U.S. Department of Justice
Federal Bureau of Prisons

Program Statement

OPI: HSD/SAS
NUMBER: **P6090.01**
DATE: 1/15/2005
SUBJECT: Health Information Management

1. **PURPOSE AND SCOPE.** To ensure an accurate and complete health record and qualified health record practitioners are available for delivering health services. A quality health record system/health information management system is essential to provide all Health Services staff with an accurate understanding of a patient's:

- history,
- diagnosis, and
- mode of treatment.

2. **PROGRAM OBJECTIVES.** The expected results of this program are:

a. A health record which enables all health team members to document health encounters and events will be managed and maintained.

b. Critical patient information will be communicated among health care personnel through the health record.

c. Continuity of care will be maintained when inmates are transferred to other Bureau institutions.

3. **DIRECTIVES REFERENCED**

P1222.06	Forms Management (9/17/97)
P1240.05	Records and Information Management Programs (9/21/00)
P1351.05	Release of Information (9/19/02)
P5800.13	Inmate Systems Management Manual (6/28/02)
P6031.01	Patient Care (1/15/05)

4. **STANDARDS REFERENCED**

a. American Correctional Association (ACA) 4th Edition Standards for Adult Correctional Institutions: 4-4396, 4-4413, 4-4414, and 4-4415

b. American Correctional Association (ACA) 3rd Edition Standards for Adult Local Detention Facilities: 3-ALDF-4E-31, 3-ALDF-4E-46, 3-ALDF-4E-47, and 3-ALDF-4E-48

5. **HEALTH RECORD MANAGEMENT.** Each institution will designate one or more individuals, appropriately trained in medical record management, to manage the health record system. His or her responsibilities include, but need not be limited to:

a. Managing a separate and complete health record for each inmate in an organized, standardized health record format.

b. Maintaining the confidentiality, security, and integrity of all health records and health-related data.

c. Ensuring the availability and prompt accessibility of the health record to appropriate medical staff and staff psychologists at all times.

d. Participating in quality management/quality improvement activities and functions.

Each institution must provide sufficient space, equipment, and supplies to the Health Information Management (HIM) staff to enable them to meet their responsibilities efficiently.

Minimal equipment requirements are as follows:

- Photocopier,
- Facsimile machine,
- Personal computer,
- Copies of all applicable Health Services policies,
- Medical Dictionary, and
- Health Records Management Text (Edna Huffman, current edition).

6. **HEALTH RECORD DOCUMENTATION.** The health record is a compilation of data from many sources regarding the preventive, curative, and rehabilitative care and treatment of the inmate.

- The health record must be readily available, complete, current, and accurately reflect the inmate’s health status.

- The health record is protected by the Privacy Act of 1974 from the scrutiny of unauthorized individuals.

a. **Authentication.** Each component of the health record must be authenticated (signed or initialed and dated) by the health care provider.

- Health care providers will sign their name and credentials when documenting in the health record. A block stamp or printed name and credentials, will also be used indicating the provider's name and professional credentials.

- All health record entries will be legible.

- All health record entries will be made in black or dark blue ink.

- Military time (i.e., 0700, 1200, 1400, etc.) will be used for all entries in the health record.

- Only approved abbreviations (Attachment B) will be used in the health record.

b. **Correction of Errors.** Correction of errors in the health record will be made as follows:

- A neat line will be drawn through the incorrect information with an explanatory note (i.e., error, wrong chart); and

- The date of the correction and the person's initials will be added to the correct data.

c. **Late Entries.** A late entry will be documented by writing "late entry for (date/time)."

- The date and time of the entry will be the date and time the note is actually written.

7. **HEALTH RECORD ORGANIZATION.** The health record is a compilation of data from many sources regarding preventive, curative, and rehabilitative care and treatment of the inmate.

- The health record must be readily available, complete, current, and accurately reflect the inmate's health status.

- The health record is protected by the Privacy Act of 1974 from the scrutiny of unauthorized individuals.

a. **Registration Number.** An inmate identification number is assigned to each inmate and all records are filed permanently by that number regardless of the number of subsequent admissions. The inmate's full name and register number will be recorded on a label and affixed to the upper right reinforced margin of the folder or on the end above the color coded numbers.

Each page filed within the record must be clearly identified with the inmate's name and number as well as the institution's name. Forms requiring continued use from institution to institution will not be stamped or labeled with the institution's name. These forms include:

- Laboratory Backing Sheet (SF-514);
- Radiographic Backing Sheet (SF-519);
- Problem List (BP-620); and
- Immunization Record (BP-619).

b. **Organization of the Health Record.** The content and format of health records will be maintained uniformly.

(1) All outpatient health care records pertaining to a sentenced inmate will be filed in a yellow, six-part, hard back, press board jacket. The health records of un-sentenced prisoners, or holdovers, of less than 90 days duration will be maintained in a two-part folder.

(2) Psychology Services will maintain psychological raw data, testing, and screening interviews in a folder separate from the health record. Other Psychology reports provided by Psychology Services will be filed under the Psychology divider in Section 2.

