DICTATION OF MEDICAL RECORDS

The Health Information Management Department uses an outside transcription service to transcribe dictated reports. Any questions regarding dictation should be directed to the transcription coordinator:

Shands: 244-5227
UF: 244-9300

Any telephone may be used for dictations. Please reference the **Shands Dictation Instruction Card** provided in this Resident Manual for dictation instructions, in addition to instructions on signing notes.

TRANSCRIBED REPORTS WILL BE AVAILABLE TO YOU THROUGH EPIC. PLEASE REMEMBER IT IS YOUR RESPONSIBILITY TO REVIEW, EDIT (IF NECESSARY) AND SIGN OFF ON ALL OF YOUR DICTATIONS THROUGH EPIC. REPORTS THAT ARE NOT SIGNED BY AN ATTENDING PHYSICIAN ARE CONSIDERED DELINQUENT BY MEDICAL RECORDS.

Dictation Tips

When dictating please be sure to speak the following:

- YOUR NAME
- PATIENT'S NAME (PLEASE SPELL OUT AT LEAST THE LAST NAME).
- MRN (YOU MUST SPEAK THIS AS WELL AS PUNCH THIS INTO THE PHONE).
- DOS, ADMISSION DATE & DISCHARGE DATE (WHERE APPLICABLE).
- DOB (IF AVAILABLE)
- IF YOU ARE MAKING AN ADDENDUM, STATE THIS AT THE BEGINNING.
- CARBON COPY RECIPIENTS, INCLUDING NAME & ADDRESS (WHERE APPROPRIATE).

Commonly Dictated Hospital Reports:

Operative Reports (Worktype ID #3):

An operative report is required on all surgical procedures.

The operative report should contain the following:

1) Patient name	7) Assistant surgeon(s)	13) Complications
2) Unit number	8) Procedure	14) Indications for surgery
3) Date of procedure	9) Pre-operative diagnosis	15) Description of procedure
4) Attending physician	10) Post-operative diagnosis	16) Attending surgeon signature
5) Attending surgeon	11) Anesthesia	
6) Resident surgeon	12) Specimens	

NOTE: To be in compliance with The Joint Commission (TJC) requirements, operative reports are to be dictated immediately after surgery.

Discharge Summary (Worktype ID #4):

A dictated/documented discharge summary is required on patients with a stay greater than 48 hours. An expired patient requires a dictated death summary. A dictated/documented final discharge note is acceptable for normal newborns and hospital stays under 48 hours of a minor nature.

The discharge summary should contain:

1) Patient Name	8) Discharge diagnosis	15) Hospital course
2) Unit Number	9) Reason for admission	16) Significant findings
3) Attending name	10) History of present illness	17) Impression/plan
4) Resident name	11) Past medical and surgical histories	18) Discharge medications
5) Date of admission	12) Current medications	19) Discharge instructions, including diet and activity
6) Date of discharge	13) Allergies	20) Signature of attending
7) Admitting diagnosis	14) Physical examination	

History & Physical (Worktype ID #1):

A completed dictated/documented History and Physical is required on all patients.

The History and Physical should contain:

1) Patient Name	8) Family/Social History	15) Signature of author and attending.
2) Unit Number	9) History of present illness	
3) Date of admission	10) Past medical and surgical history	
4) Attending name	11) Current medications	
5) Resident name	12) Allergies/Adverse reactions	
6) Reason for admission	13) Physical examination – review of systems/vital signs	
7) Chief Complaint	14) Impression/Plan	