health Care Information[2]

E 1869 Guide for Confidentiality, Privacy, Access, and Data Security Principles for Health Information including Computer-Based Patient Records[2]

E 1902 Guide for Management of the Confidentiality and Security of Dictation, Transcription, and Transcribed Health Records[2]

E 1985 Guide for User Identification and Authorization[2]

E 1986 Guide for Information Access Privileges to Health Information[2]

E 1987 Guide for Individual Rights Regarding Health Information[2]

E 1988 Guide for Training of Persons Who Have Access to Health Information[2]

E 2084 Specification for Authentication of Healthcare Information Using Digital Signatures[2]

E 2085 Guide on Security Framework for Healthcare Information[2]

E 2086 Guide for Internet and Intranet Healthcare Security[2]

E 2147 Specification for Audit and Disclosure Logs for use in Health Information Systems[2]

E 2182 Specification for Clinical XML DTDs in Healthcare[2]

E 2183 Guide for XML DTD Design, Architecture, and Implementation[2]

3. Terminology

3.1 *Definitions:*

3.1.1 *alias, n*—heading synonymous with and which shall be replaced by the specified heading. No alias (synonym) shall be used in place of the specified heading. The aliases presented are examples only, that is, no attempt has been made to identify all potential aliases.

3.1.2 *amendment, n*—a correction or addendum to a document.

3.1.3 *author, n*—the person originating content for a healthcare document.

3.1.4 *document, n*—see *healthcare document*.

3.1.5 *format, n*—the arrangement of the content of a healthcare document for display. In this specification, format refers to

[1] This specification is under the jurisdiction of ASTM Committee E31 on Healthcare Informatics and is the direct responsibility of Subcommittee E31.28 on Electronic Healthcare Records.

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[2] *Annual Book of ASTM Standards*, Vol 14.01.

the sequencing of the sections and subsections used in a healthcare document, the appearance of their headings, their line spacing, and their alignment.

3.1.6 *healthcare document*, *n*—healthcare information, however generated, pertinent to a specific individual and recorded to serve a specific use.

3.1.7 *healthcare information*, *n*—worded, numeric, imaged, or data-streamed material used to communicate the healthcare experience of, and related services for, an individual.

3.1.8 *health record*, *n*—healthcare information retrievable from one or more sources, however displayed, pertinent to an individual, used to describe and measure that individual's health status and health care over time and across settings, to facilitate healthcare management through one or more episodes of care, including preventive or health maintenance activities.

3.1.9 *medical transcriptionist*, *n*—a medical language specialist who interprets and transcribes dictation by physicians and other healthcare professionals regarding patient assessment, workup, therapeutic procedures, clinical course, diagnosis, prognosis, and so forth, in order to document patient care and facilitate delivery of healthcare services. **AAMT (1)**[3]

3.1.10 *practitioner*, *n*—an individual who is qualified to practice a health care profession, for example, physician, nurse, or physical therapist. Practitioners are often required to be licensed as defined by law.

3.1.11 *provider*, *n*—a business entity that furnishes health care to a consumer; it includes a professionally licensed practitioner who is authorized to operate a healthcare delivery facility. **E 1384**

3.2 *Acronyms:*

3.2.1 *AAMT*—American Association for Medical Transcription

3.2.2 *CPT-4*—Physician's Current Procedural Terminology—Fourth Edition (**2**)

3.2.3 *DTD*—document-type definition

3.2.4 *ICD-9-CM*—International Classification of Diseases, Ninth Edition, Clinical Modification (**3**)

3.2.5 *JCAHO*—Joint Commission on Accreditation of Healthcare Organizations

3.2.6 *SOAP*—Subjective, Objective, Assessment, Plan

3.2.7 *XML*—extensible markup language

4. Significance and Use

4.1 This specification is intended to result in consistency in the names of headings of sections and subsections (when used), their arrangement, and their appearance in individuals' healthcare documents.

