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CASE STUDIES IN HEALTH INFORMATION MANAGEMENT

FOURTH EDITION

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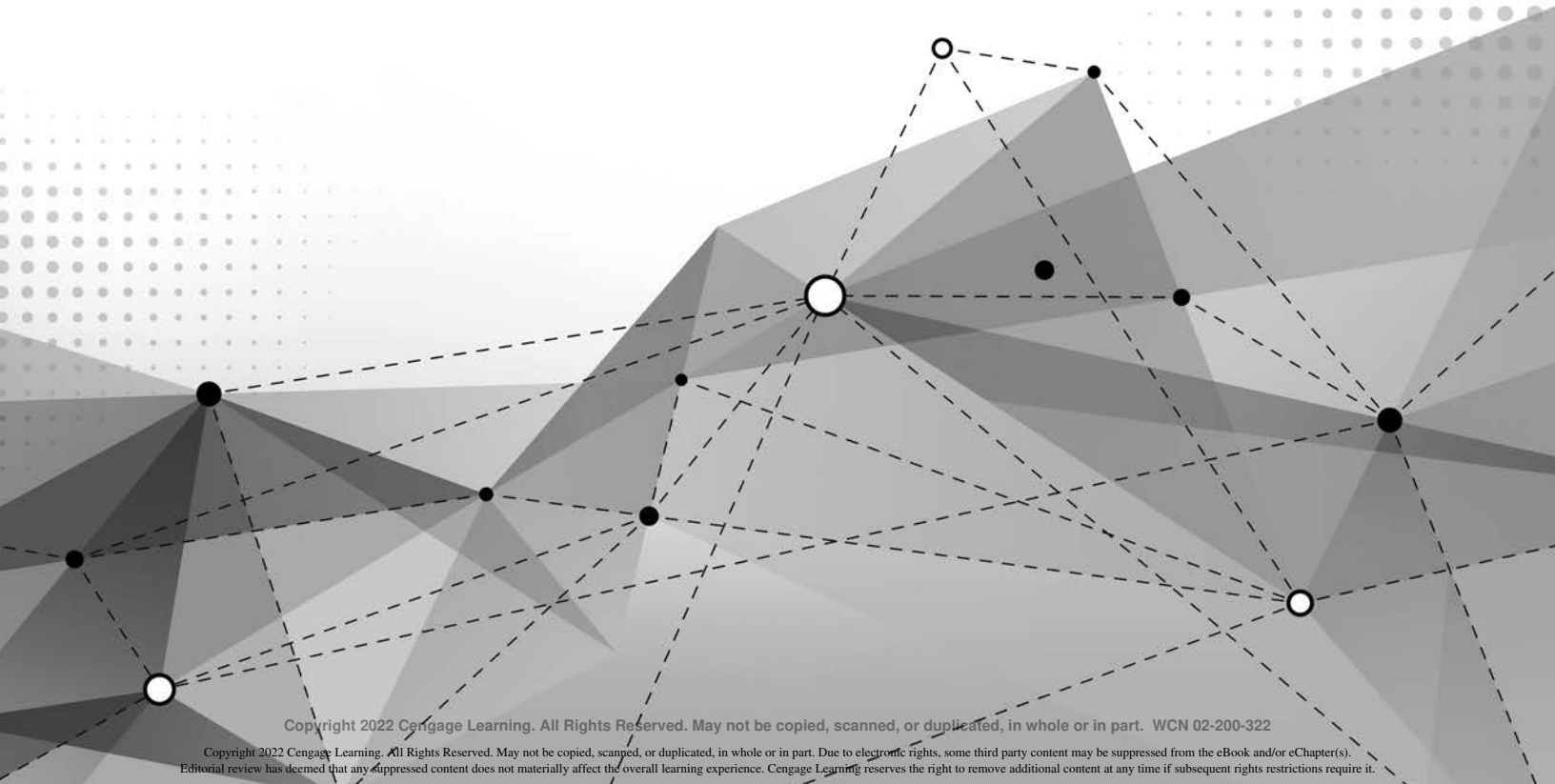

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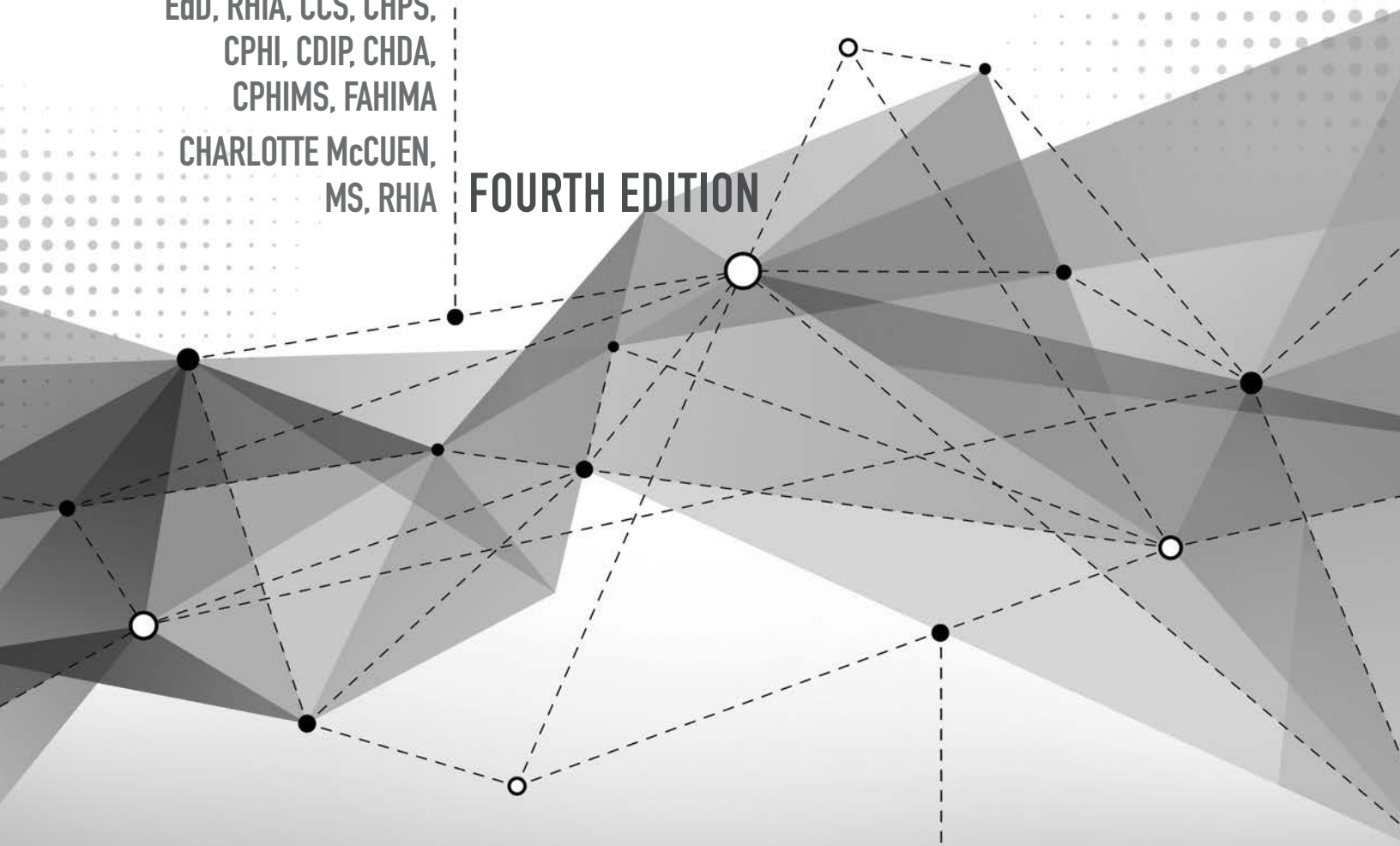

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Section 5

PREFACE

Case Studies in Health Information Management, Fourth Edition, answers the educational need for a comprehensive case study workbook for Health Information Management (HIM) educators and students. The case format will help the student move from theory to application and analysis. The 261 comprehensive case studies are designed to provide both the AS and BS student with an opportunity to experience a wide range of HIM situations.

CASE STUDY FRAMEWORK

The cases are based on real-life HIM scenarios and demand thought and action from the HIM student. Critical thinking is a cornerstone of HIM practice. These case studies were designed to assist students at all levels develop and strengthen their critical thinking skills. Each case brings the user into the HIM setting and invites him or her to consider the variables that influence the information management situation. The students are then expected to utilize HIM principles in making decisions based on these multiple variables.

Case Studies in Health Information Management, Fourth Edition, provides instructors with a transitional tool to help guide students in "bridging the gap" between content knowledge and on-the-job performance in actual HIM practice. The cases represent a unique set of variables to offer a breadth of learning experiences and to capture the reality of HIM practice. Therefore, students should not expect to be able to just look up the answers in the textbooks. They will have to draw on everything that they have learned to answer many of the questions in the case studies.

ORGANIZATION

The cases are grouped into parts based on seven major HIM topics:

- Section 1 Data Content, Structure, and Information Governance
- Section 2 Information Protection: Access, Archival, Privacy, and Security
- Section 3 Informatics, Analytics, and Data Use
- Section 4 Revenue Management
- Section 5 Compliance
- Section 6 Leadership
- Section 7 Healthcare Statistics and Research Methods

Within each section, we attempted to organize cases by subject area and then from less to more difficult. The classification of the cases is subjective and, as we all know, many of the HIM principles pertain to more than one HIM topic. For example, some cases in different sections may be quite similar but were included in the section for a different focus on the subject (e.g., personal health record [PHR] is addressed in Health Data Management as well as in Information Systems [IS]). Although reimbursement issues and coding go hand in hand, we have not included a variety of coding questions because there are already a myriad of excellent coding texts and workbooks. Our focus is on principles and compliance rather than specific codes.

FEATURES

- *Case study questions* are written in such a way that the answers cannot be looked up in a textbook but instead must be found by drawing on the knowledge acquired during study, promoting critical thinking.
- *True-to-life scenarios* are used throughout, including actual forms, codes, and the like that the HIM professional will utilize on the job.

INSTRUCTOR & STUDENT RESOURCES

Additional instructor and student resources for this product are available online. Instructor resources available include:

- The *Online Instructor's Manual,* which contains answers or suggested answers to every question found in the workbook. The *Online Instructor's Manual* contains Word files that can be easily manipulated by instructors so they can alter the information to meet their individual needs.
- *A Case Study Correlation Grid,* which illustrates at a glance which case studies contain principles related to the latest versions of the American Health Information Management Association (AHIMA), Registered Health Information Administrator (RHIA), and Registered Health Information Technician (RHIT) curriculum competency statement domains. The cases are aligned with the Commission on Accreditation of Health Informatics and Information Management Education (CAHIIM) standards for accreditation.

Student assets include web links, as referenced in the case studies; spreadsheets to assist in completing individual case studies; and a glossary of key terms. Sign up or sign in at www.cengage.com to search for and access this product and its online resources.

FEATURES

- Over 260 case studies mapping to curriculum domains.
- Aligns to Commission on Accreditation of Health Informatics and Information Management Education (CAHIIM) standards for accreditation.
- Promotes application of concepts to real-world problems and situations.
- Realistic presentation and dialogue to prepare students for situations they may encounter on the job.

- Designed to capture student interest with stimulating and fresh graphics.
- In addition, the student will find PDF, Excel, and Word files that relate to various concepts and cases.
- Instructor's manual provides complete answer keys.

