

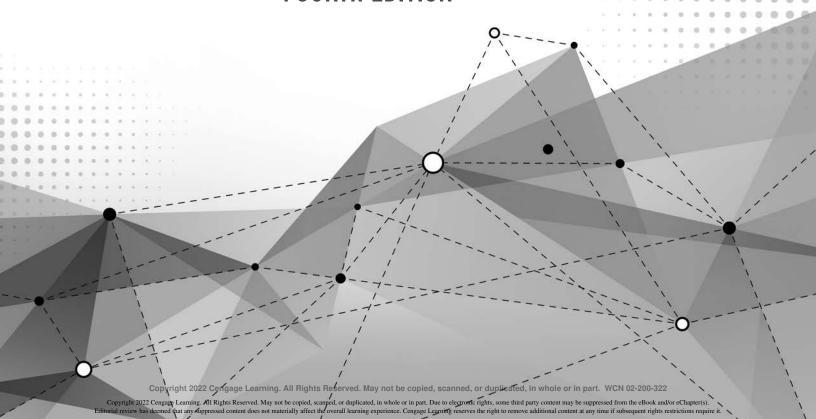
CASE STUDIES IN HEALTH INFORMATION MANAGEMENT

FOURTH EDITION

PATRICIA SCHNERING NANETTE B. SAYLES CHARLOTTE McCUEN



FOURTH EDITION



CASE STUDIES IN HEALTH INFORMATION MANAGEMENT

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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

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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.

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Charlotte McCuen, M.S., RHIA

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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

XX ACKNOWLEDGMENTS

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Charlotte McCuen, MS, RHIA

SECTION ONE

DATA CONTENT, STRUCTURE, AND INFORMATION GOVERNANCE



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. Abdomer 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.
	Surgical Pathology Frozen Section: Lung LLL Wedge Biopsy reflects nonsmall cell carcinoma

Problem-Oriented Record Format

Read the patient visit report shown in Figure 1-1 to determine the correct response to the follow	vina auestions

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

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.		

PEnterprise 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 eler	nents of a single-entity MPI	and a multi-facility	enterprise N	1PI through
professional journals and develo	p a list of references used (e	.g., Journal of AHIMA	I) .	

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.

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.

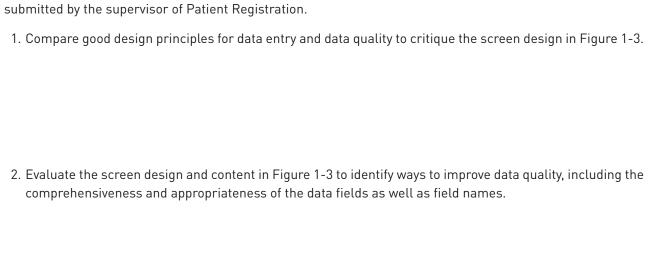
CHART CHECKOUT	
Medical Record Number	
Patient Name	
Location Checked Out To	
Date Checked Out	
Initials	
Save	

FIGURE 1-2 Chart Checkout Screen

..........

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



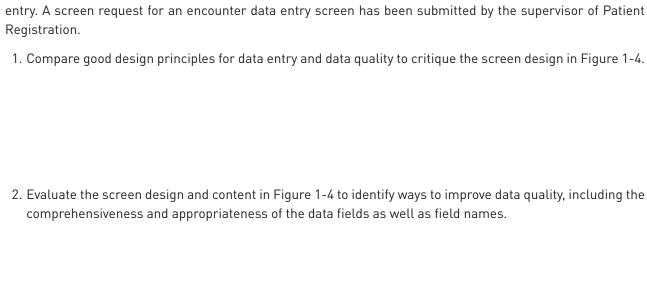
To help you in your project, you may reference form design and control in the textbook Today's Health Information Management: An Integrated Approach by Dana McWay.

PATIENT DEMOGRAF	PHIC DATA ENTRY SCREEN
Medical Record Number	Hair Color
Patient Name	Social Security Number
Address	
City, State	
Zip Code	
Save	el

FIGURE 1-3 Patient Demographic Data Entry Screen

PEncounter 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



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.

ENCOU	NTER DATA ENTRY
Name: Smith, John DOB: 10/10	Medical Record Number: 123-45-6789
Admission Date	Bed
Admitting Physician	☐ Advanced Directive
Attending Physician	
Service 🔻	
Notice of Privacy Practices Given O Y	es O No
Save	Cancel

FIGURE 1-4 ENCOUNTER DATA ENTRY SCREEN

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.

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.

	CODING ABST	RACT SCREEN	
Patient Name		Principal Procedure	
Medical Record Number		Other Procedures	
Principal Diagnosis			
Other Diagnoses			
Save	ncel		

FIGURE 1-5 Coding Abstract Screen

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

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.

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.

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.

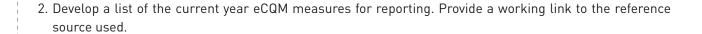
- 1. **Level 1:** For informational purposes, visit the CMS website for "MDS 3.0 training." Review the official MDS and compile the following information:
 - a) MDS 3.0 required data sections.
 - b) Types of data included under each section.
 - c) Where in the health record you would expect to find the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

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.



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.