4.2 Primary benefits of this consistency in presentation include: *(1)* facilitating identification and retrieval of health information in a manner that will enhance the quality and efficiency of health services, patient safety, and patient privacy, *(2)* providing easier access to relevant health information within a record, *(3)* enabling greater information sharing within and among enterprises, and *(4)* promoting greater efficiency in transcription and other forms of data capture. Secondary benefits include improved access to health information for reimbursement, legal, research, and statistical purposes.

4.3 Consistent with provider policy, the application of this specification is the responsibility of the author of the healthcare document, the medical transcriptionist or other person responsible for entering information into the healthcare document, or a combination thereof.

4.4 Annex A1 specifies the headings of sections and subsections (when used), their arrangements, and their appearance in history and physical examination reports, consultation reports, emergency department notes, clinic notes, nurses notes, therapists notes, treatment summaries (including discharge, transfer, and death summaries). These headings for sections and subsections may also appear in other healthcare documents.

5. Specifications

5.1 *Sections and Subsections: Headings, Arrangement, and Appearance*—The specified headings shall be utilized for sections and subsections when used within individual healthcare documents, shall be ordered and arranged as listed, and shall be presented with the appearance specified. Definitions are offered to clarify the meanings of the headings. Sample aliases are noted to identify some terms that shall be converted to assure a uniform specified heading; other aliases shall be similarly converted. Comments are included as appropriate.

5.1.1 *Arrangement*:

5.1.1.1 *Section Headings*—When used, section headings shall be placed in the sequence specified and shall be left-margin aligned. Each section and its heading shall be separated from the previous section by a line space or the equivalent. The initial entry regarding a section (even if that initial entry is a subsection heading) shall begin on the line immediately following the section heading and shall be left-margin aligned.

5.1.1.2 *Subsection Headings*—When used, subsection headings shall be placed in the sequence specified and shall be left-margin aligned under their respective sections. When a subsection heading is the initial entry following a section heading, that subsection heading shall be entered on the line immediately following the section heading. Each subsection and its heading shall be separated from the previous section or subsection by a line space or the equivalent.

5.1.1.3 *Inclusion*—None of the sections or subsections is required, but if such information is included, the specified headings shall be used.

5.1.1.4 *Content Following Section or Subsection Headings*—Content following headings shall begin on the next line and shall be aligned at the left margin throughout, below the heading. No content shall follow on the same line as a section or subsection heading. Multiple paragraphs within sections and subsections shall be separated by a line space.

5.1.2 *Appearance*:

5.1.2.1 Section heading terms shall be in uppercase letters (for example, PAST HISTORY).

5.1.2.2 Subsection heading terms shall be in initial capital letters followed by lowercase letters with the exception of conjunctions, articles, and prepositions of fewer than four letters, which shall be in all lowercase letters (for example, Alcohol and Substance Abuse).

[3] The boldface numbers in parentheses refer to the list of references at the end of this standard.

5.1.2.3 Content following headings shall be in uppercase and lowercase according to standard language usage, with the exception that the term ALLERGIES and any SUBSTANCE to which the individual is allergic shall be in all uppercase letters.

6. Keywords

6.1 appearance; arrangement; format; headings; healthcare document; sections; subsections

ANNEX

(Mandatory Information)

A1. HEADINGS FOR SECTIONS AND SUBSECTIONS OF HISTORY AND PHYSICAL EXAMINATION REPORTS AND RELATED HEALTHCARE DOCUMENTS

A1.1 *Headings for sections and subsections*—The headings below shall be applied to sections and subsections when used within history and physical examination reports, consultation reports, emergency department notes, clinic notes, nurses notes, therapists notes, treatment summaries (including discharge, transfer, and death summaries). The headings may also apply to other healthcare documents.

A1.1.1 In certain instances specific formats for portions of healthcare documents are in accepted usage, for example, SOAP notes and problem oriented medical reports. When the section or subsection terms in the following list are utilized within such format conventions, this standard specification shall be applicable to such use.

