

# 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

**Michael Hoelscher**



## **Sample Medical Documentation:**

## Embracing the Melody of Appearance: An Emotional Symphony within **Sample Medical Documentation**

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### **Table of Contents Sample Medical Documentation**

1. Understanding the eBook Sample Medical Documentation
  - The Rise of Digital Reading Sample Medical Documentation
  - Advantages of eBooks Over Traditional Books
2. Identifying Sample Medical Documentation
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Sample Medical Documentation
  - User-Friendly Interface
4. Exploring eBook Recommendations from Sample Medical Documentation

- Personalized Recommendations
- Sample Medical Documentation User Reviews and Ratings
- Sample Medical Documentation and Bestseller Lists
- 5. Accessing Sample Medical Documentation Free and Paid eBooks
  - Sample Medical Documentation Public Domain eBooks
  - Sample Medical Documentation eBook Subscription Services
  - Sample Medical Documentation Budget-Friendly Options
- 6. Navigating Sample Medical Documentation eBook Formats
  - ePub, PDF, MOBI, and More
  - Sample Medical Documentation Compatibility with Devices
  - Sample Medical Documentation Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Sample Medical Documentation
  - Highlighting and Note-Taking Sample Medical Documentation
  - Interactive Elements Sample Medical Documentation
- 8. Staying Engaged with Sample Medical Documentation
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Sample Medical Documentation
- 9. Balancing eBooks and Physical Books Sample Medical Documentation
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Sample Medical Documentation
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Sample Medical Documentation
  - Setting Reading Goals Sample Medical Documentation
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Sample Medical Documentation

- Fact-Checking eBook Content of Sample Medical Documentation
- Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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