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 Co	ounty Hospi	tal			
Admission I	Information		INPA	TIENT	
1-13-2017 0530 322 22	n/Bed / 03 Accom.	Bill. Type Rel. Info.	Med. Re	oc. Number 09 99	Fin. Cl.
Patient Name Diana Lynn Prince Nick Name	Maiden Name	Account 1		Donor	·
100 Windy Lane Cabbage	Cleveland	State Zip Code 314	02	Facility ID 8888	8
Sex Race Marital Date of Birth Age 22 SSN 251-0 Religion Place of Worship	10-1333			State	
Patient Employer	Occupation J			Work Phone	
Address	home	maker	State	Zip Code	
Emergency Contact		Home Phone		Work Phone	
	City	State Zip Code			
Insurance Co. D. Cabbage	Authorization Number	GA .	3/402 Phone	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1 - 5 - 14
Blue Cross/Blue Shield	0/23457	78 PZ	(706)555-/	009
Insurance Co. 2	Authorization Number	ma	Phone		
Insurance Co. 3	Authorization Number		Phone		
Admission Physician Tames Mercy OBS Doctor Code 018	Answering Serv. Phone	Beeper 127	HPIN	15244	12
Dianes Merty 1000 1018	555- N199	1	4///	1 2 ~ 7.	<u> </u>
Referring Physician City	200 0111	State	Ph	none Number	
Admit Diagnosis OB for delivery at term Pre-Admit Clerk Admit Glerk Memos Admit Typ Memos	e Admit Source	Accident Date	4	Accident Time	
Pre-Admit Clerk Admit Clerk Memos					
· ·					
Normal Yaginal Delivery Jubal Ligation	y, sportar	eous			
Consulting Physicians:				Assembl	ly
				Code/Ab	
Discharge Date 1-14-2017 Discharge Time				Entered	
Discharge Date	Days	•		Deficien Final An	•
AMA Post Op Death -48 Hrs. Death -48 Hrs.	ocam wim Autoj			Final An	arysis

FIGURE 1-7 Mother's Obstetric Record

Prince, Diana Lynn DOB 9/1/1995 MR 09 09 99, 10032145	Cabbage County Hospital
	Olympia Alleide Berli
	Obstetric Admitting Record
ASSESSMENT 1 / 12 / 2 N/2 N/25	RISK ASSESSMENT
Admission Date:/13_/_2017	Risk Factors: None
G T P A L EDC 1-16-2017 EGA 39+ LMP 4-18-2016	
Perinatal Transfer (From-Place)	
Arrival on Unit: Ambulatory Wheelchair Stretcher	Antepartum Tests: None
Reason for Admission Rule out labor	Sonogram 12
Reason for Admission	- Sanaguan A
1 1 1 1 1	
Allergies //6 known drug allergies	
Labor Began: Date) Hx Herpes Virus: → No Yes
Membranes on Admission:	+Culture and/or Herpes Lesion:
Intact Ruptured: Date Time	Hx Blood Transfusions: Yes
Fluid:	Previous Alcohol and/or Drug Use: 🖫 No 🔲 Yes
Bleeding (Describe):	Other
a breaking (beschie).	Smoker: Two Yes
TO S. AND S. AND S. AND S.	Hx Hepatitis: 🖸 No 🗆 Yes
Patient:	Last Oral Intake:
☐ Been vomiting ☐ Glasses ☐ Exposed to infection ☐ Contact lenses	Fluids - Date 1-12-2017 Time 2/00
	Solids - Date
Prenatal: Care: No Pres	Name/Type of Medication Last Taken Brought In
Prev. Adm. L&D: No Pres Record: No Pres	
Education: Two Yes	
	AL ASSESSMENT
HT. 5'2" WT. 149 BP 156/70 FHR 150	Urine dipstick; Protein
T 37 P 115 R 24 Dilation 4	Glucose Ketone
Fffacement 8	Other:
DTR'S 4 Station Station	none oraciea
Mental Status AVINE & COPPLOPULACE Presentation	vertex at admission.
PLAN Plans for Aposthosis	Pediatrician Jim Jelanski MW.
Plans for Anesthesia:	Support Person father of Laby
Specify Type None planned	d Tubal Ligation:
Pt. has: Living Will: ☐ No ☐ Yes Durable Power of Attorney: ☐ No ☐	Di 100 100 100 100 100 100 100 100 100 10
☐ Information regarding Advance Directives given to patient.	Mother/Baby
Advised of video broadcast	DETERMINAL
Referred to resource group Referred to physician	INTERVENTION EFM/VE
- Referred to physician	Disposition: Admit
Patient Orientation: Fetal Monitor	To mes Mossil MA
□ Nurses Call Light □ Visiting Policy	Physician's Name James Mercy, M.D.
Consent Forms: NA	Notified by
☐ Preanesthesia Evaluation ☐ Support Person	Date
☐ Metabolic Screening ☐ Sibling Visitation	RN SIGNATURE LIVEY AIREN, RN
	RN SIGNATURE ZUCY TIKEN, KIV