(3) Health records from Bureau contract facilities or privately operated secure adult correctional facilities under Bureau contract will be incorporated within Bureau records in the appropriate sections.

c. **Health Record Format**

(1) **Section 1.** All similar forms (i.e., SF-600s, laboratory reports, x-ray reports, medication sheets) will be filed chronologically with the most current on top. Female specific laboratory and x-ray results (pap smear, mammogram,

pelvic, ultrasound, etc.) will be filed under the OB/GYN divider in Section 2. The following forms in Section 1 will not be separated by institution:

- Medical Summary of Federal Prisoner/Alien In Transit (BP-S659);
- SF-600 (most recent on top); and
- Medical Emergency Code Form (in chronological order with SF-600s).

Note: When a record is transferred with an inmate, a new SF-600 will be placed on top of the BP-S659 created for this particular inmate movement. Any BP-S659 created at an institution is to be filed beneath the current SF-600 (Examples: to and from court, admissions to local hospitals). Inmate pictures are to be placed in back of Section 1 on the inside of the folder. Wound and evidentiary photographs (outpatient) will be filed in Section 5 and inpatient photographs will be filed in Section 4.

(a) **Laboratory Divider.** All laboratory reports, regardless of size, will be filed chronologically with the most recent on top. If small lab sheets are used, they will be mounted on a backing sheet (SF-514).

(b) **X-Ray/Diagnostic Reports Divider.** All diagnostic imaging studies to include MRIs, CT Scans, and ultrasounds (excluding evaluations of female breasts, uterus and ovaries) are to be filed chronologically with the most recent on top. If half sheet x-ray forms are used, they will be mounted on a backing sheet (SF-519).

The forms listed below (similar forms together with most recent on top) will also be filed in the X-Ray/Diagnostic Divider:

- ECG's/EKG’s
- Stress Tests
- Holter Monitors
- EEGs
- EMGs
- NCVs
- Doppler Studies

Note: Any laboratory or x-ray report documented on a consultation form will be filed beneath "Laboratory" or "Radiology" divider.

(c) **Medication and Treatment Divider**

- Psychotropic Medication Consents (BP-689 through BP-698)
- Medication Administration Records (most recent on top)
- Tuberculosis Preventive Treatment Program monitoring form (optional)
- Monthly INH Side Effect Interview and Monitoring form (after completion of treatment)(BP-S652)
- Outdated chronic medication sheets

The forms listed below (similar forms together with most recent on top) will also be filed in the Medication and Treatment Divider:

- Physical Therapy
- Respiratory Therapy (includes PFTs)
- Speech and Language
- Activities
- Other Therapies

(2) **Section 2.** Forms are to be filed in the following sequence, top down:

- Patient Problem List (BP-S620)
- Chronic Medication/Summary Sheet (sheets that are outdated or from previous institutions will be moved to Section 1)
- Immunization Record (BP-S619)
- Tuberculosis Chemo-prophylaxis Record (BP-S636)
- Monthly INH Side Effect Interview and Monitoring form (BP-S652) (move to Section 1, Medications divider after completion of treatment)
- Flow Sheets/Graphics (Flow sheets may be developed at the local institution)
- HIV Chronic Care Flow Sheet (BP-S637)

(a) **History and Physical Divider**

- Report of Medical Examination or dictated history and physical (SF-88) (file all physicals with most recent on top)
- Anatomical Figure (SF-531) (optional)
- Medical History Report (BP-S360) (all history forms filed with most recent on top)

- Intake Screening (BP-S354) (forms filed with most recent on top)
- Outpatient Assessments (Pain, Nursing, AIMS (Abnormal Involuntary Movement Scale), Social Work, Addiction Research Foundation Clinical Institute Withdrawal Assessment-Alcohol (BP-S708), respirator fit testing, etc.)

(b) **Consultation Divider**

- Transfer Summary/Medical Summary
- Nursing Discharge Summary
- Consultation Sheet (SF-513) and documentation (i.e., letter provided as a result of a specialist's evaluation performed either in the institution or the local community).
- Optometry consultations
- Prescription eyeglass orders
- Audiology reports

(c) **Psychology Divider**

- Suicide Risk Assessment
- Other Psychology Reports

(d) **Outpatient Surgery Divider** (all forms related to a specific procedure will be filed together in the order listed)

- Report of Operation
- Anesthesia Reports
- Tissue/Pathology Report
- Authorization for Procedure
- Other related forms

(e) **OB/GYN Divider** (all female specific forms and reports related to evaluation of breasts, uterus, ovaries, etc.)

- Flow Sheets (GYN, prenatal, etc.)
- Consultations
- Diagnostic procedures (i.e., pap smears, mammograms, pelvic, OB ultrasound, cervical biopsy reports).

Note: Institutions are authorized to use OB/GYN forms consultant providers recommend.

(3) **Section 3 - Dental Section** (all forms are separated by institution except dental radiographs)

- All dental radiographs
- Dental Treatment Record (continuation)
- Clinical Dental Record (BP-S618.060)
- Health Questionnaire
- Consultation Form
- Consent Form for oral/maxillofacial surgery
- Other pertinent dental information records (i.e. Tissue Reports, Dental Laboratory Form (BP-S383) Inmate Property Record).

(4) **Section 4 - Inpatient/Death Records.** Autopsy Reports and Death Summaries for other than inpatients are to be filed at the top of this section.

Inpatient records from both institution and community facilities during an inmate's incarceration in Bureau custody will be filed in this section and separated by each admission to inpatient status. Dividers will be used to separate admissions with the most recent on top. Upon discharge from inpatient status, all medication consents will be filed in Section I and and treatment refusals will be filed in Section V.