NEW TO THIS EDITION

Over 30 new case studies have been added to *Case Studies in Health Information Management,* Fourth Edition, set in a variety of healthcare environments, including hospitals, ambulatory care centers, nursing facilities, medical centers, long-term care facilities, state departments of health, and physician practices. This variety gives students an idea of the wide range of professional opportunities available to them.

The new and revised case studies are focused on giving students an opportunity to think critically about real-world challenges they may face, with an emphasis on trending healthcare topics, such as the following:

- Electronic Health Records Use and Implementation
- Health Information Exchanges
- Personal Health Records
- Compliance
- National Comparative Data
- Developing and Analyzing Operation and Department Budgeting
- System Benefits Analysis
- Use of PERT and Gantt Programs for Analysis and Evaluation of Projects
- Using National Health Data to Determine Facility Data Comparison

ABOUT THE AUTHORS

Patricia Schnering, RHIA, CCS

A self-employed entrepreneur, Patricia Schnering, RHIA, CCS, is the founder, owner, author, and publisher for Professional Review Guides, Inc., and PRG Publishing, Inc. In addition to earning a baccalaureate degree in Business Administration from the University of South Florida, she is a graduate of the Health Information Management program at St. Petersburg College and holds both CCS and RHIA certifications. Prior to entering the health information management field, Patricia worked for 13 years with a national corporation in departmental management. Since 1993, she has worked in health information services supervisory positions as an HIM consultant and as an adjunct HIM instructor at St. Petersburg College. She has served as president of her local professional association (GCHIMA) and a delegate to the state organization (FHIMA), where she has served on the board of directors, been a committee member, and received the FHIMA Literary Award in 2000 and 2006.

Nanette B. Sayles, EdD, RHIA, CCS, CHPS, CPHI, CDIP, CHDA, CPHIMS, FAHIMA

Nanette Sayles is a 1985 graduate of the University of Alabama at Birmingham Medical Record Administration (now Health Information Management) program. She earned her master's of Science in Health Information Management (1995) and her master's in Public Administration (1990) from the University of Alabama at Birmingham. She earned her doctorate in Adult Education from the University of Georgia (2003). She is currently Associate Professor in the Health Information Management program at East Central College in Union, Missouri. She has a wide range of health information management experience in hospitals, consulting, system development/implementation, and education. Nanette received the 2005 American Health Information Management Association Triumph Educator Award.

Charlotte McCuen, M.S., RHIA

Charlotte McCuen, has 30 years of experience in health information management. She currently is an independent contractor as editor and co-author of HIM textbooks and Adjunct Faculty in the Health Information Management BS program at University of Cincinnati. She served as Associate Professor and Clinical Coordinator for 14 years in the Health Information Management Baccalaureate and Associate degree programs at Macon State College in Macon, Georgia. She also served 15 years as HIM Director of an acute care hospital and a state psychiatric/forensic acute care hospital. She consulted for long-term care facilities, a behavioral health hospital, physician offices, and renal dialysis centers. She received her bachelor degree in Medical Record Administration from Medical College of Georgia and her master's degree in Health Care Policy and Administration from Mercer University. Charlotte volunteers professional service to both AHIMA and the Georgia Health Information Management Association (GHIMA). She has served on the AHIMA program committee and president of GHIMA 2011-2012. She was the recipient of the Mentor Award for GHIMAA in 2004.

ACKNOWLEDGMENTS

I especially wish to express my gratitude to Nanette Sayles and Charlotte McCuen, who were instrumental in creating this book. Nanette and Charlotte are seasoned professionals and are experienced instructors in HIA and HIT programs. Their level of energy and dedication to the profession is amazing.

I have enjoyed working with the staff at Cengage Learning. They have been quite accommodating and have taught me a lot about the process of publishing. I thank Stephen Smith, Charu Verma, and all the other Cengage team members that made this book possible.

There are some special people in my life who were always there when I needed them. My late husband, Bob, always kept me grounded, as I tended to spin off in space while I worked on the books, and my mother, Emma Miller, was my role model for perseverance leading to success. She embodied grace, courage, strength, and endurance.

My thanks would not be complete without acknowledging all the HIM/HIT professionals, educators, and students who support our efforts by letting us know what would be useful to them and how we can improve the products we produce. Special thanks for the educators who were willing to take personal time to review our product for quality and value. Thank you for the letters and words of encouragement.

My reward is knowing that the materials you use here may assist you in preparing for the challenge of the workplace. I wish you the best now and throughout your career.

Until we meet...

Patricia Schnering, RHIA, CCS

This case study book is one that I have wanted to do for a long time. It is a product that I believe will be useful to both health information management educators and students. For this goal to be realized, it took a lot of support from several people:

- My husband, Mark, who is supportive of the various projects that I am working on, including this project.
- My parents, George and Jeanette Burchfield, who taught me to work hard and the importance of education.
- My coauthors, Pat Schnering and Charlotte McCuen, and their hard work on this book.

Without their hard work, this case study book would not exist. I am not sure any of us knew what we were getting ourselves into when we decided to commit to this project.

To the students, it is my hope that you find this book a useful part of your preparation to enter the exciting and challenging world of health information management.

To the educators, I hope that you will find this case study book valuable as you develop and continue to refine your courses.

Nanette B. Sayles, Ed.D, RHIA, CCS, CHPS, CPHI, CDIP, CHDA, CPHIMS, FAHIMA

I would like to extend my sincere thanks to my colleagues, Dr. Nanette Sayles and Ms. Patricia Schnering, for their professional experience, dedication, and contribution to the development of this book. Their input of real-world experiences and knowledge of working in the health information field helped in the development of the case studies presented. I thank the peer reviewers for comments and suggestions in development of the book and keeping it applicable to HIM scenarios. I would like to give thanks to special people in my life. First, I thank my husband and children for their understanding throughout the development of the book. I also extend gratitude to my parents who always encouraged me to strive for my dreams. Their example of work ethic, diligence, and determination has shown me that your goals can be achieved. Without their support, this text would not have been possible.

Charlotte McCuen, MS, RHIA

SECTION ONE

DATA CONTENT, STRUCTURE, AND INFORMATION GOVERNANCE

CASE 1-1

Subjective, Objective, Assessment, and Plan (SOAP) Statements and the Problem-Oriented Health Record (POHR)

Evaluate each of the following unrelated statements extracted from problem-oriented health record (POHR) documentation. Determine whether each statement is a subjective (S), objective (O), assessment (A), or plan (P) entry from the patient records.

1. _____ Rule out myocardial infarction.
2. _____ Patient complains of pain in the left ear and upon neck movement.
3. _____ BP 130/80. Pulse 85. Respirations 20. Temperature 98.6. Lungs clear. Heart regular. Abdomen nontender.
4. _____ Compare baseline mammogram 2006 to current mammogram.
5. _____ Uncontrolled hypertension.
6. _____ Chest pain.
7. _____ Pedal edema was 2+.
8. _____ Possible aortic aneurysm.
9. _____ Rule out cancerous tumor following biopsy of thyroid lesion.
10. _____ Patient complained of headache, fatigue, and photosensitivity.
11. _____ Patient states, "I am thirsty all the time."
12. _____ Discharge home with home health nursing and durable medical equipment. Follow-up in one week with Dr. Brantley. Home medications of Plavix 75 mg, Zetia 10 mg, Norvasc 25 mg, and Tricor 145 mg.
13. _____ BUN 21.0 mg/dL, ALB 6.0 gm/dL, bilirubin total 6.3 mg/dL.
14. _____ Percussion was normal.
15. _____ MRI brain with and without contrast: negative findings.
16. _____ Complaining of pain in the low back.
17. _____ Chest x-ray: negative. EKG: A-fibrillation. Total LDH: 145.
18. _____ Laceration measured 2 cm above right brow.
19. _____ Determine treatment following results of radiology studies.
20. _____ Surgical Pathology Frozen Section: Lung LLL Wedge Biopsy reflects nonsmall cell carcinoma involving pleural nodule.

CASE 1-2

Problem-Oriented Record Format

Read the patient visit report shown in Figure 1-1 to determine the correct response to the following questions.

1. What is the patient's chief complaint?

2. What information in the scenario is "subjective"?

3. What information in the scenario is "objective"?

4. Does Dr. Jenkins have a definitive assessment of Ms. Gerry's problem? If so, what is it?

5. What is the plan for this patient?

PATIENT VISIT REPORT

HISTORY OF PRESENT ILLNESS: Ms. Gerry is an 85-year-old female who fell out of a wheelchair today. She comes in complaining of severe pain in her left hip. X-ray reveals an intertrochanteric fracture of the left hip.

PAST MEDICAL HISTORY: Alzheimer's disease, GERD, COPD, coronary artery disease.

MEDICATIONS: Zantac 75 mg in the AM; Synthroid 88 mcg in the AM; Norvasc 2.5 mg in the AM; Nebulizer QID; Coumadin 2.5 mg Monday, Wednesday, Friday, and Saturday.

PHYSICAL EXAM: Shortening of the left leg; good bilateral pedal pulses.

PLAN: Medical clearance. Vitamin K to decrease protime. Bucks traction. Open reduction and internal fixation of left hip if cleared for surgery.

X-RAY AFTER SURGERY: Diffuse osteopenia present. Patient is post placement of a dynamic hip screw within the proximal left femur. There is near anatomical alignment of the intertrochanteric femoral neck fracture.

FIGURE 1-1 Patient Visit Report

CASE 1–3

Master Patient Index and Duplicate Health Record Number Assignment

The ad hoc report shown in Table 1-1 (Master Patient Index [MPI] Discrepancy Report) is a reporting function of the MPI system. This system function applies weights for the probability, on a scale from 1 to 15, that the two patient encounters in each case are likely to pertain to the same patient or not. The policy of the hospital is to retain the survivorship record number when correcting duplicate number assignments on the same patient.

Evaluate the MPI management report provided in Table 1-1 to differentiate potential duplicate medical record number assignments.

1. For each pair of patients listed, which health record number should be retained, based on the hospital policy?

2. Which numbers listed do you think require further documentation review to determine if the patients are the same or not?

3. Which record documentation or data elements from the patient record could be used for determining "matches" of the same patient versus different patients?

TABLE 1-1 MPI Discrepancy Report

MPI Discrepancy Report						
Case	**Patient Name**	**MR#**	**SSN**	**DOB**	**Residence**	**Wt.**
1	John Carmichael	016792	256-14-9876	1/5/1982	111 Holly Dr.	14.1
	J. D. Carmichael	019156	256-14-9876	1/5/1982	295 Stream Dr.	
2	Susan A. Pherris	042121	031-55-8642	5/4/2002	Hwy. 24, Box 11	5.0
	Susan Ferris	050377	386-12-7854	5/4/1962	456 First St.	
3	Amanda Johns	114682	487-09-4210	8/2/1984	219 Bates St.	10.4
	Amanda Willis	143022	487-09-4211	8/2/1984	532 Jesse Dr.	
4	Jonathan Allen, III	015467	276-22-9768	1/9/1955	131 Oaks Rd.	2.5
	Jonathan Allen	139878	297-46-2089	9/8/2006	197 Trey Cir.	
5	William Jones	122199	698-28-7667	2/6/2004	100 Windy Rd.	13.0
	Bill Jones	140981	698-28-7661	2/6/2004	100 Windy Rd.	
6	Tracy Lemon	130961	209-88-0120	1/9/2001	28 Hillman Ave.	1.5
	Treina Lemon	098972	462-90-0156	8/5/2006	101 Troy Ct.	

