

# Medical Record Documentation

## Policy

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It is the policy of UTM&B to initiate and maintain a complete and accurate medical record for every individual assessed, cared for, treated, or served. Documentation in the medical record shall be sufficient to identify the patient, support the diagnosis, justify the treatment, document the course and results of treatment, and promote continuity of care among health care providers. Medical record documentation is to be timely, meaningful, authenticated, and legible. All relevant documents and entries should be entered into the medical record at the time the service is rendered. The electronic medical record (EMR) must be used for documentation in all areas where its implementation has been completed.

Every individual documenting in the medical record is responsible for the entire content of his/her documentation, whether the content is original, copied, pasted, imported or reused. Those who document are responsible for the accuracy, medical necessity, and documentation requirements of each of their notes.

In addition, they are responsible for the proper maintenance of their In Basket by reviewing it regularly to prevent delinquencies in the medical record. Faculty members should ensure that resident notes are accurate and consistent with this policy at the time of co-signing any note.

More specific documentation requirements can be found in the [Medical Staff Bylaws](#), [Medical Staff Rules and Regulations](#), and the booklet, "The Medical Record and Health Information Management Services" published by the Department of Health Information Management (HIM).

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## Legibility

1. All entries must be legible, including handwritten/electronic signatures.
2. Black ink is recommended for hardcopy medical record entries.

## Patient Identification

1. Every page in the medical record or electronic medical record screen must be identifiable by patient name and complete medical record number (including the alpha suffix). It is preferred that this information be available on both sides of a document.
  2. If the Department of Health Information Management (HIM) receives documents with incomplete, illegible and/or missing patient identification, an attempt will be made to properly identify the patient. Documents successfully identified will be
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# Sample Medical Documentation

**Richard Bailey**

A red circular graphic with a gradient, appearing as a partial circle or a thick arc, located to the right of the name Richard Bailey.

## **Sample Medical Documentation:**

## Whispering the Techniques of Language: An Mental Quest through **Sample Medical Documentation**

In a digitally-driven earth wherever monitors reign supreme and instant connection drowns out the subtleties of language, the profound strategies and emotional nuances hidden within phrases often go unheard. However, nestled within the pages of **Sample Medical Documentation** a captivating literary value pulsing with organic thoughts, lies a fantastic journey waiting to be undertaken. Penned by a skilled wordsmith, that wonderful opus attracts readers on an introspective journey, softly unraveling the veiled truths and profound affect resonating within the material of every word. Within the psychological depths with this emotional review, we will embark upon a honest exploration of the book is primary styles, dissect its interesting writing fashion, and yield to the strong resonance it evokes strong within the recesses of readers hearts.

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