Discharged Chart Order (Only for MRCs). Community inpatient stays do not have to be filed in the prescribed order.

- Cover Sheet
- Advance Directives (includes questionnaires)
- Death Pictures
- Wound and Evidentiary Photographs (inpatient)
- Autopsy Report (preliminary & final, if different)
- Death Certificate
- Summaries (transfer, discharge, forensic evaluations, pre-release review, amendments, updates, etc.)
- Consent to Admission (Mental Health)
- Treatment Plans and Reviews (excludes Nursing Care Plans)
- History & Physical (Initial Physical Assessment)
- Doctors Orders (includes all inpatient orders)
- Consultation Reports
- Assessments (psychological, psycho-social, social, education, religious, activity therapy, AIMS, vocational, all except nursing)
- Progress Notes

- Nursing Care Plan
- Nursing Notes
- Nursing Assessment
- Medication Consents
- Medication Administration Records
- Notification of Medication Hearings and Related Documents
- Graphics
- Flow Sheets
- Cardiac Arrest Records
- Operative Report
- Tissue Report
- Report of Anesthesia
- Consent for Surgery
- Evaluations - Pre and Post Anesthesia Records
- Lab Reports
- X-ray Reports
- Scans, EKG, monitors, stress test, EMG, tomogram, echos, nerve conduction, etc.
- Physical Therapy (PT)
- Occupational Therapy (OT)
- Respiratory Therapy (RT)
- Activity Therapy (AT)
- Speech Therapy (ST)
- Dialysis Records
- Other Therapy
- Refusal for Treatment
- Other Reports

(5) **Section 5**

- Medical Duty/Idle form (most recent on top)
- Inmate Injury Report (BP-362) (most recent on top)
- Medical Treatment Refusal (BP-358) (most recent on top)
- Wound and Evidentiary Photographs (outpatient)

(a) **Advance Directives Divider**

- Advance Directive

(b) **Civilian Records Divider** "non-Bureau records" (i.e. records from county jails, records prior to incarceration, copies of D.C. Dept. of Corrections records, etc.)

(6) **Section 6 - Administrative.** All records in this section are to be filed chronologically without a prescribed order of forms. Forms filed in this section include:

- HIV Counseling Documentation (BP-489)
- Inmate Request to Staff Member (BP-148)
- Institution Administrative Remedy Appeal (BP-229)(copy)
- Authorization for Release of Medical Information (BP-621)
- HIV Classification Form (optional)
- Vaccination Consents
- Nicotine Replacement Therapy Approval
- Nicotine Therapy Consent Form
- Photographic Consents
- General correspondence
- Legal Papers
- Other non-medical forms

8. **FORMS.** All forms used in the outpatient health record, except for outside consultant forms, will have the Chief Medical Record Administrator's prior approval to provide a systematic integrated record and eliminate unapproved forms being used in the health record. The Chief Medical Record Administrator, Central Office, Health Services Division, will receive all requests for proposed forms from the field.

- Revised or new forms will be submitted in final format to the Forms Manager, Information Management Office, Policy and Information Management, Central Office, for approval. Once approved, the form will be incorporated into the appropriate health record filing format.

- If the form(s) changes or affects any personnel policies, practices, or conditions of employment, the forms will be negotiated, as appropriate, in accordance with applicable laws, rules, regulations, and the Master Agreement.

In-patient forms at MRCs will be handled locally until further notice. Forms generated for ancillary services (PT, RT, social work, etc.) at MRCs that are also used in outpatient settings are also authorized to be handled locally. If any of the form(s) changes or affects any personnel policies, practices, or conditions of employment, the forms will be negotiated, as appropriate, in accordance with applicable laws, rules, regulations, and the Master Agreement.

Overprints on the SF-600 and SF-513 are authorized to assist with complete documentation to guide the health care providers.

Forms are obtained from the following sources:

a. **Bureau forms** are ordered in accordance with the Program Statement on Forms Management. Biannual form orders are coordinated through each institution's Business Office. Refer to the Program Statement on Forms Management.

b. **Standard forms** may be obtained from the General Services Administration (GSA) using the GSA Catalog available in the Business Office. Selected GSA forms are available on BOPDOCS and may be reproduced.

It will be the HSA's responsibility to ensure that adequate supplies of forms are maintained.

9. **LABELS.** The only labels, if applicable, that may be used either on the front cover or within the health record include the following:

a. "Allergic to:_____" (centered beneath **BOP Health Record** heading).

b. "Advance Directive on File" (centered below **BOP Health Record** and allergy label, if applicable).

c. **"Sensitive Limited Official Use"** (may be abbreviated to **LOU** - lower left corner on front cover).

d. **Multiple Volume Labels.** Multiple volumes of a health record will be marked with a white adhesive label located on the front of the health record in the right upper corner horizontal with label containing identifying information.

Example: Volume I of II.

e. **SOAP Label (BP-355).** This label is used for writing progress notes when the health record is not available (e.g., health care provider rounds in segregation). The notes are made in SOAP format on the self-adhesive label. The label is then attached as the next entry on the SF-600 in the health record.

f. Copies of medication labels provided by the pharmacy may be affixed to a backing sheet and used as a chronic medication summary sheet.