CASE 1–4

Enterprise MPI (E-MPI)

As the assistant health information management (HIM) director of a growing health system network that currently includes three hospitals and sixteen outpatient clinics, you are a member on the Information Systems Committee. You have been asked to oversee the development of a standardized, system-wide enterprise MPI that will include all patients and their information from all encounters within the system network.

1. **Level 1:** Research the core elements of a single-entity MPI and a multi-facility enterprise MPI through professional journals and develop a list of references used (e.g., *Journal of AHIMA*).

2. **Level 2:** Develop a data dictionary, defining each of the data elements needed.

3. **Level 3:** Design a data display screen of a multi-facility enterprise MPI screen.

CASE 1-5

Chart Checkout Template Screen Design and Data Quality

You have been recently hired by a vendor who develops chart management software. In your role as the subject matter expert, it is your responsibility to ensure that the system will meet the needs of users in the HIM department. One of your first duties is to evaluate the screens that have been designed over the past few months when the vendor's company did not have an HIM professional on staff. The first one that you review is the chart checkout screen for the chart locator.

1. Evaluate the screen design in Figure 1-2 to identify ways to improve data quality, including the comprehensiveness and appropriateness of the fields on the screen. Make recommendations for improvement.

To help you in your project, you may reference form design and control in the textbook *Today's Health Information Management: An Integrated Approach* by Dana McWay.

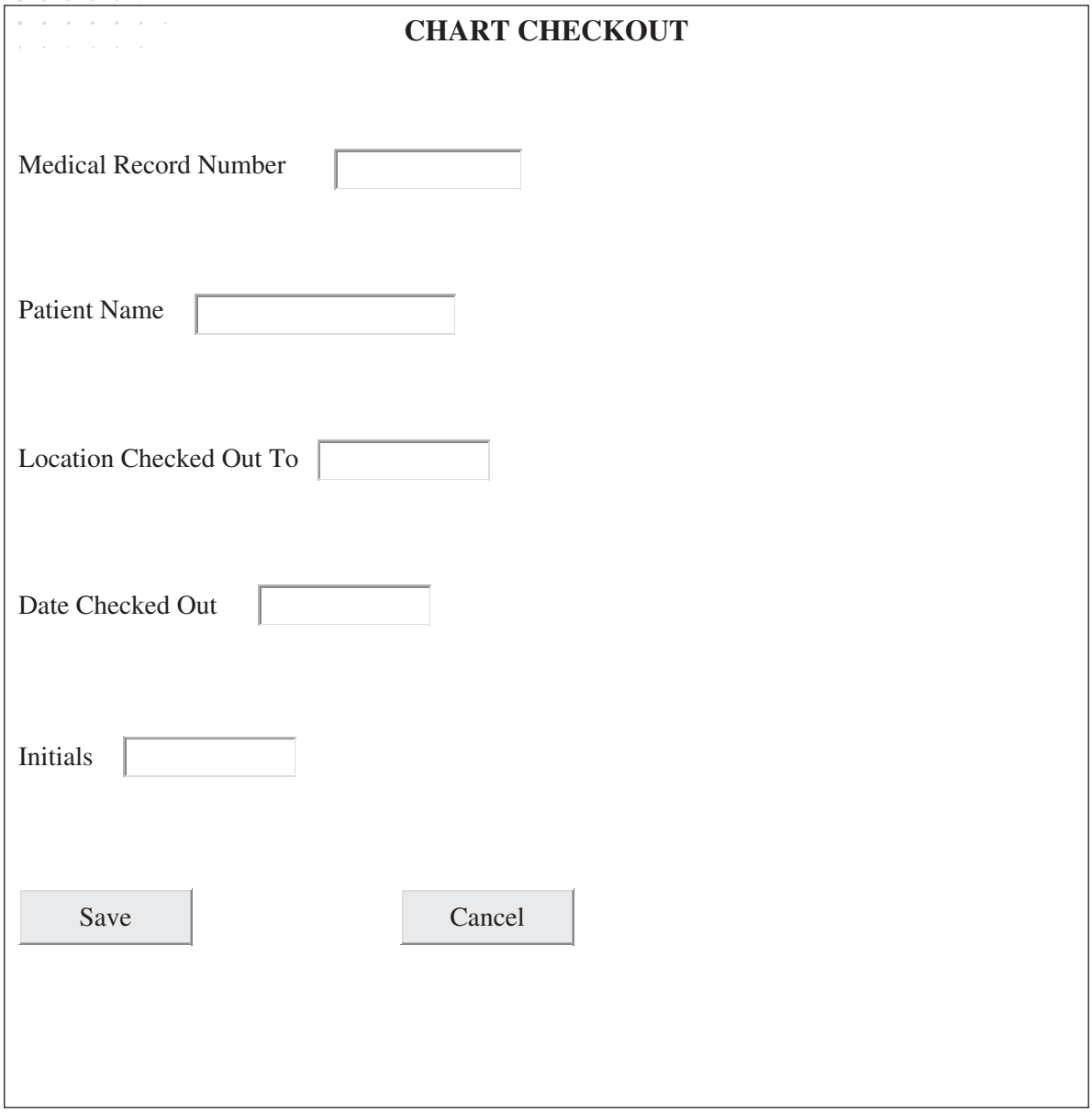


FIGURE 1-2 Chart Checkout Screen

CASE 1-6

Patient Demographic Data Entry Template Screen Design and Data Quality

You are the assistant HIM director and you are on the Health Information Systems (HIS) Committee for overseeing screen design for data entry. A screen request for a patient demographic data entry screen has been submitted by the supervisor of Patient Registration.

1. Compare good design principles for data entry and data quality to critique the screen design in Figure 1-3.

2. Evaluate the screen design and content in Figure 1-3 to identify ways to improve data quality, including the comprehensiveness and appropriateness of the data fields as well as field names.

To help you in your project, you may reference form design and control in the textbook *Today's Health Information Management: An Integrated Approach* by Dana McWay.

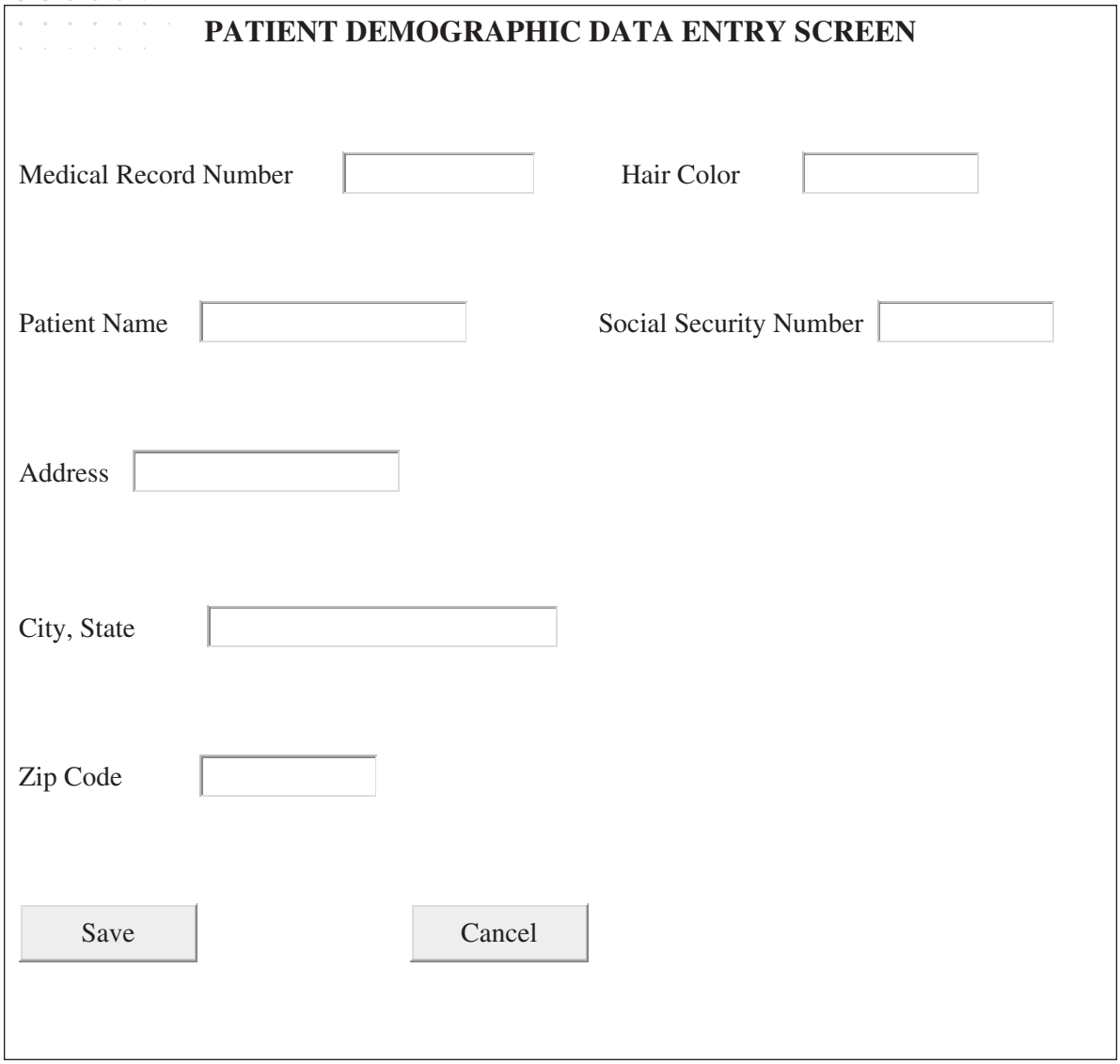


FIGURE 1-3 Patient Demographic Data Entry Screen

CASE 1-7

Encounter Abstract Template Screen Design and Data Quality

You are the assistant HIM director and you are on the HIS Committee for overseeing screen design for data entry. A screen request for an encounter data entry screen has been submitted by the supervisor of Patient Registration.

1. Compare good design principles for data entry and data quality to critique the screen design in Figure 1-4.

2. Evaluate the screen design and content in Figure 1-4 to identify ways to improve data quality, including the comprehensiveness and appropriateness of the data fields as well as field names.

To help you in your project, you may reference form design and control in the textbook *Today's Health Information Management: An Integrated Approach* by Dana McWay.