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

Prince, Diana Lynn DOB 9/1/1995 MR 09 09 99, 10032145		Cabbage Coun	ty Hospital
		Obstetric Admittir	ng Record
ASSESSMENT		RISK ASSESSMENT	***************************************
Admission Date: 1 / 10 / 2017 Time 013	0 22	Risk Factors: None	
G T P A L EDC 1-16 EGA 3 2 0 0 2 LMP 4-18-2016			
Perinatal Transfer (From-Place)		-	
Arrival on Unit: Ambulatory Meelchair Stretche	er	Antepartum Tests: None	• 77 - 77 • 77
Reason for Admission rule out labo	1	OB sonogram	$\cup XZ$
Reason for Admission		- Co solvery	
Allergies no known drug alle	gies		
Labor Began: Date	300	Hx Herpes Virus: ☑ No ☐ Yes	
Membranes on Admission:		+Culture and/or Herpes Lesion:	
Intact Ruptured: Date Time		□ No □ Yes Date □	
Fluid: Clear Meconium Foul Smelling		Hx Blood Transfusions: No Y	
Vaginal Bleeding: None Normal Show		Other	lo 🗀 les
☐ Bleeding (Describe): ————————————————————————————————————		Smoker: Yes	
		Hx Hepatitis: Two Yes 1 +	
Patient: Prince	nce, Dian	a Lynn ——————————————————————————————————	<u>655-2</u> 9
	OB 9/1/19	95 1-9-2017	
Contact le		0, 10032145 1-9-2017	7 Time 2000
1411	(0) 0))	Current Medications: None	Time
Prenatal: Care: No Yes			Last Taken Brought In
Prev. Adm. L&D: ☑No ☐ Yes Record: ☐ No	☐ Yes	PNYS+FESU4 1	-9-2017
Education: ENo	☐ Yes PHYSICAL A	COECOMENT	
HT. CLOU WT. LUNC BP 1534 FHR	PHISICALA	SSESSMENT	•/
52 1972 775 -	-	Urine dipstic	ek: Protein
T 31.3c P 82 R 20 Dilation	.1	Gluce	ose/V Ketone/V
Effaceme	nt		Ketone
DTR'SStation_			
Mental Status about & swinted Presentati	on		
PLAN		Pediatrician Jim Jelan	SKI, M.D.
Plans for Anesthesia:		Support Person / Ather	baly
Specify Type	one planned	Tubal Ligation: □No □Yes	Ø
	/	Desires Circumcision: ☐No ☐Yes	
Pt. has: Living Will: No Yes Durable Power of Attorney	r: L⁴No □Yes	Pt. plans: Private	☐ Breast feeding
☐ Information regarding Advance Directives given to patient. ☐ Advised of video broadcast		Mother/Baby	Bottle feeding
Referred to resource group		INTERVENTION	
☐ Referred to physician		Procedures	
Patient Orientation: TFetal Monitor		Disposition:	
Patient Orientation: Fetal Monitor Nurses Call Light		Physician's Name	
Visiting Policy		1 1	RAI
Consent Forms: NA		Notified by Jones,	Time 0200
Preanesthesia Evaluation Support Person		Date	Time U~00
Metabolic Screening Sibling Visitation		1 1	P11
		RN SIGNATURE	no /1/4

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

Cabbage County Hospital Prince, Diana Lynn DOB 9/1/1995 MR 09 09 99, 10032145 **OBSTETRIC HISTORY & PHYSICAL** Date 1-13-2017 Time 0700 (24 Hr.) **OBSTETRIC LAB PROFILE** ABO A FPAL 2002 Race Last Hgb/Hct _ _ Hgb Screen LMP3-18-16EDC 1-16-17 EGA 39 Antibody Screen Prev C/S ☐ No ☐ Yes: LTCS ☐ No ☐ Yes ☐ Unknown Ultrasound □ No ☐ Yes Urine Culture __ Date 6-3-16 EDC /-16-17 EGA 9 WKA. 1° Gluçose Screen __ RPR WYL Date _ EDC Chlamydia . Drug Allergies ☐ No ☐ Yes Other Lab(s) _ HIVE ACOG Criteria for Elective Delivery Met? ☐ Yes ☐ No ☐ N/A Initials HISTORY Past Medical History Social History Ociganotte, OFTOH, Odrugs Family History ROS _ Admission History PHYSICAL EXAMINATION General WOND Mental Status Dormal Abnormal
HEENT Argus laung round Negative to light Neck
Heart Regular rate and neighbor Presentation/Lie Vanter Other Cervix Dil 3 cm Eff 70 70 Stn Consist Cx Position □ Borderline ☐ Contracted Membranes □ Intact □ Ruptured Rectal . Extremities Other _ Fetal Monitor Assessment PHYSICIAN SIGNATURE