A1.2 *Patient-identifying Data*—Patient-identifying data are addressed in Guide E 1384.

A1.3 Section Heading: CHIEF COMPLAINT(S)

A1.3.1 *Definition*—The patient's stated reason(s) for presenting, (typically presented as one complaint in the patient's own words).

A1.3.2 CHIEF COMPLAINT replaces Presenting Complaint, Primary Complaint, Complaint, CC, Presenting Problem, and other aliases.

A1.3.3 *Comments*—If there are multiple complaints of equal significance to the patient, identify them collectively as CHIEF COMPLAINTS. When multiple complaints are prioritized by the patient, present the primary one as the CHIEF COMPLAINT and include others in a subsection with the heading Additional Complaints.

A1.3.3.1 Additional Complaints.

A1.4 Section Heading: REASON FOR ENCOUNTER

A1.4.1 *Definition*—Condition, diagnosis, or treatment plan for which the individual is entered into a service, whether inpatient or outpatient. More formal statement than CHIEF COMPLAINT and presented in practitioner's terms rather than patient's.

A1.4.2 REASON FOR ENCOUNTER replaces Reason for Admission, Reason for Visit, Reason for Service, and other aliases.

A1.5 Section Heading: HISTORY OF PRESENT ILLNESS

A1.5.1 *Definition*—History related to the Chief Complaint or Reason for Encounter, or both.

A1.5.2 HISTORY OF PRESENT ILLNESS replaces HPI, Present Illness, PI, History of Present Health, and other aliases.

A1.6 Section Heading PAST HISTORY

A1.6.1 *Definition*—The individual's significant health history other than that pertinent to the current reason for seeking healthcare services. If any information on the individual's past history is included in the document, it shall be included in this section. This section may include information on medical, surgical, psychiatric, social, family, dental/oral, perinatal, medication, immunization, alcohol and substance abuse, diet, education, work history, and so forth, in narrative form or as subsections.

A1.6.2 PAST HISTORY replaces Past Medical History, PMH, Health History, and other aliases.

A1.6.3 *Subsection Headings:*

A1.6.3.1 Medications. Enter non-current medications here. Address current medications in A1.8.

A1.6.3.2 Immunizations

A1.6.3.3 Education

A1.6.3.4 Habits

A1.6.3.5 Social

A1.6.3.6 Family

A1.6.3.7 Medical

A1.6.3.8 Surgical

A1.6.3.9 Psychiatric (Psychiatric replaces Mental and other aliases.)

A1.6.3.10 Obstetrical/Gynecologic

A1.6.3.11 Dental/Oral

A1.6.3.12 Alcohol and Substance Abuse (This topic may be addressed in the subsection Habits rather than within its own subsection.)

A1.6.3.13 Diet

A1.6.3.14 Work History

A1.7 Section Heading: ALLERGIES

A1.7.1 *Definition*—Hypersensitivity to specified medications and other substances. All of the individual's known allergies shall be listed here, even though they may be listed in other sections. Manifestations and treatment of the allergies should also be addressed here.

A1.7.2 ALLERGIES replaces Sensitivities and other aliases.

A1.7.3 *Comments:* Substances to which a person is allergic shall be entered in capital letters.

A1.7.4 Multiple ALLERGIES.

A1.7.4.1 Enter multiple ALLERGIES in a numbered, vertical list.

A1.8 Section Heading: CURRENT MEDICATIONS

A1.8.1 *Definition*—All medications that the patient was taking upon presentation shall be listed here, even though they may be listed in other sections. Address non-current medications in A1.6.3.1.

A1.8.2 CURRENT MEDICATIONS replaces Medications, Meds, Current Drugs, and other aliases.

A1.9 Section Heading: REVIEW OF SYSTEMS

A1.9.1 *Definition*—Systematic record of the status and functioning of the body's systems and regions. This section may include information on various body systems in narrative form or as subsections.

A1.9.2 REVIEW OF SYSTEMS replaces ROS, System Review, and other aliases.