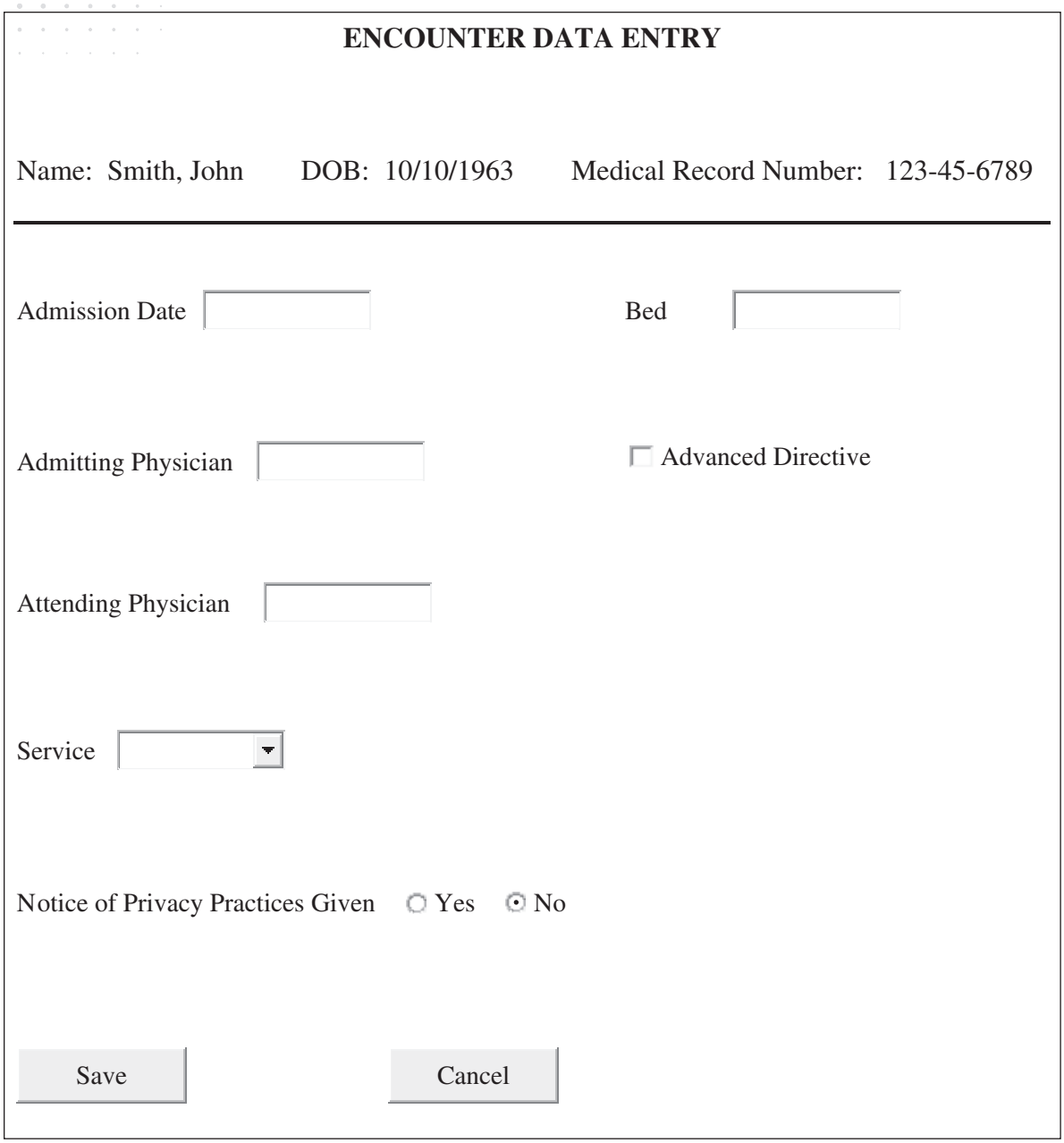


FIGURE 1-4 ENCOUNTER DATA ENTRY SCREEN

CASE 1-8

Coding Abstract Template Screen Design and Data Quality

You are the assistant HIM director and you are on the HIS Committee for overseeing screen design for data entry. A screen request for a coding abstract screen has been submitted by the supervisor of the Coding department.

1. Compare good design principles for data entry and data quality to critique the screen design in Figure 1-5.

2. Evaluate the screen design and content in Figure 1-5 to identify ways to improve data quality, including the comprehensiveness and appropriateness of the data fields as well as field names.

To help you in your project, you may reference form design and control in the textbook *Today's Health Information Management: An Integrated Approach* by Dana McWay.

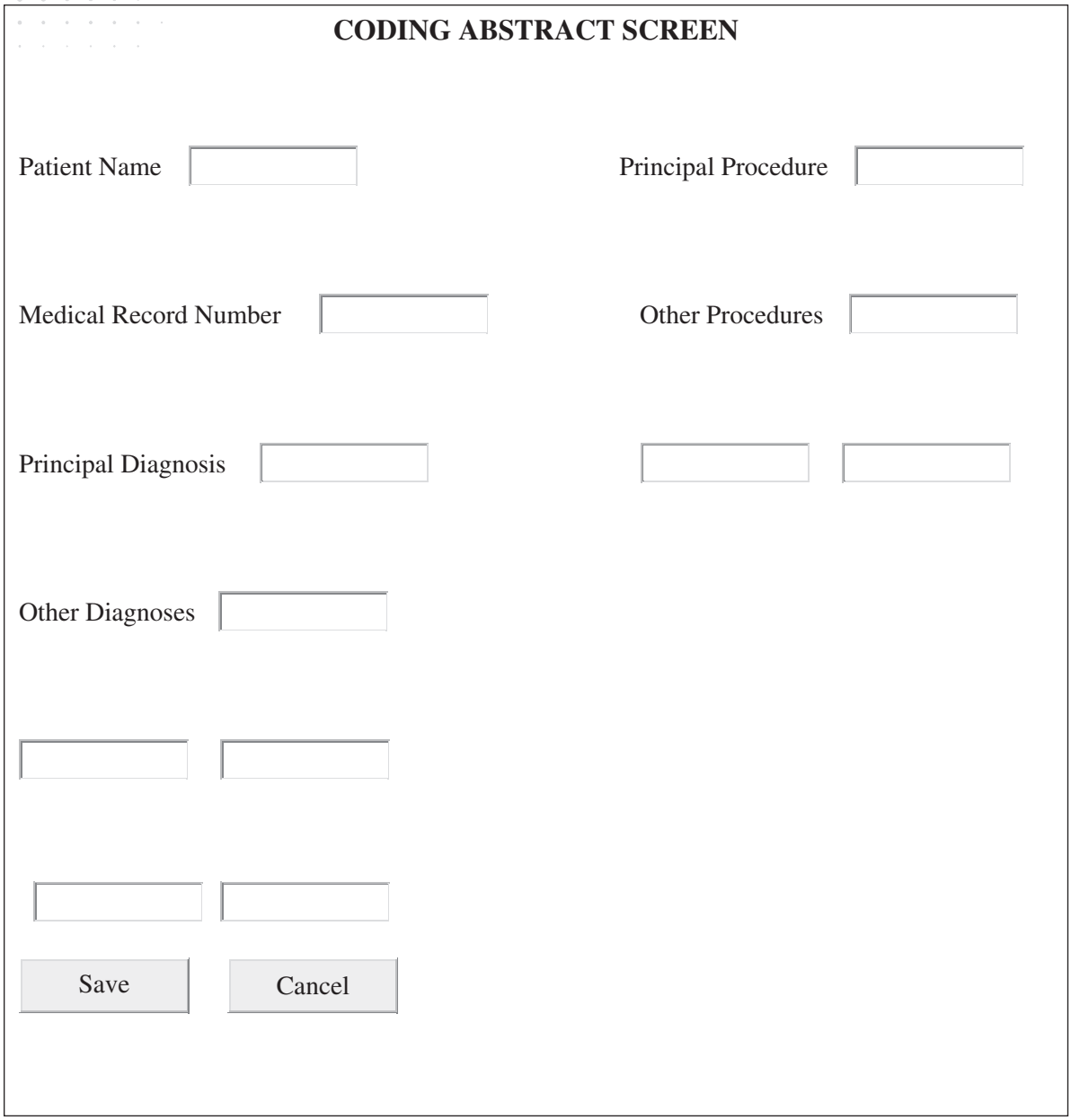


FIGURE 1-5 Coding Abstract Screen

CASE 1-9

Design a Template Screen for Radiology and Imaging Service Examinations

You are a member of the Forms or Screen Design Committee of an ambulatory diagnostic center. You have been assigned the task of developing a requisition and imaging report to be used for radiology and imaging service exams. The new report needs to combine both the requisition and radiology interpretative report on the same form or electronic health record (EHR) screen. Follow directions of your instructor to design a computer entry screen utilizing Microsoft Access, Microsoft Excel, or Microsoft Word, and include all data elements specified in the following list.

- Patient Name
- Date of Birth
- Medical Record Number
- Encounter Number
- Attending Physician
- Referring Physician
- Encounter Date
- Diagnosis/Condition
- Interpretation

CASE 1-10

Documentation Requirements for the History and Physical Report

As the chart completion supervisor, you are to meet with the HIM director to discuss documentation requirements among various agencies and state laws, such as the timeliness of the History and Physical Report, by which the hospital abides. The purpose of the meeting is to make sure the policy and procedure for analyzing patient record documentation remain current with regulatory agency documentation requirements.

1. Research The Joint Commission, Centers for Medicare and Medicaid Services (CMS), and Det Norske Veritas (DNV) standards for the documentation of the history and physical for an acute hospital admission to discover the differences in requirements.

2. Create a table showing the differences between Joint Commission standards, the Conditions of Participation (COP) with CMS, and the DNV.

CASE 1-11

Focused Review of Patient Record Documentation: Operative Report

As the HIM documentation supervisor, you are meeting with the quality improvement (QI) manager to assist in developing an audit template to be used for a quality review of patient record operative reports. Research the latest Joint Commission standard requirements to provide the QI manager for creating the template.

1. Create a list of required data elements that would be applicable in development of an audit data collection tool for operative reports, inclusive of the time requirement for completion.

CASE 1-12

Data Collection in Long-Term Care: Minimum Data Set Version 3.0

The company that you work for owns 25 long-term nursing and rehabilitation centers throughout the state. Your regional director has asked you to develop an audit process for quality review of the Minimum Data Set Version 3.0 (MDS 3.0) on completion requirements for the (comprehensive) Full Assessment Form. The process will review data collection among the corporation's homes to assess the accuracy and efficiency of reporting MDS data to Centers for Medicare & Medicaid Services (CMS) for reimbursement of care.

Table 1-12A is provided on the student companion website for you to use in entering information on data sections.

Please visit the web links section of the student companion website to access the online material referenced in this case study.

1. **Level 1:** For informational purposes, visit the CMS website for "MDS 3.0 training." Review the official MDS and compile the following information:
   a) MDS 3.0 required data sections.
   b) Types of data included under each section.
   c) Where in the health record you would expect to find the data to complete each section of the MDS.

2. **Level 2:** Listen to the online panel discussion "MDS 3 Interdisciplinary Team" to leverage in answering the following questions:
   a) Which section of MDS 3.0 requires using the resident's health record for completion?
   b) What problems are likely to be encountered while completing MDS 3.0?
   c) What suggestions would you make to overcome these problems?

3. **Level 3:** Listen to the CMS presentation "VIVE: Video on Interviewing Vulnerable Elders" to leverage in answering the following questions:
   a) What sections of MDS 3.0 must be completed by interview?
   b) What are the advantages of using an interview format for gathering these data?
   c) According to the training video, how long do these interviews typically take?
   d) Describe some of the techniques suggested for the interview process.

CASE 1-13

Data Collection for Joint Commission ORYX Performance Measures

The hospital organization you have been employed with over the past few months wants to improve outcomes in a few areas of disease management. You are aware a problem exists in timeliness of appropriate data being captured for external reporting of patient care. You sit on a committee to develop an organizational quality improvement program. In preparation for the next administrative staff meeting, you are to report on disease management against benchmark standards with The Joint Commission ORYX performance measures for comparable metrics.

As the HIM manager, you initially plan to visit jointcommision.org and review literature published on ORYX data element requirements. You are particularly interested in the current year.

1. Develop a report for the committee, with a brief introduction explaining what ORYX reporting requirements are, purpose of reporting, and relatively new methods of reporting using eCQM data submission.

2. Develop a list of the current year eCQM measures for reporting. Provide a working link to the reference source used.

3. Summarize the report with a recommendation whether you feel your organization should adopt eCQM reporting and why. Include online reference sources, including working links to literature to support development of the committee report.