10. **ADVANCE DIRECTIVES.** Advance Directives are written instruments allowing individuals to express health care wishes when they become incapacitated (i.e., Living Will, Durable Power of Attorney).

- A copy of this declaration will be made part of the health record and must be easily accessible.

Anytime a patient with an Advance Directive is transferred to an outside health care facility, a copy of the Advance Directive will accompany the patient to inform the receiving facility of its existence.

11. **FEDERAL PRISONERS IN TRANSIT.** The complete health record, including all volumes, will be transferred with a designated inmate. The health records of inmates on writ or other temporary release will remain at the parent institution.

a. **Lost/Missing Records.** For inmates who arrive at designated institutions without their record or with portions missing, the following procedures will be followed:

(1) A SENTRY **Inmate History** transaction is performed at the receiving institution to determine each institution where the inmate was housed. A BOPNet GroupWise e-mail message will be sent to each institution which housed the inmate in-transit stating the inmate arrived without his or her record or portions of it.

(2) Each institution will search its files for the missing records; this includes checking with the institution Inmate Systems Manager. If the records cannot be located, an e-mail will be sent to the institution currently housing the inmate to report the search's negative results. Records that are located will be sent by Express Mail to the institution housing the inmate.

(3) If the Medical Record of Prisoner In-Transit form (BP-S659) is lost in transit, the first institution that subsequently receives the inmate will make a duplicate from the copy contained in the health record. This form will be clearly marked as a duplicate, stating why it is prepared and the date.

If the health record is also unavailable, contact will be made with the transferring institution to obtain the necessary information or a telefax of its file copy of the BP-S659, and prepare a duplicate marked as noted above.

If none of these sources are available, the institution currently housing the inmate in-transit will prepare a new BP-S659, appropriately marked as a secondary document, using any source of information available (interview of inmate, etc.).

b. **Medical Town Trips.** Generally, the record does not accompany the inmate during medical town trips. However, consultants may request to review the health record in lieu of copies. It is permissible to provide the consultant staff with the original record.

After the town trip is completed the health record will be returned to Health Services. Under no circumstances will inmates be allowed access to their health records while on escorted trips.

12. **SECONDARY RECORDS.** Institutions with inpatient facilities will maintain a secondary record system to include a diagnostic and operative index. All diagnoses, infections, complications, and operations for discharged patients will be recorded in standard terminology.

- The diagnoses and operations are coded using the current international classification system (ICD-9-CM).

13. **MORTALITY REVIEW.** The complete, original health record of a deceased inmate will be forwarded to the Health Services Administrator (HSA) to be included in a packet for the Office of Quality Management, Health Services Division, Central Office. If certain portions of the death file, such as the death certificate or final autopsy report are unavailable, they will be forwarded as soon as possible.

14. **HEALTH RECORD REVIEW.** Maintaining accurately documented and complete health records requires HIM and clinical staff to conduct regular health record reviews.

Health Services meetings will include a summary of the health record review findings to identify documentation errors. Training will be offered to Health Services staff to prevent these errors. For instance, if a review of health records shows that staff are not signing all entries, the requirement to sign all entries will be stressed.

a. **Monthly Review.** At least 15 records will be reviewed each month. The records to be reviewed will be selected from records pulled for sick call or scheduled appointments to cover all services provided. The Outpatient Health Record Audit Worksheets

(Attachment A) will be used, however, local modification may be made to meet the institution's needs and comply with JCAHO standards.

- Records will be reviewed, audit worksheets completed, results discussed, and worksheets kept for at least one year.

b. **Documentation.** If a record does not have an item (e.g., chief complaint, name, institution), then a "no" will be checked on the Health Record Audit Worksheet. One omission, such as a name missing on one page, would justify a "no" even if all other pages have the patient's name.

- Findings and corrective actions taken (if applicable) must be documented on the review sheets.

c. **Results.** Results from reviews will be summarized and reported to the appropriate committee meeting (i.e., Medical Record Committee, Health Services Staff Meeting) at least quarterly. The desired result from monitoring and staff education is an improvement in the quality of documentation.

15. **SIGNATURE AND INITIAL LOG.** A system will be maintained in the HSU containing the signature of individuals, including consultants, who make entries in the health record. This system will include the printed name and title/credentials along with the individual's signature and initials.

- **This is a permanent record and entries may never be obliterated or changed.**

16. **FILING SYSTEM.** The health record must be managed so that it is readily available to the medical staff at all times.

a. Outpatient health records are filed on open shelves. An appropriate charge-out system will be maintained when a record is removed from the shelf. The charge-out system will contain the following information:

- Inmate name and register number;
- The date the record is signed out; and
- The location and/or person signing the record out.

b. All outpatient health records are filed by inmate number according to the numeric Terminal Digit 2 filing system. The files will be divided into 100 sections (00 - 99). Within each section, the records are filed numerically by the digits preceding the terminal digit numbers.

(1) All institutions must use color coded numbers affixed to the right reinforced margin with the following standard colors:

0 Ames Red	1 Ames Gray	2 Ames Blue
3 Ames Orange	4 Ames Purple	5 Ames Black
6 Ames Yellow	7 Ames Brown	8 Ames Pink
9 Ames Green		

The size of the labels **must** be 1 7/8" x 1 7/8," large digit reverse block.