A1.9.3 *Subsection Headings:*

A1.9.3.1 General

A1.9.3.2 Skin (Skin replaces Integument, Dermatologic, Derm, and other aliases.)

A1.9.3.3 Head (Head replaces HEENT and other aliases.)

A1.9.3.4 Eyes (Eyes replaces Ocular and other aliases.)

A1.9.3.5 Ears (Ears replaces Otorhinolaryngology and other aliases.)

A1.9.3.6 Nose, Sinuses (Nose, Sinuses replaces Otorhinolaryngology, ENT, and other aliases.)

A1.9.3.7 Mouth and Throat (Mouth and Throat replaces ENT and other aliases.)

A1.9.3.8 Neck

A1.9.3.9 Breasts

A1.9.3.10 Respiratory (Respiratory replaces Cardiorespiratory, Pulmonary, Lungs, Chest, and other aliases.)

A1.9.3.11 Cardiac (Cardiac replaces Cardiorespiratory, Cardiovascular, Cor, Heart, and other aliases.)

A1.9.3.12 Gastrointestinal (Gastrointestinal replaces GI and other aliases.)

A1.9.3.13 Genitourinary (Genitourinary replaces Urinary, GU, and other aliases.)

A1.9.3.14 Gynecologic (Gynecologic replaces OB/GYN, Reproductive, and other aliases.)

A1.9.3.15 Musculoskeletal (Musculoskeletal replaces Muscular, Skeletal, and other aliases.)

A1.9.3.16 Peripheral Vascular (Peripheral Vascular replaces Vascular and other aliases.)

A1.9.3.17 Neurologic

A1.9.3.18 Hematologic

A1.9.3.19 Endocrine

A1.9.3.20 Psychiatric (Psychiatric replaces Mental and other aliases.)

A1.10 Section Heading: PHYSICAL EXAMINATION

A1.10.1 *Definition*—Includes examiner's findings on visual inspection, palpation, auscultation, and percussion of the patient. The physical examination may or may not include mental status examination, and the mental status examination may precede the physical examination instead of follow it. This section may include information on body systems and organs in narrative form or as subsections.

A1.10.2 PHYSICAL EXAMINATION replaces PE, Exam, Examination, Physical, Physical Exam, Pertinent Physical Findings, and other aliases.

A1.10.3 *Subsection Headings:*

A1.10.3.1 General

A1.10.3.2 Vital Signs

A1.10.3.3 Skin (Skin replaces Integument, Dermatologic, Derm, and other aliases.)

A1.10.3.4 HEENT (HEENT replaces the collective heading "Head, Eyes, Ears, Nose, Throat," and other aliases. When these body parts are addressed separately rather than collectively, use the headings as indicated in A1.10.3.5-A1.10.3.8.)

A1.10.3.5 Head

A1.10.3.6 Eyes

A1.10.3.7 Ears

A1.10.3.8 Nose

A1.10.3.9 Mouth and Throat (Mouth and Throat replaces ENT and other aliases.)

A1.10.3.10 Neck

A1.10.3.11 Lymph Nodes (Lymph Nodes replaces Lymphatics and other aliases.)

A1.10.3.12 Thorax and Lungs (Thorax and Lungs replaces Chest and other aliases.)

A1.10.3.13 Cardiovascular (Cardiovascular replaces Heart, Cor, and other aliases.)

A1.10.3.14 Breasts

A1.10.3.15 Abdomen

A1.10.3.16 Pelvic (Pelvic replaces Genitorectal and other aliases)

A1.10.3.17 Ano-rectal (Ano-rectal replaces Rectal, Genitorectal, Prostate, and other aliases.)

A1.10.3.18 Peripheral Vascular

A1.10.3.19 Musculoskeletal

A1.10.3.20 Extremities

A1.10.3.21 Neurologic

A1.10.3.22 Mental Status

A1.11 Section Heading: MENTAL STATUS EXAMINATION (4)

A1.11.1 *Comment:* The mental status examination may or may not be included in the physical examination, and it may either precede or follow the physical examination.