CASE 1-14

Birth Certificate Reporting Project

Cabbage Patch Hospital is a rural community hospital in Georgia that had one live birth yesterday. You are the birth certificate coordinator responsible for reporting births with the state's electronic birth registry. This registry is used to create the birth certificates of newborn babies in the hospital. Pertinent identity information was obtained from an interview with the mother and from her obstetric record.

Find valid information from the interview given in Figure 1-6. The remainder of the prenatal, perinatal, and postnatal information can be found in the mother's health record (obstetric record) provided in Figure 1-7.

The obstetrician who delivered the baby was James Mercy, MD, license number 52443. His office is at 210 Cabbage Circle, Cleveland, Georgia 31402. The certifier field on the birth certificate should be left blank because the doctor will be notified to sign before mailing the certificate. Once the birth certificate data fields are all complete, the form is submitted electronically to the vital records registrar. The state vital records office will sign the registrar field of the completed birth certificate and maintain it on file at the vital records office in Cabbage County, where the baby was born.

1. Compile needed patient data from the interview and obstetric record to complete the birth certificate form found in Figure 1-8. Figure 1-8 is also provided in the student resources for ease in completing.

INTERVIEW WITH MOTHER

The mother's name is Diana Lynn Prince, maiden name Quinn, DOB 9-1-1995, Social Security number 251-00-1333. Ms. Prince is a homemaker who was born in Arizona, where she completed her high school education. She later relocated to her new hometown, the city of Cleveland, Georgia. She lives with her husband, Charles Anthony Prince, at 100 Windy Lane, Cleveland, GA 31402. The record indicates Ms. Prince was admitted on 1-13-2017 in labor. Charles Anthony Prince was born in Maryland on 10-5-1991 and has the Social Security number 231-20-3120. Mr. Prince is a black male of American descent who completed four years of college with a bachelor's degree in business. Ms. Prince and her husband chose to name their baby boy Lawrence Anthony Prince. The mother did give consent to release information to the Social Security Administration for issuance of a Social Security number for the baby.

FIGURE 1-6 Interview with Mother

Cabbage County Hospital

Admission Information — INPATIENT

Admit Date	Admit Time	Location	Room/Bed	Accom.	Bill. Type	Rel. Info.	Med. Rec. Number	Fin. Cl.
1-13-2017	0530	322	224/03	P	00	Y	09 09 99	8

Patient Name	Nick Name	Maiden Name	Account Number	Donor
Diana Lynn Prince			10032145	N

Street Address	County	City	State	Zip Code	Facility ID
100 Windy Lane	Cabbage	Cleveland	GA	31402	88888

Sex	Race	Marital	Date of Birth	Age	SSN
F	B	M	9-1-1995	22	251-00-1333

Religion	Place of Worship	City	State
Neo			

Patient Employer	Occupation	Work Phone
N/A	homemaker	

Address	City	State	Zip Code

Emergency Contact	Relationship	Home Phone	Work Phone
Charles Anthony Prince			

Address	County	City	State	Zip Code
100 Windy Lane	Cabbage	Cleveland	GA	31402

Insurance Co. 1	Authorization Number	Phone
Blue Cross/Blue Shield	012345678 PZ	(706) 555-1009
Insurance Co. 2 N/A	Authorization Number	Phone
Insurance Co. 3	Authorization Number	Phone

Admission Physician	Service	Doctor Code	Answering Serv. Phone	Beeper	
James Mercy	OBS	018	799-8888	032	UPIN 52443
			555-0199		

Referring Physician	City	State	Phone Number

Admit Diagnosis	Admit Type	Admit Source	Accident Date	Accident Time
OB for delivery at term	1	1	N/A	

Pre-Admit Clerk	Admit Clerk	Memos
	APT	

Normal Vaginal Delivery, spontaneous
Tubal Ligation

Consulting Physicians:

	Assembly
	Code/Abstract
	Entered
	Deficiency
	Final Analysis

Discharge Date 1-14-2017 Discharge Time _____ Days Stay _____

Results: ☐ Alive ☐ Post Op Death +48 Hrs. ☐ Death +48 Hrs. ☐ Death with Autopsy
☐ AMA ☐ Post Op Death −48 Hrs. ☐ Death −48 Hrs.

FIGURE 1-7 Mother's Obstetric Record

Prince, Diana Lynn
DOB 9/1/1995
MR 09 09 99, 10032145

Cabbage County Hospital

Obstetric Admitting Record

ASSESSMENT

Admission Date: 1/13/2017 Time 0535 Age 22

G	T	P	A	L

EDC 1-16-2017 EGA 39+
LMP 4-18-2016

Perinatal Transfer (From-Place) N/A

Arrival on Unit: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher

Reason for Admission rule out labor

Allergies No known drug allergies

Labor Began: Date 1-13-2017 Time 0500

Membranes on Admission:
☑ Intact ☐ Ruptured: Date _____ Time _____

Fluid: ☐ Clear ☐ Meconium ☐ Foul Smelling

Vaginal Bleeding: ☑ None ☐ Normal Show

☐ Bleeding (Describe): _____

Patient: ☑ Recent URI ☐ Been vomiting ☐ Exposed to infection ☐ Dentures ☐ Glasses ☐ Contact lenses

Prenatal: Care: ☐ No ☑ Yes

Prev. Adm. L&D: ☐ No ☑ Yes Record: ☐ No ☑ Yes Education: ☑ No ☐ Yes

RISK ASSESSMENT

Risk Factors: ☑ None

Antepartum Tests: ☐ None
Sonogram X2

Hx Herpes Virus: ☑ No ☐ Yes
+Culture and/or Herpes Lesion:
☐ No ☐ Yes Date _____

Hx Blood Transfusions: ☑ No ☐ Yes

Previous Alcohol and/or Drug Use: ☑ No ☐ Yes

Other _____

Smoker: ☑ No ☐ Yes

Hx Hepatitis: ☑ No ☐ Yes

Blood Type: A+

Last Oral Intake:
Fluids - Date 1-12-2017 Time 2100
Solids - Date 1-12-2017 Time 2100

Current Medications: ☐ None

Name/Type of Medication	Last Taken	Brought In

PHYSICAL ASSESSMENT

HT. 5'2"	WT. 149	BP 156/70
T 37	P 115	R 24
DTR'S + 2		
Mental Status alert + appropriate		

FHR 150
Dilation 4 cm.
Effacement 80 %
Station _____
Presentation vertex

Urine dipstick: Protein _____
Glucose _____ Ketone _____
Other: none obtained at admission.

PLAN

Plans for Anesthesia:
Specify Type _____ ☐ None planned

Pt. has: Living Will: ☐ No ☐ Yes Durable Power of Attorney: ☐ No ☐ Yes
☐ Information regarding Advance Directives given to patient.
☐ Advised of video broadcast
☐ Referred to resource group
☐ Referred to physician

Patient Orientation: ☐ Fetal Monitor ☐ Nurses Call Light ☐ Visiting Policy

Consent Forms: ☐ NA
☐ Preanesthesia Evaluation ☐ Support Person
☐ Metabolic Screening ☐ Sibling Visitation

Pediatrician Jim Jelanski, MD.
Support Person father of baby
Tubal Ligation: ☐ No ☑ Yes
Desires Circumcision: ☐ No ☑ Yes
Pt. plans: ☐ Private ☑ Mother/Baby ☐ Breast feeding ☑ Bottle feeding

INTERVENTION

Procedures EFM/VE
Disposition: Admit
Physician's Name James Mercy, M.D.
Notified by _____
Date 1-13-2017 Time 0610

RN SIGNATURE Lucy Aiken, RN

FIGURE 1-7 Mother's Obstetric Record *(continued)*

Prince, Diana Lynn
DOB 9/1/1995
MR 09 09 99, 10032145

Cabbage County Hospital

Obstetric Admitting Record

ASSESSMENT

Admission Date: 1/10/2017 Time 0130 Age 22

G	T	P	A	L
3	2	0	0	2

EDC 1-16 EGA 39
LMP 4-18-2016

Perinatal Transfer (From-Place) ____

Arrival on Unit: ☐ Ambulatory ☑ Wheelchair ☐ Stretcher

Reason for Admission rule out labor

Allergies no known drug allergies

Labor Began: Date 1-9-2017 Time 2300

Membranes on Admission:
☑ Intact ☐ Ruptured: Date ____ Time ____

Fluid: ☐ Clear ☐ Meconium ☐ Foul Smelling

Vaginal Bleeding: ☑ None ☐ Normal Show

☐ Bleeding (Describe): ____

RISK ASSESSMENT

Risk Factors: ☑ None

Antepartum Tests: ☐ None
OB sonogram X 2

Hx Herpes Virus: ☑ No ☐ Yes
+Culture and/or Herpes Lesion:
☐ No ☐ Yes Date ____

Hx Blood Transfusions: ☑ No ☐ Yes

Previous Alcohol and/or Drug Use: ☑ No ☐ Yes

Other ____

Smoker: ☑ No ☐ Yes

Hx Hepatitis: ☑ No ☐ Yes A+

Patient: ☑ Recent URI ☐ Been vomiting ☐ Exposed to infection ☐ Dentures ☐ Glasses ☐ Contact le

Prince, Diana Lynn
DOB 9/1/1995
MR 09 09 99, 10032145

1-9-2017 Time 2200
1-9-2017 Time 2000

Prenatal: Care: ☐ No ☑ Yes
Prev. Adm. L&D: ☑ No ☐ Yes Record: ☐ No ☐ Yes
Education: ☑ No ☐ Yes

Current Medications: ☐ None

Name/Type of Medication	Last Taken	Brought In
PNV's + FESO4	1-9-2017	

PHYSICAL ASSESSMENT

HT. 5'2"	WT. 149½	BP 153/75
T 37.3 C	P 82	R 20

DTR'S ____
Mental Status alert + oriented

FHR ____
Dilation ____
Effacement ____
Station ____
Presentation ____

Urine dipstick: Protein N
Glucose N Ketone N
Other:

PLAN

Plans for Anesthesia:
Specify Type epidural ☐ None planned

Pt. has: Living Will: ☐ No ☐ Yes Durable Power of Attorney: ☑ No ☐ Yes
☐ Information regarding Advance Directives given to patient.
☐ Advised of video broadcast
☐ Referred to resource group
☐ Referred to physician

Patient Orientation: ☑ Fetal Monitor ☑ Nurses Call Light ☐ Visiting Policy

Consent Forms: ☐ NA
☑ Preanesthesia Evaluation ☑ Support Person
☑ Metabolic Screening ☑ Sibling Visitation

Pediatrician Jim Jelagski, M.D.
Support Person father of baby
Tubal Ligation: ☐ No ☐ Yes
Desires Circumcision: ☐ No ☐ Yes
Pt. plans: ☐ Private ☑ Mother/Baby ☐ Breast feeding ☑ Bottle feeding

INTERVENTION

Procedures ____

Disposition: ____

Physician's Name ____

Notified by J. Jones, RN
Date 1-10-2017 Time 0200

RN SIGNATURE J. Jones, RN

FIGURE 1-7 Mother's Obstetric Record *(continued)*

Prince, Diana Lynn
DOB 9/1/1995
MR 09 09 99, 10032145

Cabbage County Hospital

OBSTETRIC HISTORY & PHYSICAL

Date 1-13-2017 Time 0700 (24 Hr.)