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

Daimer Diamet			Ca	ibbag	e Cour	nty Hospital
Prince, Diana Ly	nn			C		
DOB 9/1/1995	4					
MR 09 09 99, 10	032145					
WIK 09 09 99, 10	032143		Lob	or and	Doliver	y Summary
				00-018/10 ON 1018/00		
Labor Summary	Delivery Data		Delivery D	ata (Co	nt.)	Infant Data
G T Pt A L Type & Rh	Method of Delivery		Surgical Procedure	s	□ None	Assessment
	□ VBAC		Tubal ligation	□ Cur	ettage	
32002 A+	Cephalic		☐ Specimen to Pat	hology		
Maternal transport ☐ Yes ☐ No	Spontaneous		Delivery Anesthesi	ia	□ None	- Crruna
Presentation	□ Low forceps Type: _		1=Local	2=Puc		i i a a a la la
Vertex	u Mid forceps		3=Paracervical	(4)Epi		vigorolisey.
□ Face or brow	Rotation: to		5=Spinal	6=Ge	neral	- Marsome at
□ Breech:	□ Vacuum Extractor		Administered by:_			THE TOTAL SECTION OF THE PROPERTY OF THE PROPE
☐ Transverse lie ☐ Compound	Breech					good.
□ Unknown	□ Spontaneous					
Complications • None	☐ Partial extraction (assisted ☐ Total extraction	d)	Delivery Room Me Agent/Drug	Dose	Route	Plan & Intervention
□ No prenatal care	☐ Forceps to A.C. head		Agenobiug	Dosc	Route	□ Term □ IMC □ NICU 19 MB
☐ Preterm labor (<37 weeks) ☐ Postterm (>42 weeks)			Time/Signature			
☐ Febrile (> 100.4°) when adm.	Cesarean (details in operativ		Time/Signature			
□ PROM (> 12 hrs. preadmit)	☐ Low cervical: transverse	pedt		- 1-	-	
□ Meconium	□ Low cervical: transverse		Agent/Drug	Dose	Route	
□ Foul smelling fluid	□ Classical		Name of the State			
☐ Hydramnios ☐ Abruption	☐ Cesarean hysterectomy		Time/Signature			
□ Placenta previa		od Loss				uo
☐ Bleeding-site undetermined	/	c 500 ml.	IV Fluids:			Heart rate Respiration Muscle tone Reflex irritation Skin color Totals
☐ Toxemia (mild) (severe)	The state of the s	> 500 ml.				rate ratio
☐ Seizure activity		cify amt.	Time/Signature			Heart rate season Muscle tone Reflex irritat Skin color
□ Precipitous labor (< 3 hrs.)	□ Adherent (ml.)	0.50			T SK K H
☐ Prolonged labor (> 20 hrs.) ☐ Prolonged latent phase	☐ Ut. exploration Det	ail in remarks				1 min 2 2 2 1 1 8
□ Prolonged active phase	□ Configuration		Maternal O2:	□ Yes	□ No	
☐ Prolonged 2nd stage (> 2.5 hrs.)	□ Normal			□ LR	□ DR	15 min 222219
☐ Secondary arrest of dilation	□ Abn.:		Chronology			Basic Infant Data
□ Cephalopelvic disproportion	□ To pathology □ Y	es PNo	Chronology	1,	2010	basic illian bala
☐ Cord prolapse ☐ Decreased FHT variability	Cord	14	EDC date:	1-16	12017	Medical rec. no.:
☐ Extended fetal bradycardia	□ Nuchal cord X:/	/A	1	7a	TOWN HOUSE	9850
□ Extended fetal tachycardia	☐ True knot		Gestation:	21	weeks	ID bracelet no.:
☐ Multiple late decelerations	2 Umbilical vess				-	of Male □ Female
□ Acidosis (pH 7.2)	Cord blood:	□ Not obt.	• Admit to	Date	Time	Birth order: of [1] [2] [3] [4]
□ Anesthetic complications	Cord blood gas: No	1200	hospital	1-13	1535	,
 □ Multiple variable decelerations □ HSV 	pH pCO2 pO2 _	B.E	Membranes		11.00	Weight: lbs ozs.
		lone	ruptured	1-13	1652	3050 Grams
0	☐ Median suture:		Onset of	1-13	25-10	Grams
	☐ Mediolateral		labor	110	0500	Length: 1912 (n)
	□ Degree:		 Complete cervical dil. 	1-12	1500	Erythromycin oint.
Scalp pH: □ Yes □ No		lone	• Delivery of	10	مدده	DS HILL
Induction None		gree perineal	infant	1-13	0659	RN: JAMUE NO.
□ ARM □ Oxytoc. □ Prostin	□ Vaginal		Delivery of		,	Deceased N/A
□ Serial X: days	□ Cervical		placenta	1-13	0203	Deceased
Augmentation Wone	Other: Vaging	al)			107	Date:/ Time:
□ ARM □ Oxytoc.	d Other:		Í			☐ Antepartum ☐ Intrapartum ☐ Neonatal (in delivery room)
		^				a reconatal (in derivery footh)
Monitor W LR W DR None	Del. room no.:	3	Remarks:			
External: □ FHT □ UC Internal: □ FHT □ UC	Dather	als.				
00000000 00000000 001500000	Support penc	rug				
Medications Total dose	Maternal BP:	U				
Tentaryl O.Ima					1 11.	1 - 011
	James Mi	eccu. Mh	DNI .	1	. M 14	nho KN
	Attending physician	CALLID.	RN signature:	~		nbo, RN. Mercy, MD
Time of last narcotic:			Dhusistee	. (Tames	Meneral mal
Time of last narcotic:	Assisting physician	i	Physician signature		- white	11009,110
	William Markant Ch	V-11	D. L. I. CL	. n/		7

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
nission I	Date: 1	-13-2011 Time: 06:30
N 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.
Qa	1.50	Activity: Dedrest
~	0630	□ Bathroom privileges
		☐ May ambulate ☐ with fetal monitor ☐ without fetal monitor
00		Fetal Monitor: No D'External Internal
la	0634	Labs:
		□ Virinalysis: □ None □ Routine □ Microscopic □ Culture & Sensitivity
		Dipstick urine for protein, glucose, ketone, and nitrite.
		☐ Biochemical Profile I for patient desiring PPS.
		□ RPR
		Type and Screen
la	0638	Other Labs IV Fluids:
,		IV Fluids:
		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:/mg IVF q 1-2hr prn pain
		Physician Signature: James Merry, MD.
		Physician Signature: James Merry, M. RN Init/Signature: Lucy Likes, RN.
		•