A1.11.2 MENTAL STATUS EXAMINATION replaces Mental Status, Mental Status Exam, MSE, and other aliases.

A1.11.3 *Subsection Headings:*

A1.11.3.1 General Description

A1.11.3.2 Emotion (Emotion replaces Affect, Mood, and other aliases.)

A1.11.3.3 Perceptual Disturbances

A1.11.3.4 Thought Process

A1.11.3.5 Orientation

A1.11.3.6 Memory

A1.11.3.7 Impulse Control

A1.11.3.8 Judgment

A1.11.3.9 Insight

A1.11.3.10 Reliability

A1.12 Section Heading: DIAGNOSTIC STUDIES

A1.12.1 *Definition*—Studies made to determine the nature of a disease or condition. Differentiation between DIAGNOSTIC STUDIES (A1.12) and PROCEDURES (A1.19) shall be resolved through guidance provided in CPT or ICD9 coding conventions.

A1.12.2 DIAGNOSTIC STUDIES replace Tests, Diagnostic Tests, Laboratory Findings, Lab Studies, Lab Tests, Lab Results, Ancillary Tests, X-rays, Imaging Studies, Pathology, and other aliases.

A1.12.3 *Subsection Headings:*

A1.12.3.1 Laboratory

A1.12.3.2 Pathology

A1.12.3.3 Imaging (Imaging replaces X-rays and other aliases.)

A1.12.3.4 Cardiovascular

A1.12.3.5 Other

A1.13 Section Heading: FINDINGS

A1.13.1 *Definition*—Clinically significant observations. Such observations may be included under the heading Diagnostic Studies or one of its subsections, or may be stated here.

A1.13.2 FINDINGS replaces Pertinent Findings and other aliases.

A1.14 Section Heading: DIAGNOSIS or DIAGNOSES

A1.14.1 *Definition*—The decision reached regarding the nature of a disease or condition.

A1.14.2 DIAGNOSIS or DIAGNOSES replaces Assessment, Impression, and other aliases.

A1.14.3 *Subsection Headings:*

A1.14.3.1 Admitting (Admitting replaces Admission and other aliases.)

A1.14.3.2 Primary (Primary replaces Principal and other aliases.)

A1.14.3.3 Secondary

A1.14.3.4 Provisional (Provisional replaces Presumptive and other aliases.)

A1.15 Section Heading: PROGNOSIS

A1.15.1 *Definition*—A forecast of the probable course and/or outcome of a disease or condition.

A1.15.2 PROGNOSIS replaces Outlook, Predicted Course, and other aliases.

A1.16 Section Heading: PLAN

A1.16.1 *Definition*—Proposed program of action. The PLAN may include the Orders if they are integral to the Plan.

A1.16.2 PLAN replaces Admission Plan, Treatment Plan, Discharge Plan, and other aliases.

A1.17 Section Heading: ORDERS

A1.17.1 *Definition*—A directive, for example, about treatment, examination, drugs, and other care given to a patient.**(5)**

A1.17.2 ORDERS replaces Treatment Orders, Medication Orders, Further Care, and other aliases.

A1.17.3 *Subsection Headings:*

A1.17.3.1 Admission

A1.17.3.2 Therapeutic

A1.17.3.3 Diagnostic

A1.17.3.4 Discharge

A1.17.3.5 Standing

A1.17.3.6 Teaching

A1.17.3.7 Problem Prevention

A1.17.3.8 Activities of Daily Living

A1.17.3.9 Monitoring

A1.18 Section Heading: COURSE

A1.18.1 *Definition*—Narrative discussion of events and significant findings, treatment, and response over the encounter period.

A1.18.2 COURSE replaces Hospital Course, Treatment Course, and other aliases.

A1.19 Section Heading: PROCEDURES/ INTERVENTIONS

A1.19.1 *Comment:* Differentiation between DIAGNOSTIC STUDIES (A1.12) and PROCEDURES/INTERVENTIONS (A1.19) shall be resolved through guidance provided in coding conventions such as CPT, ICD, ABCcodes, SNOMED, NIC, and so forth.