Age 22 Race B FPAL 2002
LMP 3-18-16 EDC 1-16-17 EGA 39
Prev C/S ☐ No ☐ Yes: LTCS ☐ No ☐ Yes ☐ Unknown
Ultrasound ☐ No ☒ Yes
Date 6-3-16 EDC 1-16-17 EGA 9 wks.
Date _____ EDC _____ EGA _____
Drug Allergies ☒ No ☐ Yes _____
ACOG Criteria for Elective Delivery Met?
☐ Yes ☐ No ☐ N/A _____ Initials

OBSTETRIC LAB PROFILE

ABO A Rh + MSAFP _____ Cytol _____
Last Hgb/Hct _____ Date _____ Hgb Screen _____
Antibody Screen _____
Rubella immune HBSAg _____
Urine Culture _____
1° Glucose Screen 94
RPR WNL Date _____ Chlamydia -
Other Lab(s) HIV -

HISTORY

Past Medical History ∅
Family History ∅ Social History -cigarette, -ETOH, -drugs
ROS ∅
Admission History 22 y/o, P2002, admitted with occasional contractions. Had uneventful antepartum course.

PHYSICAL EXAMINATION

General WDWN Vital Signs T 37.3 C P 82 R 20 BP 153/75
Mental Status ☐ Normal ☐ Abnormal Skin _____
HEENT pupils equal, round, reactive to light Neck _____
Heart Regular rate and rhythm
Lungs _____ Breasts soft/non-tender
Abdomen Fundal Ht _____ FHR 130 EFW _____ Presentation/Lie vertex Other _____
Cervix Dil 3cm Eff 70% Stn -2 Consist _____ Cx Position _____ Other _____
Pelvic Assessment ☐ Adequate ☐ Borderline ☐ Contracted _____
Membranes ☐ Intact ☐ Ruptured _____ Date _____ Time _____ (24 Hr.)
Rectal _____ Extremities _____ Neuro _____
Other _____

Fetal Monitor Assessment reactive

Impressions 39 wks. Plans anticipate NSVD

PHYSICIAN SIGNATURE James Marcy, M.D.

FIGURE 1-7 Mother's Obstetric Record *(continued)*

Prince, Diana Lynn
DOB 9/1/1995
MR 09 09 99, 10032145

Cabbage County Hospital

Labor and Delivery Summary

Labor Summary

G	T	Pt	A	L	Type & Rh
3	2	0	0	2	A+

Maternal transport ☐ Yes ☐ No

Presentation ☐ Position
☑ Vertex
☐ Face or brow
☐ Breech: _____
☐ Transverse lie ☐ Compound
☐ Unknown

Complications ☑ None
☐ No prenatal care
☐ Preterm labor (<37 weeks)
☐ Postterm (>42 weeks)
☐ Febrile (> 100.4°) when adm.
☐ PROM (> 12 hrs. preadmit)
☐ Meconium
☐ Foul smelling fluid
☐ Hydramnios
☐ Abruption
☐ Placenta previa
☐ Bleeding-site undetermined
☐ Toxemia (mild) (severe)
☐ Seizure activity
☐ Precipitous labor (< 3 hrs.)
☐ Prolonged labor (> 20 hrs.)
☐ Prolonged latent phase
☐ Prolonged active phase
☐ Prolonged 2nd stage (> 2.5 hrs.)
☐ Secondary arrest of dilation
☐ Cephalopelvic disproportion
☐ Cord prolapse
☐ Decreased FHT variability
☐ Extended fetal bradycardia
☐ Extended fetal tachycardia
☐ Multiple late decelerations
☐ Acidosis (pH 7.2)
☐ Anesthetic complications
☐ Multiple variable decelerations
☐ HSV
☐ _____
☐ _____

Scalp pH: ☐ Yes ☐ No

Induction ☑ None
☐ ARM ☐ Oxytoc. ☐ Prostin
☐ Serial X: _____ days

Augmentation ☑ None
☐ ARM ☐ Oxytoc.
☐ _____

Monitor ☑ LR ☑ DR ☐ None
External: ☐ FHT ☐ UC
Internal: ☐ FHT ☐ UC

Medications	Total dose
Fentanyl	0.1mg

Time of last narcotic: 0615

Delivery Data

Method of Delivery
☐ VBAC
Cephalic
☑ Spontaneous
☐ Low forceps ☐ Mid forceps Type: _____
☐ Rotation: _____ to _____
☐ Vacuum Extractor
Breech
☐ Spontaneous
☐ Partial extraction (assisted)
☐ Total extraction
☐ Forceps to A.C. head
Cesarean (details in operative notes)
☐ Primary ☐ Repeat
☐ Low cervical: transverse
☐ Low cervical: vertical
☐ Classical
☐ Cesarean hysterectomy

Placenta
☑ Spontaneous
☐ Expressed
☐ Manual
☐ Adherent
☐ Ut. exploration
☐ Configuration
☐ Normal
☐ Abn.: _____
☐ To pathology ☐ Yes ☑ No

Blood Loss
☐ < 500 ml.
☐ > 500 ml.
Specify amt.
(ml.)
Detail in remarks

Cord
☐ Nuchal cord X: N/A
☐ True knot
[2] ☑ Umbilical vessels
Cord blood: ☑ Lab ☐ Not obt.
Cord blood gas: No
pH ___ pCO2 ___ pO2 ___ B.E. ___

Episiotomy ☑ None
☐ Median suture: _____
☐ Mediolateral _____
☐ Degree: _____

Laceration ☐ None
[1] [2] [3] [4] Degree perineal
☐ Vaginal
☐ Cervical
☐ Uterine rupture
☐ Other: vaginal

Del. room no.: 03
Support pench: father of baby
Maternal BP: _____ P: _____
FHT: _____ Time: _____
Attending physician: James Mercy, MD
Assisting physician: _____

Delivery Data (Cont.)

Surgical Procedures ☐ None
☑ Tubal ligation ☐ Curettage
☐ Specimen to Pathology

Delivery Anesthesia ☐ None
1=Local 2=Pudendal
3=Paracervical 4=Epidural
5=Spinal 6=General
Administered by: _____

Delivery Room Meds ☐ None

Agent/Drug	Dose	Route

Time/Signature: _____

Agent/Drug	Dose	Route

Time/Signature: _____

IV Fluids: _____
Time/Signature: _____

Maternal O2: ☐ Yes ☐ No ☐ LR ☐ DR

Chronology
EDC date: 1 / 16 / 2017
Gestation: 39 weeks

	Date	Time
• Admit to hospital	1-13	0535
• Membranes ruptured	1-13	0652
• Onset of labor	1-13	0500
• Complete cervical dil.	1-13	0558
• Delivery of infant	1-13	0659
• Delivery of placenta	1-13	0703

Infant Data

Assessment
- crying vigorously.
- Movement good.

Plan & Intervention
☐ Term ☐ IMC ☐ NICU ☑ MB

Apgar Scores

	Heart rate	Respiration	Muscle tone	Reflex irritation	Skin color	Totals
1 min	2	2	2	1	1	8
5 min	2	2	2	2	1	9

Basic Infant Data
Medical rec. no.: _____
ID bracelet no.: 9850
☑ Male ☐ Female
Birth order: 1 of [1] [2] [3] [4]
Weight: 6 lbs 11 ozs.
3050 Grams
Length: 19 1/2 in
☑ Erythromycin oint.
RN: P. Smith, RN
Deceased N/A
Date: __/__/__ Time: _____
☐ Antepartum ☐ Intrapartum
☐ Neonatal (in delivery room)

Remarks: _____

RN signature: L. Mimbs, RN
Physician signature: James Mercy, MD

White - Mother's Chart Yellow - Baby's Chart Pink - physician

FIGURE 1-7 Mother's Obstetric Record *(continued)*

Prince, Diana Lynn
DOB 9/1/1995
MR 09 09 99, 10032145

Cabbage County Hospital

Labor & Delivery Admission Orders

Admission Date: 1-13-2017 Time: 0630

RN Init.	Time	
		Admit to Labor & Delivery
		Allergies: NKDA
		Patient may ambulate if desired and labor uncomplicated.
		NPO except for ice chips and medications.
		Measure intake q 8h and output q void.
		Obtain external fetal monitor strip for 30 minutes on admission.
la	0630	Activity: ☑ Bedrest ☐ Bathroom privileges ☐ May ambulate ☐ with fetal monitor ☐ without fetal monitor
		Fetal Monitor: ☐ No ☑ External ☐ Internal
la	0634	Labs: ☑ Hemoglobin & Hematocrit: ☐ STAT ☐ Routine
		☑ Urinalysis: ☐ None ☑ Routine ☐ Microscopic ☐ Culture & Sensitivity
		☑ Dipstick urine for protein, glucose, ketone, and nitrite.
		☐ Biochemical Profile I for patient desiring PPS.
		☐ RPR
		☑ Type and Screen
		☐ Other Labs
la	0638	IV Fluids: D5LR @ 125 cc/hr through 18 gauge intravenous catheter. May adjust IV rate as indicated for hydration.
		IV Fluids for epidural bolus: RL only (at least 1500cc intake before epidural placement)
		Maternal and fetal vital signs per intrapartum standard of care.
		Catheterize PRN: if patient bladder distended and patient unable to void.
		Sedation: Fentanyl 0.1mg IVP q 1-2hr prn pain

Physician Signature: James Mercy, MD.

RN Init./Signature: Lucy Aiken, RN.

FIGURE 1-7 Mother's Obstetric Record *(continued)*

Prince, Diana Lynn
DOB 9/1/1995
MR 09 09 99, 10032145
Date: mo/day/yr

Cabbage County Hospital

Health History Summary

Age 22 Date of birth 9-1-1995 Race or ethnicity Black Religion (non) Years married 3yrs
Social Security Number 251-00-1333
Work Tel. no. Home Tel. no.
Work Tel. no. Home Tel. no.
Referring physician
Attending physician James Mercy, MD.
OPTIONAL FOR INSURANCE, ETC.,

Medical History

Check and detail positive findings including date and place of treatment. Precede findings by reference number.

	Patient	Family	
1. Congenital anomalies	☐	☐	
2. Genetic diseases	☐	☐	
3. Multiple births	☑	☐	Patient is a twin.
4. Diabetes mellitus	☐	☑	Mother, Maternal G'mother.
5. Malignancies	☐	☐	
6. Hypertension	☐	☑	Maternal G'mother.
7. Heart disease	☐	☑	Maternal G'mother.
8. Rheumatic fever	☐		
9. Pulmonary disease	☐	☑	Sister.
10. GL problems	☐		
11. Renal disease	☐	☐	
12. Genitourinary tract problems	☐		
13. Abnormal uterine bleeding	☐		
14. Infertility	☐		
15. Venereal disease	☐	☐	
16. Phlebitis, varicosities	☐		
17. Neurologic disorders	☐	☐	
18. Metabol./endocrine disorders	☐	☐	
19. Anemia/hemoglobinopathy	☐	☐	
20. Blood disorders	☐	☐	
21. Drug abuse	☐		
22. Smoking/alcohol use	☐		
23. Infectious diseases	☐		
24. Operations/accidents	☐		
25. Allergies/meds sensitivity	☐		NKDA
26. Blood transfusions	☐		
27. Other hospitalizations	☐		
28. _____	☐	☐	
29. _____	☐	☐	
30. No known disease/problems	☐	☐	

Menstrual History Onset 13 age | Cycle q. 28 days | Length 3 days | Amount | LMP 4-8-2016 mo/day/yr quality

Pregnancy History Grav 3 | Term 2 | Pret 0 | Abort 0 | Live 2 | EDC 1-16-2017 mo/day/yr

No.	Month/ year	Sex	Weight at birth	Wks gest	Hrs. in labor	Type of delivery	Details of delivery: Include anesthesia and maternal or newborn complications. Use Risk Guide numbers where applicable.
1.	9-09	F	5lb 6oz	38		NSVD	without complication
2.	8-11	M	7lb 10oz	39		NSVD	without complication
3.							
4.							
5.							
6.							
7.							
8.							