(2) **Only the last two digits** of the first five digits of the inmate registration number will be coded and placed on the record.

Example: Reg. No: 01234-567, the color coded numbers will be 34.

(3) The fifth digit will be placed at the immediate bottom of the tab on the side of the record holder. The fourth digit will be placed immediately above the fifth digit label.

c. All active records charged out must be returned by the end of the workday.

17. **RECORD RETENTION.** Health records are retained in their original form after the inmate's release from the Bureau. HIM staff will purge files routinely to remove inactive health records.

HIM staff will ensure health records of released inmates are transferred to Inmate Systems Management (ISM). ISM will maintain the consolidated inactive records until they are sent to the Regional Federal Records Storage Center. Refer to Program Statement, Inmate Systems Management Manual for schedule of retention.

18. **RELEASE OF MEDICAL INFORMATION.** Medical reports must be exchanged freely between Federal and non-Federal health care professionals and other organizations to contribute to a fuller understanding of the inmate's physical and mental status.

Except as required by law, any record that contains clinical, social, financial, or other data on a particular inmate will be treated in a strictly confidential manner and will be protected from loss, tampering, alteration, destruction, unauthorized duplication, and unauthorized or inadvertent disclosure of information.

Release of medical reports and information to a **routine user** requires a written request stating the reason for the information, however the inmate's consent is not required. Routine uses for physical and mental health records have been published in the Federal Register; 67 FR 11712 (5/14/02).

a. **Incarcerated Inmate Review of Health Record.** The following procedures apply to the release of health records to an inmate who is currently incarcerated in a Bureau institution:

An inmate seeking review and copies of his/her health records must complete an Inmate Request to Staff Member (BP-S418) in order to review or receive copies of the record. The BP-S148 will be addressed to the HSA or his/her designee.

(1) Prior to review of records by an inmate (or copies given to an inmate), health services staff will review the records to determine if a legitimate security concern exists (i.e. whether there is any information which, if disclosed to the inmate, might reasonably be expected to harm the inmate or another person). The reviewer may have to consult the institution physician in evaluating records for release.

(2) Currently incarcerated inmates may review their records, including laboratory results or other HIV-related information, but may not receive a copy. HIV-related health records may be forwarded to a third party of the inmate’s choosing outside the institution, provided that the inmate authorizes the disclosure in writing.

(3) The HSA/Designee will make the copies in a reasonable amount of time and give them to the inmate. An entry on the SF-600 will be made with the following information:

- Date of release;
- Number of copies;
- Items released (as an example, this can be accomplished by notations such as "SF-600 dates inclusive of 01-01-93 thru 03-06-94");
- Items withheld; and
- Signature.

The original BP-S148 will be filed in section 6 of the health record.

(4) If information is withheld from the inmate, he/she will be provided a copy of the SF-600 entry denying the release and advised that they may send an Freedom Of Information Act (FOIA) request for the withheld records to the:

Central Office, Office of General Counsel,
Freedom of Information (FOI) Section
320 First Street NW
Washington DC 20534.

(5) If the inmate makes an FOIA request, a copy of the records withheld and the SF-600 entry will be forwarded to the Regional Office. The Regional Counsel's Office will conduct a review of the document(s) which the institution has indicated on the SF-600 were not released.

Regional Counsel staff members, in coordination with the Regional Health Systems Administrator, if necessary, will determine whether the document(s) will be released to the inmate, or exempted from mandatory disclosure to the inmate under the provisions of the FOIA. Under all circumstances, the Regional Counsel's Office will make any direct release of records to the inmate and/or inform the inmate of the denial(s) and his/her appeal rights.

(6) A system will be maintained for tracking requests for releasing medical information including:

- Patient name and number;
- Requester name;
- Date requests received;
- Disposition of requests (date);
- Number of pages copied;
- Number of pages withheld; and
- Fee, if any.

(7) The Bureau has limited facilities to reproduce copies of x-ray, xerography, and ultrasonography films. Therefore, when copies are requested, the HSA/designee will acquire the current costs for reproduction from a community source. The requesting inmate will be financially responsible for these costs and will provide a mailing address for a physician he/she chooses to receive the films.

- Due to security and property restrictions, the films will not be allowed in inmate housing units.

b. **Inmates Released from Federal Custody or in Community Corrections Centers (CCCs).** The following procedures apply to the release of health records to an inmate who has been released from Federal custody or is currently housed in a CCC.

(1) If an inmate seeking copies of his/her health records sends his/her request directly to the institution, the request will be returned to the inmate with instructions to make a written request to the address in Section 17.a.(4). The inmate will be further instructed that he/she must provide a signature that is notarized or signed under penalty of perjury to establish his/her identity along with the written request for records.

(2) The Office of General Counsel's (OGC) FOIA/Privacy Act Section will log all proper inmate requests, as indicated above, to review and/or copy health records. Upon receiving such a request, staff members will determine that the inmate is currently housed in a CCC or released from Federal custody and where the inmate was last designated.

The request will then be forwarded to the appropriate Regional Office which will contact the institution where the inmate was last housed and coordinate the release of records to the inmate. When the Regional Office contacts the institution, the Regional Office will have determined from the requesting inmate what medical information he/she is seeking.