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

_						_	/	1								
	Prir	ice	, Dian	a Ly	nn						(Cabbage	Cour	nty H	ospi	tal
	DO	В	9/1/19	95								0		,	1	
			09 99		032	145										
	14114	. 0,	0, 0,	, 10	032	175							•			
l.					Date:		day/y	r	Health History Summary							
Ag	.22	Date bir	of 9-1-	-199	S Ra	ce or nicity		Blac	K_Re	eligion	6	ion)		Yea mar		3 yrs
So	cial Secur	ity N	umber	T/-	00-	13	33						Work Tel. no			Home / Tel. no
_							_			_			Work Tel. no			Home Tel. no.
	ferring ysician							Attending physician	Jo	ines	- M	ereviM.	20	OPTIONAL		URANCE, ETC.,
M	edical I	High	ony			ient	Him		and deta	ail positive	findings	including date a		Preex	istina F	Risk Guide
						680	<0.	treatme	nt. Pred	ede findin	gs by re	ference number.		Control Starting		nancy/outcome at risk
	200		anomalie: eases											31. □ A		
			ns				H,	Patie	nt i	sa	twi	n.	1			de education
			ellitus									G'mother	_	100000000000000000000000000000000000000	_	disease (class I or II)
			s			1000	ī '	, , , , , , ,	","	4161	ricer	4 mojner	,			osis, active
			n			1000	F	Mater	nel	61m	the	e.				oulmonary disease
			se				W.	Mater	114	1 me	11	,		The state of the s		phlebitis
			ever				_ ,	" werer	nal	90	othe	· ·		37. □ E	The same of the same of	•
			disease				1	siste	r.							(on medication)
			s					2/2/6	•					100000000000000000000000000000000000000		(treated)
			se											110000000000000000000000000000000000000		ns (spontaneous/induced)
		1700	ry tract p			_								41. □ ≥		
			terine ble			1000										preterm or SGA infants
														125000000000000000000000000000000000000		4,000 gms
			sease			100000								100000000000000000000000000000000000000		nization (ABO, etc.)
			ricosities				_									age during previous preg.
			disorders											100000000000000000000000000000000000000		preeclampsia
		T. 12	docrine d				П									scarred uterus
			noglobino				$\overline{\Box}$							0.55	100755	hout familial support
			ders				\Box									oregnancy in 12 months
														1000100000		(≥ 1 pack per day)
			ohol use											51.		
			seases			- 70								52.		
24.	Operation	ons/	accidents											53. 🗆		
25.	Allergies	s/me	ds sensi	tivity			NK	DA						Indicate	s pream	ancy/outcome at high risk
26.	Blood tr	ansf	usions .			<u> </u>								54. □ A	50 3000	- a
27.	Other ho	ospi	talization	s										F1 55 15 7 V 12 5 5 6 6		mellitus
28.			303000000000000000											56. □ H		
29.																disease (class III or IV)
30.	No know	vn d	isease/pr	oblem	s											enal disease
Mo	netrual	One	et	Cvc	lo.	\neg	Leng	th	Amo	unt	L	4-8-201	,			al/chromosomal anomalie
	tory		3 49		28		-	3 day:		, unit	M P	mo/day/yr	quality	60. □ H	emoglo	binopathies
Pre	gnancy	,		Grav			Pre		_	Live 2	E D	1-16-20	17	202011-02		nization (Rh.) or drug abuse
-	Month/		Weight	Wks	Hrs.		e of	~U A	Deta	ails of deliv	very: Inc	ude anesthesia		63. 🗆 H	abitual	abortions
S	year	Sex	at birth	gest	in labor		very		and n	naternal o	r newbo	n complications. where applicable	э.			ent cervix
1.	9-199	F	5/6/02	38		NS	M	Иm	16.	at p	וחות	lication		1555 / E. L. C.		l or neonatal death rologically damaged infan
	0	M					•	101	11					1.0000000000000000000000000000000000000		nt social problems
2.	8-11	γ'/	7/0/02	39		11/	SYD	wi	the	at C	ony	PLICATION	h	68.	,	
3.														69.		
4.		П												70.		
900		\vdash		-		_								370000000000000000000000000000000000000	ical Ri	sk Status
5.		Ш													/	actors noted
6.														72. 🗆 A		iciois noted
7.		\Box												73. 🗆 A		ck
-		H									-					
8.		1 1												Signatur	e Zu	en fiken RN

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

Prince, Diana Lynn	Cabbage County 1	Hospital
DOB 9/1/1995		
MR 09 09 99, 10032145	1	
4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	,	
Date: 6-70-201	Initial Pregnancy P	rofile
History Since LMP (/) Check and det	tail all positive findings below: Use reference numbers	15. Nutritional Assessment
STREET IN STREET	- // -	☐ Adequate ☐ Inadequate
Headaches Nausea/vomiting	·a()	
	enw	☐ Nutritional counseling
3. Abdominal pain		
4. Urinary complaints		Remarks:
5. Vaginal discharge		
6. Vaginal bleeding		
7. Edema (specify area)		
9. Rubella exposure		16. Medications Since LMP
10. Other viral exposure		□ None □ Exposure to drugs
11. Radiation exposure		
12		Describe:
13		
14. Contraception prior		
to conceptionNone □		
Type D. Novum 1/35		
Last usedmo/day/yr		
Initial Physical Examination Height 52	Weight 140 Pregravid 13.7 B.P. 29/12 Pulse 82	OPTIONAL
2		
17. Skin	tail all abnormal findings below: Use reference numbers.	
18. EENT		()
19. Mouth		1 .)(,
20. Neck 🗹 🗆		1 7 . 11 . 1
21. Chest		[()
22. Breast		
23. Heart		
24. Lungs		1 / ' \
25. Abdomen		1 /.
26. Musculoskeletal		
27. Extremities		
28. Neurologic		
Pelvic Examination		1 4
29. Ext. genitalia 🗖 🔲		
30. Vagina		-~~
31. Cervix		
		3mix / Im
32. Uterus (describe)		1) (
33. Adnexa		[(24)
34. Rectum 🗹 🗌		15 81
35. Other 🗆 🗆		
36. Diag. 37. Shape	38. S.S. 39. Ischial	1(-)
conj sacrum Bony 40. Pubic 41. Trans.	notch spines	
arch — outlet —	sag.diam 43. Coccyx	Exam mo/day/yr 6-10-201
Pelvis 44. Classification Gynecoid	☐ Android ☐ Anthropoid ☐ Platypelloid	done on in
45. Estimation	☐ Borderline ☐ Contracted	by: James Mercy

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

.......