Preexisting Risk Guide

Indicates pregnancy/outcome at risk

31. ☐ Age< 15 or > 35
32. ☐ < 8th grade education
33. ☐ Cardiac disease (class I or II)
34. ☐ Tuberculosis, active
35. ☐ Chronic pulmonary disease
36. ☐ Thrombophlebitis
37. ☐ Endocrinopathy
38. ☐ Epilepsy (on medication)
39. ☐ Infertility (treated)
40. ☐ 2 abortions (spontaneous/induced)
41. ☐ ≥ 7 deliveries
42. ☐ Previous preterm or SGA infants
43. ☐ Infants ≥ 4,000 gms
44. ☐ Isoimmunization (ABO, etc.)
45. ☐ Hemorrhage during previous preg.
46. ☐ Previous preeclampsia
47. ☐ Surgically scarred uterus
48. ☐ Preg. without familial support
49. ☐ Second pregnancy in 12 months
50. ☐ Smoking (≥ 1 pack per day)
51. ☐ _____
52. ☐ _____
53. ☐ _____

Indicates pregnancy/outcome at high risk

54. ☐ Age ≥ 40
55. ☐ Diabetes mellitus
56. ☐ Hypertension
57. ☐ Cardiac disease (class III or IV)
58. ☐ Chronic renal disease
59. ☐ Congenital/chromosomal anomalies
60. ☐ Hemoglobinopathies
61. ☐ Isoimmunization (Rh.)
62. ☐ Alcohol or drug abuse
63. ☐ Habitual abortions
64. ☐ Incompetent cervix
65. ☐ Prior fetal or neonatal death
66. ☐ Prior neurologically damaged infant
67. ☐ Significant social problems
68. ☐ _____
69. ☐ _____
70. ☐ _____

Historical Risk Status

71. ☑ No risk factors noted
72. ☐ At risk
73. ☐ At high risk

Signature Lucy Aiken, RN

FIGURE 1-7 Mother's Obstetric Record *(continued)*

Prince, Diana Lynn
DOB 9/1/1995
MR 09 09 99, 10032145
Date: 6-10-2016 mo/day/yr

Cabbage County Hospital

Initial Pregnancy Profile

History Since LMP (/) — Check and detail all positive findings below: Use reference numbers

1. Headaches ☐
2. Nausea/vomiting ☑ occasional
3. Abdominal pain ☐
4. Urinary complaints ☐
5. Vaginal discharge ☐
6. Vaginal bleeding ☐
7. Edema (specify area) ☐
8. Febrile episode ☐
9. Rubella exposure ☐
10. Other viral exposure ☐
11. Radiation exposure ☐
12. _____ ☐
13. _____ ☐
14. Contraception prior to conception ____ None ☐
Type D. Norum 1/35
Last used _____ mo/day/yr

15. Nutritional Assessment
☑ Adequate ☐ Inadequate
☐ Nutritional counseling
Remarks: _____

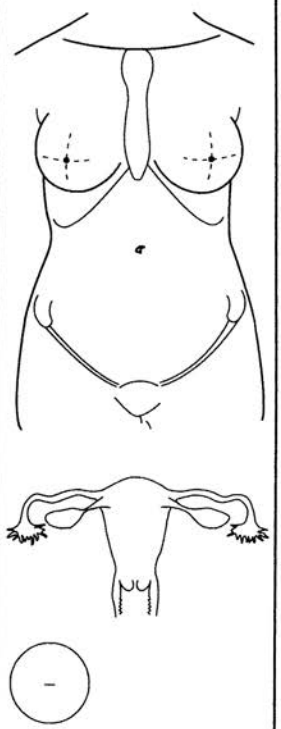
16. Medications Since LMP
☑ None ☐ Exposure to drugs
Describe: _____

Initial Physical Examination Height 5'2" Weight 140 Pregravid weight 137 B.P. 120/72 Pulse 82

OPTIONAL

SYSTEM	Normal	Abn
17. Skin	☑	☐
18. EENT	☑	☐
19. Mouth	☑	☐
20. Neck	☑	☐
21. Chest	☑	☐
22. Breast	☑	☐
23. Heart	☑	☐
24. Lungs	☑	☐
25. Abdomen	☑	☐
26. Musculoskeletal	☑	☐
27. Extremities	☑	☐
28. Neurologic	☑	☐
Pelvic Examination		
29. Ext. genitalia	☑	☐
30. Vagina	☑	☐
31. Cervix	☑	☐
32. Uterus (describe)	☑	☐
33. Adnexa	☑	☐
34. Rectum	☑	☐
35. Other	☐	☐

Check and detail all abnormal findings below: Use reference numbers.



Bony Pelvis

36. Diag. conj. _____ 37. Shape sacrum _____ 38. S.S. notch _____ 39. Ischial spines _____
40. Pubic arch _____ 41. Trans. outlet _____ 42. Post sag.diam. _____ 43. Coccyx _____
44. Classification ☐ Gynecoid ☐ Android ☐ Anthropoid ☐ Platypelloid
45. Estimation ☐ Adequate ☐ Borderline ☐ Contracted

Exam done on by: mo/day/yr 6-10-2016 James Mercy MD

FIGURE 1-7 Mother's Obstetric Record *(continued)*

Prince, Diana Lynn
DOB 9/1/1995
MR 09 09 99, 10032145

Cabbage County Hospital

Prenatal Flow Record

Historical Risk Factors and Assessment

Chlamydia (+), history

[0] Has no known risk
[1] Is "at risk"
[2] Is at high risk

Continuing Risk Assessment Guide Irevise RISK STATUS)

Date	At risk factors	Date	High risk factors
/	Uterine/cervical malformation	/	Diabetes mellitus
/	Suspect pelvis	/	Hypertension
/	Rh negative (nonsensitized)	/	Thrombophlebitis
/	Anemia (Hct <30%: Hgb <10%)	/	Herpes (type 2)
/	Venereal disease	/	Rh sensitization
/	Acute pyelonephritis	/	Uterine bleeding
/	Failure to gain weight	/	Hydramnios
/	Abnormal oresentation	/	Severe preeclampsia
/	Postterm pregnancy	/	Fetal growth retardation
/	Alcohol use	/	Premature rupt. membranes
/		/	Multiple pregnancy (preterm)
/		/	Alcohol and drug abuse
/		/	
/		/	

Initial Prenatal Screen		Additional Lab Findings				
Date: mo/day/yr		Test	Date	Result	Date	Result
Hct/Hgb	12/39	Hct/Hgb				
Patient's Blood type and Rh	A+	Blood sugar				
Antibody	NR	Antibody				
Serology	NR					
Rubella titer	Imm					
Urinalysis micro		AFP		WNL		
Pap test		HIV	6/10	neg		
Cervical culture		HEPB	6/10	neg		
		Chlamydia status neg.				

LMP 4-18-2016 Quickening date mo/dy/yr

Medication Sensitivity ☐ None known or. _____

☐ Initial prenatal instructions
☐ Attends prenatal classes
☐ Do herpes culture
☐ Do antenatal RhoGam
☐ For sterilization
☐ Circumcision
☐ Needs rubella vaccine
☐ Breast ☐ Bottle feeding

Amniocentesis
Explained on mo/day
☐ Accepted ☐ Rejected by patient

VBAC or C-Section
☐ OR records reviewed
Explained on mo/day
☐ Candidate for VBAC
☐ For Cesarean section

G	T	Pt	A	L
3	2	0	0	2

Age _____
Visit date 2016

Weight this visit	Pre-gravid	Blood pressure Base line	Urine protein	Urine Sugar	Est. weeks gestation (dates/size)	Fundal height	Fetal heart rate/quadrant	Edema	RISK STATUS (0,1,2)	Baby's physician	Return visit	Sig.
						+						
6/10 144		120/72		8/		+				Patient desires prenatal care. Will obtain prenatal labs, HIV consent and OB ultrasound for estimated gestational age.		
/		/		/		+						
/		/		/		+						
/		/		/		+						
/		/		/		+						
/		/		/		+				(1) Return to lab-4 wks for exam		
/		/		/		+				(2) PN ~~Vitamins~~, FESO4 given		
/		/		/		+				Vitamins D. Berry, RN		
/		/		/		+				* Need urine C+S next visit.		
/		/		/		+				Urine 6-10 (+) WBC and 2+ bacteria		
/		/		/		+						
/		/		/		+				Physician's signature James Mercy MD		

FIGURE 1-7 Mother's Obstetric Record *(continued)*

U.S. STANDARD CERTIFICATE OF LIVE BIRTH

LOCAL FILE NO. BIRTH NUMBER:

CHILD

1. CHILD'S NAME (First, Middle, Last, Suffix) | 2. TIME OF BIRTH (24 hr) | 3. SEX | 4. DATE OF BIRTH (Mo/Day/Yr)

5. FACILITY NAME (If not institution, give street and number) | 6. CITY, TOWN, OR LOCATION OF BIRTH | 7. COUNTY OF BIRTH

MOTHER

8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix) | 8b. DATE OF BIRTH (Mo/Day/Yr)

8c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix) | 8d. BIRTHPLACE (State, Territory, or Foreign Country)

9a. RESIDENCE OF MOTHER-STATE | 9b. COUNTY | 9c. CITY, TOWN, OR LOCATION

9d. STREET AND NUMBER | 9e. APT. NO. | 9f. ZIP CODE | 9g. INSIDE CITY LIMITS? ☐ Yes ☐ No

FATHER

10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix) | 10b. DATE OF BIRTH (Mo/Day/Yr) | 10c. BIRTHPLACE (State, Territory, or Foreign Country)

CERTIFIER

11. CERTIFIER'S NAME: _____
TITLE: ☐ MD ☐ DO ☐ HOSPITAL ADMIN. ☐ CNM/CM ☐ OTHER MIDWIFE
☐ OTHER (Specify)_____

12. DATE CERTIFIED _____/_____/_____ MM DD YYYY

13. DATE FILED BY REGISTRAR _____/_____/_____ MM DD YYYY

INFORMATION FOR ADMINISTRATIVE USE

MOTHER

14. MOTHER'S MAILING ADDRESS: 9 Same as residence, or: State: City, Town, or Location:
Street & Number: Apartment No.: Zip Code:

15. MOTHER MARRIED? (At birth, conception, or any time between) ☐ Yes ☐ No
IF NO, HAS PATERNITY ACKNOWLEDGEMENT BEEN SIGNED IN THE HOSPITAL? ☐ Yes ☐ No

16. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? ☐ Yes ☐ No

17. FACILITY ID. (NPI)

18. MOTHER'S SOCIAL SECURITY NUMBER:

19. FATHER'S SOCIAL SECURITY NUMBER:

INFORMATION FOR MEDICAL AND HEALTH PURPOSES ONLY

MOTHER

20. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)
☐ 8th grade or less
☐ 9th - 12th grade, no diploma
☐ High school graduate or GED completed
☐ Some college credit but no degree
☐ Associate degree (e.g., AA, AS)
☐ Bachelor's degree (e.g., BA, AB, BS)
☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

21. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)
☐ No, not Spanish/Hispanic/Latina
☐ Yes, Mexican, Mexican American, Chicana
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latina
(Specify)_____

22. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)
☐ White
☐ Black or African American
☐ American Indian or Alaska Native (Name of the enrolled or principal tribe)_____
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian (Specify)_____
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander (Specify)_____
☐ Other (Specify)_____

FATHER

23. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)
☐ 8th grade or less
☐ 9th - 12th grade, no diploma
☐ High school graduate or GED completed
☐ Some college credit but no degree
☐ Associate degree (e.g., AA, AS)
☐ Bachelor's degree (e.g., BA, AB, BS)
☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

24. FATHER OF HISPANIC ORIGIN? (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino)
☐ No, not Spanish/Hispanic/Latino
☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino
(Specify)_____

25. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)
☐ White
☐ Black or African American
☐ American Indian or Alaska Native (Name of the enrolled or principal tribe)_____
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian (Specify)_____
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander (Specify)_____
☐ Other (Specify)_____

Mother's Name | Mother's Medical Record No.