(3) A copy of laboratory results showing HIV status may be released to an inmate released from Federal custody. However, a copy of laboratory results or other health records showing HIV status will not be given to an inmate housed in a CCC; he/she will be orally advised of, and may review, the results while still housed in a Federal institution.

HIV-related health records may be forwarded to a third party the inmate chooses, provided the inmate authorizes the disclosure in writing.

(4) The HSA/Designee will make the copies and forward them to the Regional Office. The Regional Office will release the records directly to the inmate.

c. **Fees.** Under 28 CFR 16.11, an inmate may be charged $.10 per page for duplication. An inmate may never be charged for a review of his/her records. A charge for fees may not be levied if the total to be collected is $14.00 or less.

(1) The first 100 pages are free with no subsequent charge until a fee in excess of $14.00 is reached.

(a) Pages 1-240 = No charge.

(b) Pages 241-and above will be charged $.10 per page for each page after the first 100.

Example: 241 pages = 241-100 = 141 pages x $.10 = $14.10

335 pages = 335-100 = 235 pages x $.10 = $23.50

(2) Inmates will be informed of estimated fees. Fees will not be collected until copies have been made. Copies will not be provided to the inmate until associated fees are paid.

(3) Consult the institution's Financial Management Office regarding processing of fees. HIM staff will ensure that a Request for Withdrawal of Inmate's Personal Funds (BP-199) is completed. Payment will be made to the order of the U.S. Treasury.

d. **"Third Party" Requests.** The first party is the patient-inmate, the second party is the custodial agency holding the health records and providing care. All third party requests for medical information will be processed under direction of OGC's FOIA/Privacy Act Section in the Central Office. A dated authorization form that has been notarized or signed under penalty of perjury must accompany any request. The authorization is valid for three months from the date of patient's signature.

e. **Copying of Health Records.** The Bureau monitors the copying of health records because it is time consuming for the HIM staff and may not be relevant to the recipient. When a copy of a voluminous health record is requested, the requestor will be contacted to ask which specific portion of the health record is required.

f. **Obtaining Records From Outside Sources.** On occasion, the HSA/designee will have to request health records from hospitals and physicians of inmates formerly treated by them. When an inmate was treated elsewhere, such as a hospital, ambulatory surgical facility, nursing home, or physician's or consultant's office, clinical summaries or other pertinent documents are obtained when necessary for continuity of care.

Usually, a simple request for the health record giving the dates of hospitalization is sufficient. A request for health records will be accompanied by an authorization signed by the inmate giving permission for the health care record's release.

g. **Facsimile of Health Records.** The quality of healthcare is enhanced when patient clinical information is readily available to healthcare providers using a facsimile (fax) machine. When health record staff are transmitting a facsimile of the health record or health-related data, the following notice will appear on the cover sheet:

CONFIDENTIALITY NOTICE

> The documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.
>
> If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

/s/
Harley G. Lappin
Director

OUTPATIENT HEALTH RECORD AUDIT WORKSHEET
(TO BE COMPLETED BY HEALTH INFORMATION STAFF)

HEALTH RECORD NO.:_____ DATE:_____ REVIEWER:_____ INSTITUTION:_____	YES	NO	N/A	Provider Code# (if applicable)
A. IDENTIFYING INFORMATION ON ALL FORMS PER POLICY ? (name, reg. no., institution)				
B. CHART ORDER CORRECT FOR ALL SECTIONS ?				
C. ALLERGY LABEL ON FRONT OF RECORD (if applicable) ?				
D. ENTRIES ON SF-600 Dated				
Timed (Military)				
Legible				
SOAP Format				
Entries authenticated by signature (with credentials) and block stamp/printed				
Patient education documented				
Verbal/telephone orders authenticated within specified time frame				
E. REPORTS RECEIVED FROM OUTSIDE CONSULTATIONS AND HOSPITAL STAYS ?				
F. ALL REQUESTED STUDIES CHARTED AS ORDERED?				
G. H&P, TESTS AND CONSULTS INITIALED BY PRACTITIONER ?				
H. CHARTING ERRORS CORRECTED ACCORDING TO POLICY ?				
J. SMD ENTRIES (Review most recent entries for current institution) Present for all reportable encounters ?				
Time on encounter matches Sentry (if appropriate) ?				
Entered to Sentry within policy time frames per provider type ?				

Comments/discrepancies :

_____

_____

OUTPATIENT HEALTH RECORD AUDIT WORKSHEET
(TO BE COMPLETED BY CLINICIAN)

HEALTH RECORD NO.:_____ DATE:_____ REVIEWER:_____ INSTITUTION:_____	YES	NO	N/A	Provider Code # (if applicable)
A. Are the Chronological Notes sufficient to allow you to assume the care of the patient				
B. Are Consultations appropriate.				
C. History and Physical complete.				
D. Do entries sufficiently document the following for each encounter: S - Subjective				
O - Objective				
A - Assessment				
P - Plan				
Patient Education				
E. Problem List complete.				
F. SMD Entries - most appropriate code chosen				

Recommendation for improvement in documentation:_____

_____

_____

_____

_____

ABBREVIATION/SYMBOL LISTING

The following are medical abbreviations and symbols approved for use at Federal Bureau of Prisons facilities . It must be kept in mind that BOP health records travel with the inmate(s) to other institutions and could become involved in litigation. Abbreviations can sometimes be misinterpreted and may result in an error in patient care. For these reasons, the use of abbreviations is discouraged. Final diagnoses on discharge from an inpatient stay must be written in full, abbreviations can never be used.

