SUBJECT: Analyzing Instructions

SEE ALSO:

INFORMATION

REGULAR CHARTS:

1. The discharging resident dictates discharge Summary.

2. Must have daily note from service of which the patient is admitted or transferred. Can be written by resident or attending. If you need a daily note written, ask a resident to write you’re not except in neonatal charts.

3. The attending physician must co-sign or write one daily note each day of the admission except for the first day.

4. Pre-anesthesia notes (blue sheet) must be completed and co-signed by the anesthesia attending or the attending may write their own note on the back of the blue sheet.

5. Post-anesthesia record must be completed on the back of the blue sheet if there is no post-anesthesia not on the back of the Operative Note/Histopathology Report.

6. The general anesthesia record must be signed by the anesthesia attending.

7. The attending physician must sign operative procedure notes.

8. The attending physician and the anesthesia attending must sign Operating Room Patient Record.

9. Post-anesthesia note must be completed and signed by the anesthesia attending or resident.

10. Operative Report is usually dictated by the resident, but must be signed by the attending.

11. All physician order must be signed. If you can’t read the signature or it contains no beeper number give it to the attending physician to sign.

12. A resident or an attending must cosign all student and acting interns (AI) progress notes, physician orders, etc.

13. All Nurse Practitioners, ARNP’s, PA’s and midwife notes do not need cosigning except if you need an attending for that day.
**OB CHARTS:**

1. Discharge Summary will not have to be dictated if the admission is a normal delivery with no complication and the record is accompanied with a completed OB Discharge Summary. If there is no OB Discharge Summary Form in the chart or it is blank; the resident on the case will be asked to dictate. A normal stay is usually 5 days or less. C-sections, tubals, and OB undelivered must have a dictated discharge summary.

2. OB Summary Sheet must be completed and signed. The discharging attending must co-sign this form.

3. Daily notes must be written and an attending must co-sign all daily notes. When needing daily notes co-signed use the OB Schedule. Your L&D physician will be the physician who needs to co-sign your notes.

4. OR Section needs to be analyzed the same as regular charts.

5. All physician orders must be signed.

**NEWBORN CHARTS:**

1. Discharge summary for routine newborn stays (less than 5 days) with no complications does not need to be dictated.

2. Newborn Progress Notes/Discharge Assessment Sheet must be completed and the attending must co-sign it.

3. Daily notes—the only progress note that is required is a circumcision note if the infant is a boy.

4. The Newborn Summary Sheet is signed by the attending and is therefore considered an attending note.

5. All physician orders must be signed.

**NEONATAL CHARTS:**

1. Discharge Summary must be dictated.

2. Daily notes must be written everyday of the admission, if a note is not written ask the attending to write the missing note.

3. An attending must co-sign or write a note for each day of the admission except for the first day.

4. OR section is analyzed the same as for regular charts.

5. All physician orders must be signed.

**OBSERVATION CHARTS:**

Discharge Summary must be dictated.

**OUTPATIENT SURGERY CHARTS:**
1. OR section must be completed.

2. The resident must dictate operative report or attending if no resident listed.

Approved: _______________________________ Authorized: _________________________________
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