Prince, Diana Lynn
DOB 9/1/1995
MR 09 09 99, 10032145
torical Risk Factors and Assessment
Jugares of the

Cabbage County Hospital

Prenatal Flow Record

TISTOR	cal Risk	Factors	and As	sessmen	t	M Haa	no knowr	n riek	Initial P Scre			Addition	nal Lab Fii	ndings	
11	lam	udin	(+)	hint	ory	_ ∭ Has ∐ Is "a		iion	Date: mo	o/day/yr	Test	Date	Result	Date	Result
		gan		, , w.		2 Is at	t high risk		Hct/Hgb	12/39	Hct/Hgb				
Continu	uing Ris	sk Assess At risk			vise RISK ST		sk factors		Patient's Blood type and Rh	A+	Blood sugar		111		
/		ne/cervical rect pelvis			/_ Dia	betes melliti pertension			Antibody	NR	Antibody				
1		egative (nor	nsensiti	zed)		ombophlebi	itis		Serology	NR					
		ia (Hct <30 real disease		<10%)	more and the same and the same	rpes (type 2) sensitization			Rubella titer	Inn					
1		pyeloneph				rine bleedin			Urinalysis		100	2	LIAN		
		e to gain w	-			dramnios	mnele		micro Pap		HFF	11	NNC	-	
		mal oreser erm pregna				vere preecla al growth re			test		HIV	9/0	reg		
	_ Alcoh	ol use				mature rupt			Cervical culture		HEPL	6/10	neg		
						ltiple pregna ohol and dru				choa	undia.	stat	115	nea	,
									¥ 4-/	8-20	16	Qu	ickening date	mo	/dy/yr
								, , ,	☐ Do herpe				ted Rej	ected by	patient
	Pt A O O	1 2 / Q 6 g 6 4	assure in a		od date date	near tale trade		STATUS 0.12	☐ Do anter ☐ For sterii ☐ Circumo ☐ Needs ru ☐ Breast	lization	E 0	OR rec xplained Candid	cords revie	o/day AC	-
isit dat	00	Pre gri	des like		ses desendant distributed to	Treat Intelligible		Baby's		lization ision ubella vaccin	E 0	OR rec xplained Candid	cords revie d onm date for VB	o/day AC ction	Return visit Siç
isit dat	00	digasi dioo	Jacob Hill	W/195 - 1 1/2 1	+	tage de la company	* / k		☐ For sterii ☐ Circumc ☐ Needs rt ☐ Breast physician	lization ision ubella vaccin □ Bottle feed	E Ging	OR rec xplained Candid For Ce	cords revied onm date for VB esarean se	o/day AC ction	
isit dat	00	200 BOD ST	July de	8/	+	restricted by the state of the	i k		☐ For sterii ☐ Circumc ☐ Needs rt ☐ Breast physician	lization ision ubella vaccin □ Bottle feed	E Ging	OR rec xplained Candid For Ce	cords revie d onm date for VB	o/day AC ction	
isit dat	00	digasi dioo	Jede dree	W/195 - 1 1/2 1		near disecularia	* *		☐ For sterii ☐ Circumc ☐ Needs rt ☐ Breast physician	lization ision ubella vaccin □ Bottle feed	E Ging	OR rec xplained Candid For Ce	cords revied onm date for VB esarean se	o/day AC ction	
risit dat	00	digasi dioo	Jage of the State of	8/	+	destruction of the state of the	1 2			lization ision ubella vaccin □ Bottle feed	E Ging	OR rec xplained Candid For Ce	cords revied onmdate for VB	o/day AC ction	
isit dat	00	Bay Acor	Jeda Jr. Letter Land Land Land Land Land Land Land Land	8/	+ +	description of the second	it it is		☐ For sterii ☐ Circumc ☐ Needs rt ☐ Breast physician	lization ision ubella vaccin □ Bottle feed	E Ging	OR rec xplained Candid For Ce	cords revied onm date for VB esarean se	o/day AC ction	
isit dat	00	Lang	A de de la companya d	8/	+ + + + +	the state of the s			☐ For sterii ☐ Circumc ☐ Needs rt ☐ Breast physician	lization ision ubella vaccin □ Bottle feed	E Ging	OR rec xplained Candid For Ce	cords revied onmdate for VB	o/day AC ction	
risit data o 16 / 10 / 10 / 1	00	R972	A STATE OF S	8/	+ + + + + +	telegraphic telegr			☐ For sterii ☐ Circumc ☐ Needs rt ☐ Breast physician	lization ision ubella vaccin □ Bottle feed	E Ging	OR rec xplained Candid For Ce	cords revied onmdate for VB	o/day AC ction	
/	00	2972 /	July State Control of the Control of	8/	+ + + + + + +	to the state of th			☐ For sterii ☐ Circumc ☐ Needs rt ☐ Breast physician	lization ision ubella vaccin □ Bottle feed	E Ging	OR rec xplained Candid For Ce	cords revied onmdate for VB	o/day AC ction	
(isit dat 0 16/0/10 1/10	00	Ra72 /	The state of the s	81	+ + + + + + +	to the state of th	U Z	Pata Will HIV For Retu PAY	physician Consideration Considerat	size parties p	eneral natal pestal	or recognized and control of the con	Cords revied on modate for VB sharean se	m RAD	
(isit dat 0 16/0/10 1/10	00	Ra72 /		81	+ + + + + + + +	the distribution of the di		Pata Will HIV For Retu PAY	physician Consideration Considerat	size parties p	eneral natal pestal	or recognized and control of the con	Cords revied on modate for VB sharean se	m RAD	
isit dal 0 16 / 10 / 10 / 10 / 10 / 10 / 10 / 10	00	R972 /	July July Line Line Line Line Line Line Line Line	8/ / / / / / /	+ + + + + + + +	tuber	U Z	Pata Will HIV For Retu PAY	physician Consideration Considerat	size parties p	eneral natal pestal	or recognized and control of the con	Cords revied on modate for VB sharean se	m RAD	
isit dal o l. o	00	Ra72 / / / / / /	The state of the s	81 1 1 1 1 1	+ + + + + + + + +	to the state of th	U Z	Pata Will HIV For Retu PAY	☐ For sterii ☐ Circumc ☐ Needs rt ☐ Breast physician	size parties p	eneral natal pestal	al all ton	Cords revied on modate for VB sharean se	m RN	visit Siç