A1.19.2 PROCEDURES/INTERVENTIONS replaces Procedures Performed, Operations, and other aliases.

A1.20 Section Heading: PRACTITIONER

A1.20.1 *Definition*—An individual who is qualified to practice a health care profession, for example, physician, nurse, physical therapist. Practitioners are often required to be licensed as defined by law.

A1.20.2 PRACTITIONER replaces Provider, Physician, and other aliases.

A1.20.2.1 Credentials (MD, RN, DO, etc.) shall accompany the practitioner's name.

A1.20.2.2 Function (surgeon, consultant, etc.) when identified shall accompany the practitioner's name.

A1.20.3 *Subsection Headings:*

A1.20.3.1 Primary

A1.20.3.2 Assistant

A1.21 Section Heading: ADVANCE DIRECTIVES

A1.21.1 *Definition*—Instructional directive in written form (appropriately witnessed) that indicates the patient's wishes for medical treatment should he or she become incapacitated and unable to participate in medical decision making. (**3**)

A1.21.2 ADVANCE DIRECTIVES replaces Directive to Physicians, Medical Directive; Terminal Care Document; Advance Medical Directive, Directives, Living Will, Organ Donation, Do Not Resuscitate, and other aliases.

A1.22 *Accountability*—The document's author or other person responsible for entering into the record the author's statements shall be identified, as well as the date and place of origination and of entry.

A1.22.1 The author of the document shall be identified by name or code according to institutional policy or contract terms.

A1.22.2 The person (for example, medical transcriptionist) responsible for entering the author's statements for the document shall be identified by name or code according to institutional policy or contract terms.

A1.22.3 The date, time, and place of origination and of production shall be stated.

A1.22.3.1 Date of origination shall include the month, day, and year that the author dictated or otherwise created the report.

A1.22.3.1.1 Date of production shall include the month, day, and year that the person responsible for entering the author's statements did so.

A1.22.3.1.2 If the author does direct entry, without the assistance of another person, the date of origination and date of entry shall be the same.

A1.22.3.2 *Time*—The time shall include the hour, minute, and time zone, based on a 24-hour clock.

A1.22.3.3 *Place*—The place shall be identified by city, state or province (where applicable), and country.

A1.23 *Distribution*—The parties to whom the document is to be distributed shall be noted.

A1.24 *Amendments*—Amendments to the original document shall be identified by the heading AMENDMENT in all capital letters. Amendments may be corrections or addenda to the original document. Each shall meet the specifications for accountability as specified in A1.22.

APPENDIXES

(Nonmandatory Information)

X1. HEADINGS EXAMPLE

X1.1 The following example illustrates the arrangement and appearance of headings and the special treatment of allergies.

HISTORY AND PHYSICAL EXAMINATION

CHIEF COMPLAINT
Nausea and vomiting.

ADDITIONAL COMPLAINT
Right knee pain.

REASON FOR ENCOUNTER
Dehydration.

HISTORY OF PRESENT ILLNESS
The patient experienced onset of nausea around noon 3 days ago, followed shortly thereafter by vomiting. Vomiting has been frequent since then,….

PAST HISTORY
Social History
The patient is married and has two teenage children.

Medical History
The patient has a history of….

ALLERGIES
The patient is allergic to SULFA DRUGS.

CURRENT MEDICATIONS
The patient takes…

REVIEW OF SYSTEMS
Gastrointestinal
The patient is 8 weeks post-cholecystectomy.

Genitourinary
Hysterectomy 1985, including tubal ligation.

PHYSICAL EXAMINATION
General
The patient is a well-nourished, well-developed….

Vital Signs
Blood pressure 140/80. Pulse 92 and regular. Respirations 17.

HEENT
Head normocephalic. Eyes…. Ears… Nose and throat….