ABBREVIATIONS	MEANINGS
a:	assessment
A&Ox3	alert and oriented to time, place and name/alert and fully oriented
ac	before meals
am, AM	morning
A2	aortic second sound
AA	Alcoholics Anonymous
AAA	abdominal aortic aneurysm
AAL	anterior axillary line
AAROM	active assistive range of motion
ab	abortion
abd*	abduction
abd*	abdomen
ABG	arterial blood gas
abn	abnormal
ABX	antibiotics
AC	acromioclavicular
ACBE	air contrast barium enema
ACE	angiotensin converting enzyme
ACH	adrenocorticotrophic hormone
ACL	anterior cruciate ligament
ACLS	advanced cardiac life support
acq	acquired
AD	right ear
ADA*	American Dietetic/Dental Association
ADA*	Americans with Disabilities Act
add*	adduction
ADD*	attention-deficit disorder
ADH	antidiuretic hormone
ADHD	attention-deficit hyperactivity disorder
ADL	activities of daily living

ad lib	as desired/at pleasure
adm	admission
Admin Seg	Administrative Segregation
admin	to be administered
AE	above elbow
AF, A-fib	atrial fibrillation
AFB	acid fast bacillus
AFO	ankle foot orthosis
AFP	alpha feto protein
AG ratio	albumin/globulin ratio/anion gap
AGN	acute glomerulonephritis
AI	aortic insufficiency
AICD	automatic inplanted cardiac defibrillator
AIDS	acquired immunodeficiency syndrome
AIMS	abnormal involuntary movement scale
AIP	acute intermittent porphyria
AJ	ankle jerk
AK	above knee
AKA	above knee amputation
ALL	acute lymphocytic leukemia
ALS	amyotrophic lateral sclerosis
ALT	alanine aminotransferase
AMA*	against medical advice
AMA*	American Medical Association
amb	ambulate
AMI	acute myocardial infarction
AML	acute myelogenous leukemia
AMML	acute myelomonocytic leukemia
amp	ampule
amt	amount
ANA	antinuclear antibody
ANS	automomic nervous system
ant	anterior
AOD	arterial occlusive disease
AODM	adult onset diabetes mellitus
A&O	admission and orientation
AP*	antepartum
A&P	auscultation and percussion

AP*	apical pulse
AP*	ankle pumping
AP*	anterior-posterior
appt	appointment
appy	appendectomy
approx	approximately
ARC	AIDS related complex
ARD	acute respiratory distress
ARDS	adult respiratory distress syndrome
ARF	acute renal failure
ARNP	Advanced Registered Nurse Practitioner
AROM	active range of motion
art	artery, arterial
AS*	left ear
AS*	aortic stenosis
ASA	aspirin
ASAP	as soon as possible
ASCVD	arteriosclerotic cardiovascular disease
ASD	atrial septal defect
ASHD	arteriosclerotic heart disease
ASIS	anterior superior iliac spine
ASPD	antisocial personality disorder
asst	assistance
ASO	arteriosclerosis obliterans
AST	aspartate aminotransferase
ATFL	anterior talofibular ligament
AU	each ear
AV	atrioventricular
A-V	arteriovenous
AVF	arteriovenous fistula
AVN	avascular necrosis
AVSS	afebrile, vital signs stable
ax	axillary
Ba	barium
BAD,(D)(M)	bipolar affective disorder, (depressed)(manic)
BAEP	brainstem auditory evoked potential
BAER	brainstem auditory evoked response
Band	banded neutrophil

B&B	bowel and bladder
BBB	bundle branch block
BCC	basal cell carcinoma
BCP	birth control pill
BDI	Beck Depression Inventory
BE	barium enema
bid	two times a day
bil	bilateral
BK	below knee
BKA	below knee amputation
biw	twice weekly
BLS	basic life support
BM	bowel movement
BMI*	body mass index
BMI*	basal metabolic index
BMR	basal metabolic rate
BMT	bone marrow transplant
BO	body odor
BOP	Bureau of Prisons
BOW	bag of water
BP	blood pressure
BPD	borderline personality disorder
BPH	benign prostatic hypertrophy
BPRS	brief personality rating scale
BR	bed rest
BRP	bathroom privileges
BS*	bowel sounds
BS*	breath sounds
BS*	blood sugar
BSA	body surface area
BSE	breast self examination
BSO	by surgical opening
BTB	bone-tendon-bone (graft)
BUN	blood urea nitrogen
BUS	Bartholin-Urethra-Skenes
BTL	bilateral tubal ligation
Bx	biopsy
C&S	culture and sensitivity