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

OCAL FI	LE NO.			J.S. STANDARD CERTIFI						IRTH NUMBER	
CH	IL	_ D	 CHILD'S NAME (First, Middle, Last, Suffi 	x)			2. TIME OF I	BIRTH 24 hr)	3. SEX	4. DATE	OF BIRTH (Mo/Da
			5. FACILITY NAME (If not institution, give street	t and number)	6. CITY	TOWN, OR I	OCATION OF BI	RTH	7. CO	OUNTY OF BI	RTH
10	ТН	FD	8a. MOTHER'S CURRENT LEGAL NAME	First, Middle, Last, Suffix)		8b.	DATE OF BIRTH	(Mo/Day/	Yr)		
U	1 11	LK									
			8c. MOTHER'S NAME PRIOR TO FIRST N	ARRIAGE (First, Middle, Last, Suff	ix)	8d.	BIRTHPLACE (S	State, Terr	ritory, or F	Foreign Count	ry)
			9a. RESIDENCE OF MOTHER-STATE	9b. COUNTY		9	c. CITY, TOWN,	OR LOCA	ATION		
			9d. STREET AND NUMBER	3	1	9e. APT. NO	9f. ZIP CC	DE			9g. INSIDE CI LIMITS?
							ACT - 100 154 - 459				□ Yes □
Α	ТН	E R	10a. FATHER'S CURRENT LEGAL NAME	(First, Middle, Last, Suffix)	10b. DA	TE OF BIRTH	(Mo/Day/Yr)	10c. BIR	THPLAC	E (State, Territ	ory, or Foreign Cou
EF	RTIFI	ER	11. CERTIFIER'S NAME:			12. DATE	CERTIFIED		13. DA	ATE FILED BY	REGISTRAR
			TITLE: MD DO HOSPITAL AD	MIN. CNM/CM OTHER MI	DWIFE	MM	DD YYY	Υ	- N	MM DD	·
-	T 111		14. MOTHER'S MAILING ADDRESS: 9.5	INFORMATION FOR AD ame as residence, or: State:	MINISTRATIV	E USE	City, Town,	or Locatio	no:		
O	TH	ĿК	Street & Number:	arre as residence, ur. State.			Apartme				Zip Code:
		-	15. MOTHER MARRIED? (At birth, conception		□ Ye		SOCIAL SECU	JRITY NU			17. FACILITY ID
			IF NO, HAS PATERNITY ACKNOWLED		IOSPITAL? - Y		FOR CHILD?		es 🗆 N	0	
			18. MOTHER'S SOCIAL SECURITY NUMB					URITY N	OWREK:		
M O	THE	ER	MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)	21. MOTHER OF HISP/ the box that best de mother is Spanish/his 'No" box if mother i	ANIC ORIGIN? (scribes whether t lispanic/Latina. C s not Spanish/His	Check he heck the	22. MOTHE what the White Black of America	e mother or African can Indian	American or Alask	rs herself to b n a Native	
			Bth grade or less 9th - 12th grade, no diploma	□ Yes, Mexican, Mexi	ican American, C	hicana	(Name		rolled or	principal tribe)
			☐ High school graduate or GED	□ Yes, Puerto Rican			☐ Chines ☐ Filipino				
			completed	□ Yes, Cuban			□ Japane □ Korean	ise			
			Some college credit but no degree Associate degree (e.g., AA, AS)	☐ Yes, other Spanish.	/Hispanic/Latina		□ Vietnar	mese			
			Bachelor's degree (e.g., RA, AB, BS)	(Specify)		- 62	□ Other A □ Native				
			Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)				☐ Guama ☐ Samoa		hamorro		
			Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS,				Other (Pacific Isla	ander (Sp	ecify)	
			DVM, LLB, JD) 23. FATHER'S EDUCATION (Check the	24. FATHER OF HISPA	NIC ORIGIN2 (`hack	25 FATHE	R'S RACI	F /Check	one or more	races to indicate
- A	THE	E K	box that best describes the highest degree or level of school completed at the time of delivery)	the box that best de father is Spanish/His "No" box if father is	scribes whether t spanic/Latino. Cl	he neck the		e father o		himself to be	
		Ē.	□ 8th grade or less	□ No, not Spanish/His	spanic/Latino		□ Black	or African			
			□ 9th - 12th grade, no diploma	□ Yes, Mexican, Mexi	ican American, C	hicano	(Name			a Native principal tribe)
	pro		☐ High school graduate or GED	□ Yes, Puerto Rican			☐ Asian ☐ Chines				
	Record		completed	□ Yes, Cuban			□ Filipino	6			
	a R		Some college credit but no degree	☐ Yes, other Spanish	/Hispanic/Latino		☐ Japane ☐ Korean				
e	dic		Associate degree (e.g., AA, AS) Bachelor's degree (e.g., BA, AB, BS)	(Specify)		120	□ Vietnan □ Other A		ecify)		
ğ	Me		Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)				□ Native	Hawaiian			
S	r's						□ Guama □ Samoa	n			
Mother's Name	Mother's Medic No.		 Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD) 				□ Other F			ecify)	
<	2-	- 10	26. PLACE WHERE BIRTH OCCURRED (C	2)			1 2				OR MATERNAL ATIONS FOR
			Hospital Freestanding birthing center	NAME:		_ NPI:	-	DELIV	ERY?	Yes 🗆 No)
			□ Home Birth: Planned to deliver at home? □ Clinic/Doctor's office	9 Yes 9 No TITLE: OTHER (Sp		D OTHER	MIDWIFE			R NAME OF F D FROM:	ACILITY MOTHE