Respiratory
Lungs clear to percussion and auscultation.

Cardiac
Normal rate and rhythm.

Gastrointestinal
Right upper quadrant tender to touch. No rebound….

Pelvic
Normal external female genitalia.

FINDINGS
The patient is severely dehydrated…

DIAGNOSIS
Pending further evaluation.

PLAN
Admit. Control dehydration.

ORDERS
Medications ordered include…

Ima Doctor, MD
Admitting Physician

ADVANCE DIRECTIVES
None on file. Not discussed.

Author: 17864
Date and time of origination: 5/4/2000 10:15 PT
Place of origination: Los Angeles, CA, USA

Transcriptionist: wr214
Date and time of production: 5/8/2000 14:20 CT
Place of production: Chicago, IL, USA

X2. TEMPLATE FOR SECTIONS AND SUBSECTIONS

X2.1 The following serves as a template for the sections and subsections described in Annex A1.

NOTE X2.1—Not all sections and subsections from Annex A1 are included because not all headings apply in a single report.

CHIEF COMPLAINT

REASONS FOR ENCOUNTER

HISTORY OF PRESENT ILLNESS

PAST HISTORY
Medications

Immunizations

Education

Habits

Social

Family

Medical

Surgical

Psychiatric

Obstetrical/Gynecologic

Dental/Oral

Alcohol and Substance Abuse

Diet

Work History

ALLERGIES

CURRENT MEDICATIONS

REVIEW OF SYSTEMS
General

Skin

Head

Eyes

Ears

Nose, Sinuses

Mouth and Throat

Neck

Breasts

Respiratory

Cardiac

Gastrointestinal

Genitourinary

Gynecologic

Musculoskeletal

Peripheral Vascular

Neurologic

Hematologic

Endocrine

Psychiatric

PHYSICAL EXAMINATION
General

Vital Signs

Skin

HEENT

Neck

Lymph Nodes

Thorax and Lungs

Cardiovascular

Breasts

Abdomen

Pelvic

Ano-rectal

Peripheral Vascular

Musculoskeletal

Extremities

Neurologic

MENTAL STATUS
EXAMINATION (**4**)
General Description

Emotion

Perceptual Disturbances

Thought Process

Orientation

Memory

Impulse Control

Judgment

Insight

Reliability

DIAGNOSTIC STUDIES
Laboratory

Pathology

Imaging

Cardiovascular

Other

FINDINGS

DIAGNOSIS
Admitting

Primary

Secondary

PROGNOSIS

PLAN

ORDERS
Admission

COURSE

PROCEDURES/INTERVENTIONS

PRACTITIONER
Primary

Assistant

ADVANCE DIRECTIVES
Author
Date and time of origination
Place of origination

Transcriptionist
Date and time of production
Place of production

Distribution

AMENDMENTS

REFERENCES

(**1**) *The AAMT Book of Style for Medical Transcription*, Claudia Tessier, AAMT, 1995

(**2**) CPT-4: Physician's Current Procedural Terminology—Fourth Edition

(**3**) ICD-9-CM: International Classification of Diseases, Ninth Edition, Clinical Modification

(**4**) *Textbook of Psychiatry*, 3rd edition, Eds: Hales, RE, Yodofsky, SC, Talbott, JA, American Psychiatric Press Inc., Washington, DC, London, England, 1999.

(**5**) *Lexikon: Dictionary of Health Care Terms, Organizations, and Acronyms*, 2nd edition, O'Leary et al., JCAHO, 2001.

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(**1**) E 1633 Specification for Coded Values Used in the Computer-Based Patient Record.

(**2**) E 1959 Guide for Requests for Proposals Regarding Medical Transcription Services for Healthcare Institutions.

(**3**) *2001 Hospital Accreditation Standards*, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), 2001.

(**4**) *A Guide to Physical Examination and History Taking*, 5th edition. J.B. Lippincott Company, 1991.

(**5**) *Accreditation Manual for Hospitals*, JCAHO, 2001.

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