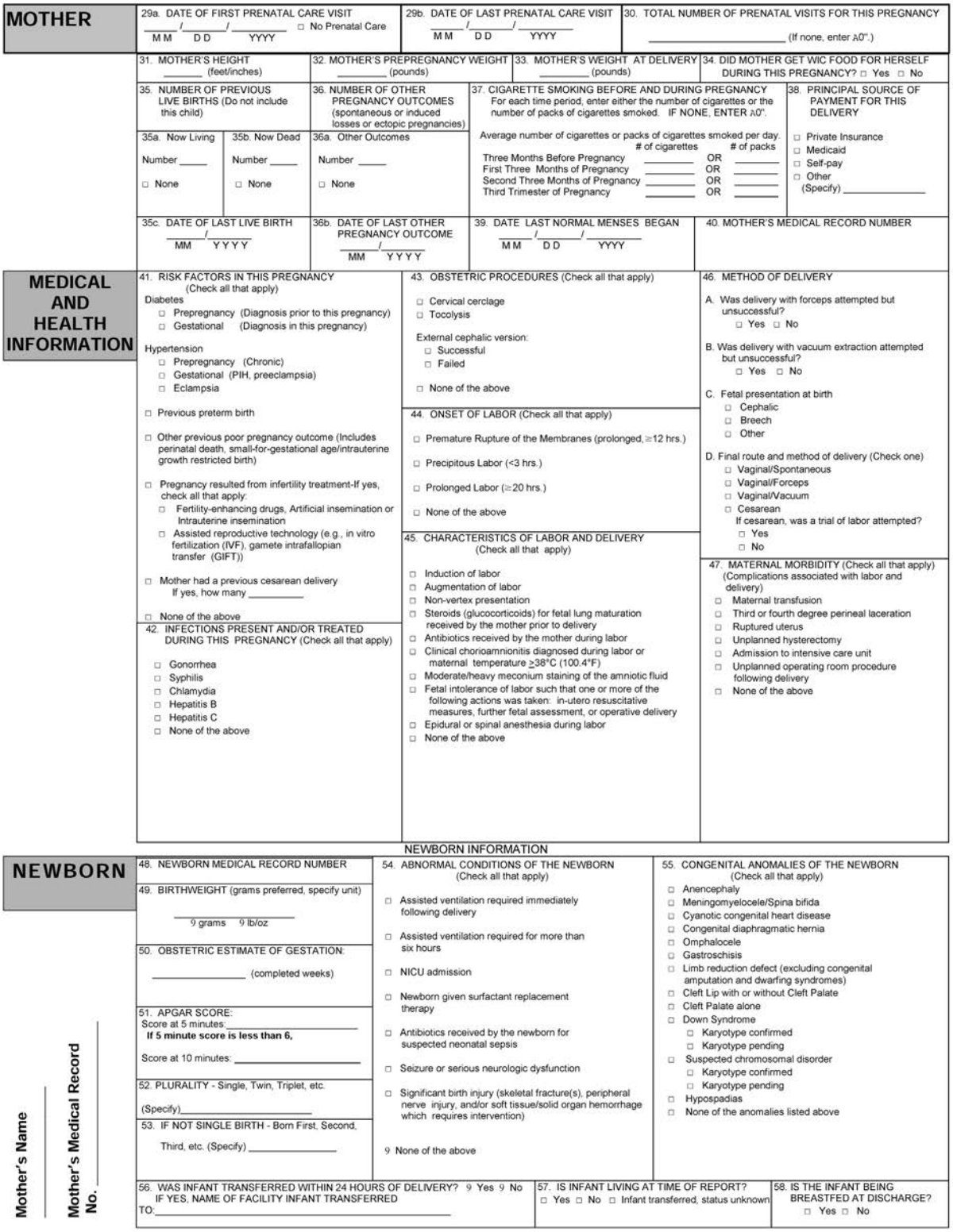
26. PLACE WHERE BIRTH OCCURRED (Check one)
☐ Hospital
☐ Freestanding birthing center
☐ Home Birth: Planned to deliver at home? 9 Yes 9 No
☐ Clinic/Doctor's office
☐ Other (Specify)_____

27. ATTENDANT'S NAME, TITLE, AND NPI
NAME: _____ NPI:_____
TITLE: ☐ MD ☐ DO ☐ CNM/CM ☐ OTHER MIDWIFE
☐ OTHER (Specify)_____

28. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No
IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM:
_____

REV. 11/2003

FIGURE 1-8 Manual Birth Certificate *(continued)*



MOTHER

29a. DATE OF FIRST PRENATAL CARE VISIT ____/____/____ (MM DD YYYY) ☐ No Prenatal Care

29b. DATE OF LAST PRENATAL CARE VISIT ____/____/____ (MM DD YYYY)

30. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY _____ (If none, enter Λ0".)

31. MOTHER'S HEIGHT _____ (feet/inches)

32. MOTHER'S PREPREGNANCY WEIGHT _____ (pounds)

33. MOTHER'S WEIGHT AT DELIVERY _____ (pounds)

34. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ☐ Yes ☐ No

35. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child)

35a. Now Living Number ____ ☐ None

35b. Now Dead Number ____ ☐ None

36. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)

36a. Other Outcomes Number ____ ☐ None

37. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY
For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER Λ0".
Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes		# of packs
Three Months Before Pregnancy	_____	OR	_____
First Three Months of Pregnancy	_____	OR	_____
Second Three Months of Pregnancy	_____	OR	_____
Third Trimester of Pregnancy	_____	OR	_____

38. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY
☐ Private Insurance
☐ Medicaid
☐ Self-pay
☐ Other (Specify) _____

35c. DATE OF LAST LIVE BIRTH ____/____ (MM YYYY)

36b. DATE OF LAST OTHER PREGNANCY OUTCOME ____/____ (MM YYYY)

39. DATE LAST NORMAL MENSES BEGAN ____/____/____ (MM DD YYYY)

40. MOTHER'S MEDICAL RECORD NUMBER

MEDICAL AND HEALTH INFORMATION

41. RISK FACTORS IN THIS PREGNANCY (Check all that apply)
Diabetes
☐ Prepregnancy (Diagnosis prior to this pregnancy)
☐ Gestational (Diagnosis in this pregnancy)
Hypertension
☐ Prepregnancy (Chronic)
☐ Gestational (PIH, preeclampsia)
☐ Eclampsia
☐ Previous preterm birth
☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
☐ Pregnancy resulted from infertility treatment-If yes, check all that apply:
☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
☐ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))
☐ Mother had a previous cesarean delivery If yes, how many _____
☐ None of the above

42. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
☐ Gonorrhea
☐ Syphilis
☐ Chlamydia
☐ Hepatitis B
☐ Hepatitis C
☐ None of the above

43. OBSTETRIC PROCEDURES (Check all that apply)
☐ Cervical cerclage
☐ Tocolysis
External cephalic version:
☐ Successful
☐ Failed
☐ None of the above

44. ONSET OF LABOR (Check all that apply)
☐ Premature Rupture of the Membranes (prolonged, ≥12 hrs.)
☐ Precipitous Labor (<3 hrs.)
☐ Prolonged Labor (≥20 hrs.)
☐ None of the above

45. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)
☐ Induction of labor
☐ Augmentation of labor
☐ Non-vertex presentation
☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
☐ Antibiotics received by the mother during labor
☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38°C (100.4°F)
☐ Moderate/heavy meconium staining of the amniotic fluid
☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
☐ Epidural or spinal anesthesia during labor
☐ None of the above

46. METHOD OF DELIVERY
A. Was delivery with forceps attempted but unsuccessful? ☐ Yes ☐ No
B. Was delivery with vacuum extraction attempted but unsuccessful? ☐ Yes ☐ No
C. Fetal presentation at birth
☐ Cephalic
☐ Breech
☐ Other
D. Final route and method of delivery (Check one)
☐ Vaginal/Spontaneous
☐ Vaginal/Forceps
☐ Vaginal/Vacuum
☐ Cesarean
If cesarean, was a trial of labor attempted?
☐ Yes
☐ No

47. MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery)
☐ Maternal transfusion
☐ Third or fourth degree perineal laceration
☐ Ruptured uterus
☐ Unplanned hysterectomy
☐ Admission to intensive care unit
☐ Unplanned operating room procedure following delivery
☐ None of the above

NEWBORN INFORMATION

NEWBORN

48. NEWBORN MEDICAL RECORD NUMBER

49. BIRTHWEIGHT (grams preferred, specify unit) _____ 9 grams 9 lb/oz

50. OBSTETRIC ESTIMATE OF GESTATION: _____ (completed weeks)

51. APGAR SCORE:
Score at 5 minutes: _____
If 5 minute score is less than 6,
Score at 10 minutes: _____

52. PLURALITY - Single, Twin, Triplet, etc.
(Specify) _____

53. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify) _____

54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)
☐ Assisted ventilation required immediately following delivery
☐ Assisted ventilation required for more than six hours
☐ NICU admission
☐ Newborn given surfactant replacement therapy
☐ Antibiotics received by the newborn for suspected neonatal sepsis
☐ Seizure or serious neurologic dysfunction
☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
9 None of the above

55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)
☐ Anencephaly
☐ Meningomyelocele/Spina bifida
☐ Cyanotic congenital heart disease
☐ Congenital diaphragmatic hernia
☐ Omphalocele
☐ Gastroschisis
☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
☐ Cleft Lip with or without Cleft Palate
☐ Cleft Palate alone
☐ Down Syndrome
☐ Karyotype confirmed
☐ Karyotype pending
☐ Suspected chromosomal disorder
☐ Karyotype confirmed
☐ Karyotype pending
☐ Hypospadias
☐ None of the anomalies listed above

56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? 9 Yes 9 No
IF YES, NAME OF FACILITY INFANT TRANSFERRED TO: _____

57. IS INFANT LIVING AT TIME OF REPORT? ☐ Yes ☐ No ☐ Infant transferred, status unknown

58. IS THE INFANT BEING BREASTFED AT DISCHARGE? ☐ Yes ☐ No

Mother's Name _____ Mother's Medical Record No. _____

FIGURE 1-8 Manual Birth Certificate *(continued)*

CASE 1–15

Clinical Coding Systems and Technology

Research literature to collect information to distinguish similarities and differences among various technologies used for coding diagnoses and procedures by coders. Technologies used include an encoder system of a logic-based automated codebook, the automated code assignment technology in natural language processing (NLP), and computer-assisted coding (CAC).

Reference resources would likely include the American Health Information Management Association AHIMA Body of Knowledge at www.ahima.org or Journal of AHIMA site at https://journal.ahima.org/.

1. Compare and contrast how each might be used differently.

2. Recommend in summation which technology you feel is most advantageous and why. Include the reference sources you utilized in your analysis.