

<p>HISTORY & PHYSICAL</p> <ul style="list-style-type: none"> • Chief Complaint • History of Present Illness • Past History <ul style="list-style-type: none"> ○ Medical History ○ Surgical History • Family History • Social History • Allergies • Medications • Review of Systems • Physical Examination • Diagnostic Studies • Diagnosis/assessment Plan 	<p>DISCHARGE SUMMARY</p> <ul style="list-style-type: none"> • Admit/Discharge Dates • Admission Diagnosis • Pertinent History • Diagnostic Studies • Hospital Course • Discharge Condition • Discharge Disposition • Discharge Medications • Discharge Instructions • Discharge Diagnosis • Final Diagnosis 	<p>PROCEDURE/ OPERATIVE NOTE</p> <ul style="list-style-type: none"> • Date of Procedure/Surgery • Preoperative Diagnosis • Postoperative Diagnosis • Operation Performed • Surgeon • Assistant • Anesthesia • Estimated Blood Loss • Operative Findings • Pathology • Description of Procedure • Complications • Disposition 	<ul style="list-style-type: none"> ✓ Dictate appropriate identification information • Physician Name • Patient Name • Second identifier • Type of Report • Important dates (admission, date of procedure, discharge) ✓ Dictate using established guidelines for headings/ subheadings appropriate for the type of dictation 	<ul style="list-style-type: none"> ✓ Dictate in appropriate areas away from distractions and noise; avoid speakerphones and cell phones ✓ Enter appropriate identification codes Physician ID Patient ID Work Type ✓ Speak in a normal conversational voice, spelling new or unfamiliar terms ✓ Avoid overuse of abbreviations.
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