FIGURE 1-8 Manual Birth Certificate (continued)

REV. 11/2003

MOTHER	29a. DATE OF FIRST PRENATAL CARE VISIT		1 1		30. TOTAL NUM	TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANC		
	M M D D YYYY		MM	DD	YYYY	-		(If none, enter A0".)
	31. MOTHER'S HEIGHT (feet/inches)		EPREGNANCY (ounds)	WEIGHT 3	 MOTHER'S WEIGH (pound) 			GET WIC FOOD FOR HERSELF S PREGNANCY? Yes No
	35. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child)	PREGNANCY (spontaneous of losses or ectop	PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)		37. CIGARETTE SMOKING BEFORE AND DURIN For each time period, enter either the number number of packs of cigarettes smoked. IF NO		of cigarettes or the DNE, ENTER A0". PAYMENT FOR THIS DELIVERY	
	35a. Now Living 35b. Now Dead 36a. Other Outcor Number Number Number		ies	Average number of cigarettes or packs of cigarette # of cigarette Three Months Before Pregnancy First Three Months of Pregnancy			☐ Private Insurance☐ Medicaid☐ Self-pay	
	□ None	□ None		Second Three Months of Pregnancy Third Trimester of Pregnancy		OR OR	Other (Specify)	
	35c. DATE OF LAST LIVE BIRTH 36b. DATE OF LA PREGNANCY MM YYYYY			39. DATE LAST NORMAL MENSES BEGAN MM / D D / YYYY		40. MOTHER'S MEDICAL RECORD NUMBER 46. METHOD OF DELIVERY A. Was delivery with forceps attempted but unsuccessful?		
MEDICAL AND HEALTH INFORMATION	AND Diabetes Prepregnancy (Diagnosis prior to this pr Gestational (Diagnosis in this pregnal		des terine Precipitous yes, Induction or Augmental Non-vertex Steroids (2) Antibiotics Clinical chematernal Moderater (2) Prepipitous (3) Antibiotics Clinical chematernal Moderater (4) Precipitous (5) Charact (he above DF LABOR (Check all that apply) a Rupture of the Membranes (prolonged, ≥12 hrs.) Is Labor (<3 hrs.) Labor (≤20 hrs.) the above TERISTICS OF LABOR AND DELIVERY (Check all that apply) of labor tion of labor x presentation glucocorticoids) for fetal lung maturation by the mother prior to delivery received by the mother during labor orioamnionitis diagnosed during labor or temperature ≥38°C (100 4°F) heavy meconium staining of the aminiotic fluid rerance of labor such that one or more of the actions was taken: in-utero resuscitative s, further fetal assessment, or operative delivery r spinal anesthesia during labor or respinal anesthesia during labor spinal anesthesia during labor spinal anesthesia during labor r spinal anesthesia during labor			
			NEWBORN I					
NEWBORN				(Check all that apply)			CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply) Anencephaly Meningomyelocele/Spina bifida Cyanotic congenital heart disease Congenital diaphragmatic hernia	
	49. BIRTHWEIGHT (grams preferre	Assisted ventilation required immediately following delivery Co. 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 serious neurologic dysfunction Nigurity and or set fits a leffectif (reap hamperhane)			□ Me			
al Record	50. OBSTETRIC ESTIMATE OF GE				imphalocele astroschisis imb reduction defect (excluding congenital imputation and dwarfing syndromes) left Lip with or without Cleft Palate left Palate alone own Syndrome Kanyotype confirmed Kanyotype pending Suspected chromosomal disorder			
	51. APGAR SCORE: Score at 5 minutes: Score at 10 minutes:							
							PLURALITY - Single, Twin, Triple (Specify) Third, etc. (Specify)	ral Hy
	Mother's Name Mother's Medic No.				56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? 9 Yes 9 No 57. IS INFANT LIVING AT TIME OF REPORT? 58. IS THE INFANT BEING 159. INFANT TRANSFERRED 159.			

FIGURE 1-8 Manual Birth Certificate (continued)

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.