Dictation Format Revision 081706

1) Enter x8000
   - From outside hospital (800) 383-7149 or 858-576-1700 x8000
   - For assistance (858) 874-7120
2) Enter **facility code**: 88#
3) Enter **User ID** *plus* "#"
4) Enter **work type**: 99#
5) Enter **account number** (bold, underlined, 8 digit number on label) *plus* "#"

*** * SPELL ALL NAMES WHEN DICTATING * ***

This is (your name) dictating an ED record for (attending name) on:
- **Patient Name, Account Number**
- **Date of Birth, Date of Service**
- **Primary Care Physician**
- **Referral Source** (PCP, other hospital/ED, telephone triage, nurse connection, urgent care, paramedics, self) - - See the referral/intake sheets
- **Time Initially Seen** (by you)
- **Chief Complaint**
- **History** - Include **four or more** of the following:
  - Location, Timing (frequency)
  - Quality (feels like), Context (while doing what)
  - Severity (or pain score), Duration (or onset)
  - Associated sign/symptoms
  - Modifying factors (worse w/ movement; took ibuprofen; was splinted)

Lisa is a 14 year old female who at about 8:00 am today (***timing***) had the onset of RLQ pain (***location***). The pain is sharp (***quality***). She was laying in bed when it began (**context**). The pain now is at a level of 6/10 (***severity***). The pain has been constant since it began (***duration and quality***). She tried taking Tylenol but this did not help (***modifying factors***). She began vomiting this afternoon (***associated signs and symptoms***).

This 10 year old male tripped today ***(timing)*** and landed on an outstretched forearm ***(location)*** during a soccer game (*context*).. He has 10/10 ***(severity)*** sharp ***(quality)*** pain in his right wrist ***(location).*** He was splinted and given motrin in triage ***(modifying factors).*** He is not complaining of pain anywhere else (*associated signs and symptoms*).

- **Review of Systems**: May obtain from Pt Info Sheet but *cannot* state: "see patient information sheet." List positive and negative systems, a minimum of five (see below), and then add, "all other systems of a complete review are negative."

1. Constitutional Symptoms (fever, malaise, weight loss)
2. Eyes; (Separate from the rest of ENT)
3. Ears, Nose, Mouth, Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary (skin and/or breast)
10. Neurological
11. Psychiatric
12. Hematologic/Lymphatic
13. Allergic/lmmunologic (Immunizations and allergies counts here)
14. Endocrine

- **Past medical history**
  - Hospitalizations/surgeries/serious illnesses
  - Meds/allergies/vaccinations
- **Family/Social hx**: list 1-2 pertinent positives or negatives. Do not use "noncontributory" or "negative." Please check against Patient Info Sheet.
- **Physical Examination**
  - Vital signs/wgt/sat [specify "normal" (≥94) or "hypoxic" (≤93) & if on RA/O2]
  - General appearance/activity level/interaction
  - General head-toe PEx *plus* problem focused exam
  - Special Considerations:
    - Lacerations: exploration, palpation
    - Ortho/extremity: perfusion, sensation, motor, tendon fx
    - Abdominal/GI/GU complaints: Gyn Hx (if applicable) LMP, sexual activity, contraception.
  - For "complex" patients (admitted, in Observation, receiving sedation) a complete physical requires at least 8 of the following 12 systems.

1. Constitutional (vital signs, general appearance)
2. Eyes
3. Ears, Nose, Mouth, Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal (note that the neck does not count as a separate system)
9. Skin
10. Neurologic
11. Psychiatric
12. Hematologic/Lymphatic

- **Medical Course/Decision Making**

"The history and physical exam were obtained by myself and (attending physician)". Document thought process. What was done and why or why not. Also note differential Dx considered and how related diagnosis were excluded. Include lab results and interpretation/implications.
Document reevaluations over what period of time, including response to treaments, medications, fluids. Document conversations with PMD and consultants. Document review of past (or outside) visits/records and old x-rays.

- **Procedure notes** (see samples below)
- **Diagnosis**: May use non-specific dx such as "fever," "abd pain," "resp distress/hypoxia" and abnormal labs ie "leukocytosis."
  Do not use "R/O, " "history of," "possible/suspected XX." ("R/O sepsis" is not a dx)
- **Disposition**: (D/C; admitted to _____; transfer to _____; left AMA).
- **Condition on D/C**: (Stable or improved for most D/C's).
- **D/C Plan** (treatment including all prescriptions, F/U, indications for return).
- **CC** COPIES TO PMD AND RELEVANT SUBSPECIALISTS. (spell 1st and last names) (Transcription may "forget" if not mentioned here.)

SAVE JOB #'S ON CLINICAL RECORD.

Keyboard controls: 1: pause 2: resume dictation 3: brief rewind/review 5: end dictation(s), obtain job # 8: end current dictation and begin next

Procedure Note Examples

1. Lumbar Puncture:
After obtaining informed consent from the parent/guardian an LP was performed under the supervision of (attending). The back was prepped and draped in sterile fashion. Landmarks were identified. (The area was infiltrated with 1% Lidocaine.) A (22) gauge spinal needle was inserted between L4 and L5. Approximately (3) mL of (clear) CSF was obtained on the (first) attempt. The needle was withdrawn and bandage applied. There were no complications and the patient tolerated the procedure well.

2.Cerumen Removal:
The patient had cerumen removed form the (left/right) ear canal in order to visualize the tympanic membrane. This was accomplished with a cerumen loop with no complications. The tympanic membrane was subsequently visualized.

3. Reduction Of Subluxed Radial Head:
The procedure was explained to the parents who consented. Under the supervision of (attending), the child's (right) arm was grasped at the distal forearm with counter traction at the elbow. Gentle traction was applied and the forearm was (supined and flexed/pronated). Palpable reduction occured. The patient resumed normal use of the arm with no complications.

4. Sedation: [Note: this "macro" is available pre-typed. Tell transcriptionist to insert "sedation macro" and just give content for each numbered blank.]

Procedure: Sedation. Indication: [1] (fx reduction not feasible without deep sedation). Presedation history and examination revealed: ASA physical status [2] (I); fasting duration [3]__ hours; family history [4] (negative) for adverse anesthetic/sedative reactions; airway class [5] (1); normal dentition/neck mobility; and no contraindications to sedation. Risks, benefits and alternatives were discussed with [6] (mother), who desired to proceed. With ECG and saturation monitors, constant nursing observation, and direct attending supervision, the patient received [7] (drug/route/dose) , achieving an appropriate level of sedation. The procedure was completed by [8] (ortho). The ED attending was at bedside continuously for [9] (15) minutes during the deep portion of the sedation. The patient was subsequently observed with serial examinations until the return of presedation mental status. The patient remained hemodynamically stable, with normal oxygen saturations and VS and no complications during procedure or recovery.

5. Laceration Repair:
The wound was prepped and draped in sterile fashion. Anesthesia was achieved with (2) mL of (1% lidocaine with epinephrine). (If nerve block please mention technique specifically). The wound was irrigated (with 500cc NS) and explored. There were no foreign bodies (tendon injuries etc). The wound was reapproximated in (1,2,3) layers suing (e. g., three 5-0 vicryl sutures in the dermis and six 6-0 nylon interrupted sutures percutaneously). There was excellent reapproximation of the wound edges.
The patient tolerated the procedure without complication.