UNDERSTANDING MEDICAL RECORDS

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Types of Medical Documentation

- History and Physical Examination Report (H & P)
- Progress Notes
- Discharge Summary
- Radiology Report
- Operative Report
- Pathology Report
- Consultation Report
- Autopsy Report
- Outpatient Clinic Notes
- Psychotherapy Notes

History & Physical Exam

- Basic Document for all Patients newly admitted to an inpatient or outpatient service
- Includes: chief complaint, history of present illness (HPI), past history (psych and medical), Social and Family History, Medication List, Review of Systems (ROS), Physical Exam (including Mental Status Exam), Assessment & Plan (Recs).
- Mental Status Exam (MSE) is the basic ‘physical exam’ for psychiatrists
Progress Notes

- Daily notes on hospitalized patients done by a physician
  - SOAP note format common (subjective, objective, assessment and plan)
- These notes will be summarized in the discharge summary so you don’t usually need to see them (except in malpractice cases)
- Increasingly, these are part of an EHR (electronic health record)

Discharge Summary

- This document summarizes the patient’s hospitalization, including final diagnoses, treatment strategies used and recommendations for future follow-up and treatment
- **Components include:** Final diagnoses, consultations (if any), a summary of labs, x-rays and procedures done, a final day note and MSE, the hospital course, a list of discharge medications & recommendations and follow-up appointments

Radiology Reports

- A description of and then a summary of findings on radiological exams (including plain x-rays, CT scans, MRIs, functional imaging)
- These reports may be included in the body of a discharge summary or consultation report
- "clinical correlation required" means the radiologist saw something that may or may not be significant depending on the clinical picture
- "normal for age" or "age-associated" means it may be part of normal aging (e.g. brain atrophy)
Operative Report
- A description of a surgical procedure along with any complications or findings. Often lists who was present and who did what.

Pathology Report
- A description of findings regarding a tissue sample of some sort (typically this is related to a ‘biopsy’).
- The significance of the findings may depend on the site of tissue sampling, symptoms the patient is having, etc.
- Not all reports are definitive and may only be as good as the sampling technique used

Consultation Reports
- When on physician asks the opinion of another regarding diagnoses and/or treatment
- Often used for specialist or second opinions
- Report should include: reason for consultation, a review of past and current history, medication review, an exam, an assessment and recommendations
- Psychiatrists are specialists and a competency evaluation is usually a consultation request from a PCP or legal representative.
Outpatient Clinic Notes

- A record of each outpatient visit.
- Should include patient complaints (or reason for return finding)
- A summary of objective findings including labs and x-rays
- An current problem list with assessment
- Treatment plan and recommendations for follow-up

Psychotherapy Notes

- A description of major thematic elements of a psychotherapy session
- May include ‘process notes’ reflecting on the interaction of patient and therapist
- May include a general assessment of how the patient is doing and directions for future sessions
- These notes are more protected than other types of notes & may include personal information that would not generally be part of the patient’s regular medical record. They are usually only available by court order (they are typically not going to be part of an EHR).

Some Tests Used for Competency Evaluations

- MMSE (mini-mental status exam)
- Trails B
- List Generation
- Clock Drawing Test
- Boston Naming Test, verbal fluency
- Kohlman Evaluation of Living Skills (KELS)

*In all of these cases it is important to know a patient’s personal baseline (if possible) as well as population normative data
The Mini-Mental State Exam

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**Trails B**

- **Instructions for Trails B:** Connect letters and numbers in an alternating fashion starting with the letter ‘A’ in an ascending pattern (A-1, B-2, etc.) without removing pen from paper.
- **Record time to completion (secs):**
Kohlman Eval of Living Skills

- The KELS involves a structured interview process with requirements for the performance of specified tasks. Performance skills and skill levels are determined within the context of age, culture, and biology (Hopkins & Smith, 1993).
- The KELS assesses 18 basic living skills. These 18 skills are distributed into five evaluation categories. The categories and skills are as follows (Bruce & Borg, 1993):

List Generation

- Number of category items that can be named in 60 secs (usual categories are animals or grocery store items)
- Average ‘animals’ for age are: ---->
- This is often impaired significantly in Alzheimer's Disease

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Average</th>
<th>Animals</th>
</tr>
</thead>
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<tr>
<td>50-59</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>60-69</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>70-79</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>80-89</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

Clock Drawing Test

- Often done as a simple screening in PCP offices (in this case it’s ‘all-or-none’ scoring)
- Instructions: The patient is asked to draw a clock face with numbers and minute and hour hands showing a predetermined time, e.g. ten past eleven.