Ca	cancer
Ca++	calcium
C/C/E	cyanosis/clubbing/edema
C/S	cesarean section
c/o	complains of
CABG	coronary artery bypass graft
CAD	coronary artery disease
CAH	chronic acute hepatitis
CALD	chronic active liver disease
CAPD	continuous ambulatory peritoneal dialysis
C1, C2, C3, etc.	cervical vertebrae or nerves by number
CI, CII, CIII, etc.	cranial nerves by number
cal	calorie
cap	capsule
CAT	computerized axial tomography
cath	catheter, catheterize
CBC	complete blood count
CBS	chronic brain syndrome
CCC	chronic care clinic
C-collar	cervical collar
CCPD	continuous cycling peritoneal dialysis
CCU	coronary care unit
CDC	Centers for Disease Control
CDH	congenital dislocation of hip
CEA	carcino-embryonic antigen
CF	cystic fibrosis
CFL	calcaneofibular ligament
CHB	complete heart block
CHD*	coronary heart disease
CHD*	congenital heart disease
chem	chemistry
chemo	chemotherapy
CHF	congestive heart failure
chol	cholesterol
chr	chronic
CIN	cervical intraepithelial neoplasia
CIS	carcinoma in situ
Cl	chloride

cl liqs	clear liquids
CLD	chronic liver disease
CLL	chronic lymphocytic leukemia
cm	centimeter
cm2	square centimeters
CMC	carpometacarpal
CML	chronic myelogenous leukemia
CMRI	cardiac magnetic resonance imaging
CMV	cytomegalovirus
CN	cranial nerves
CNS	central nervous system
CO*	cardiac output
CO*	carbon monoxide
CO2	carbon dioxide
COLD	chronic obstructive lung disease
comp	complication
conc	concentration
cond	condition
cont	continue
COPD	chronic obstructive pulmonary disease
COT, TC	content of thought
cp*	chest pain
CP*	cerebral palsy
CPAP	continuous positive airway pressure
CPB	cardiopulmonary bypass
CPK	creatine phosphokinase
CPM	continuous passive motion
CPR	cardiopulmonary resuscitation
CrCl	creatinine clearance
crea	creatinine
creps	crepitant rales
CRF, CRI	chronic renal failure (insufficiency)
CRTT	Certified Respiratory Therapy Technician
CSF	cerebrospinal fluid
C-spine	cervical spine
CT scan	computerized tomography scan
CTA	clear to auscultation
CTDB	cough, turn, deep breathe
CTLSO	cervical-thoracic-lumbar-sacral orthosis

CTRS	Certified Therapeutic Recreation Specialist
CTS	carpal tunnel syndrome
CV	cardiovascular
CVA*	cerebrovascular accident
CVA*	costovertebral angle
CVD*	cardiovascular disease
CVD*	cerebrovascular disease
CVL	central venous line
CVM	clean voided midstream (urine)
CVP	central venous pressure
c/w	consistent with
CW	crutch walking
CWMS	color, warmth, movement, sensation
CWNWB	crutch walking non weight-bearing
CWTWB	crutch walking touch weight-bearing
CWPWB	crutch walking partial weight-bearing
CWWBAT, TT	crutch walking weight-bearing as tolerated, to tolerance
Cx	cervical
CXR	chest x-ray
cysto	cystoscopy
DAT*	Dementia Alzheimers Type
DAT*	diet as tolerated
D/C	discontinue
D&C	dilation and curettage
DDX	differential diagnosis
decub	decubitus
def	deficient/deficiency
dep	dependent
DF	dorsiflexion
DI	diabetes insipidus
DIC	disseminated intravascular coagulation
DID	Dissociative Identity Disorder
DIP	distal interphalangeal
disp*	disposition
disp*	dispense
DJD	degenerative joint disease
DKA	diabetic ketoacidosis
DM (I)(II)	diabetes mellitus(Type I)(Type II)

DME	durable medical equipment
DNA	deoxyribonucleic acid
DNI	do not intubate
DNKA	did not keep appointment
DNR	do not resuscitate
DNS	did not show
D&O	Diagnostic and Observation
DO	doctor of osteopathy
DOA	dead on arrival
DOB	date of birth
DOE	dyspnea on exertion
DOI	date of injury
Dr	doctor
Ds	disease
DSD	dry sterile dressing
Dsg	dressing
D-spine	dorsal spine
DTR	deep tendon reflex
dt*	diptheria-tetanus
DT*	delirium tremens
DU	duodenal ulcer
DUB	dysfunctional uterine bleeding
DVT	deep vein thrombosis
Dx	diagnosis
Dz	disease
EBL	estimated blood loss
EBV	Epstein-Barr virus
ECCE	extracapsular cataract extraction
ECF/U	extended care facility/unit
ECG	electrocardiogram
ECHO	echocardiogram
ECT	electroconvulsive therapy
ED	emergency department
EDC	estimated date of confinement
EEG	electoencephalogram
EENT	ear,eye, nose, and throat
EES	Eythromycin
EGA	estimated gestational age

EGD	esophagogastroduodenoscopy
EKG	electrocardiogram
EMG	electomyelogram
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
ENG	electronystagmogram
ENT	ear, nose, and throat
EOM	extraocular movement
Epis	episiotomy
EPS*	extrapyradmidal symptoms/signs
EPS*	electrophysiologic study
EPSE	extrapyradmidal side effects
ER	emergency room
ERCP	endoscopic retrograde cholangiopancreatography
ERG	electroreinogram
ERT	estrogen replacement therapy
ESR	erythrocyte sedimentation rate
ESRD	end stage renal disease
EST	electroshock therapy
ESWL	extracorporeal shockwave lithotripsy
et*	and
ET*	endotracheal tube
ETOH	alcohol
EVR	evoked visual response
Ex	examination
exc	excise, excision
exp	exploratory
ext*	external
ext*	extremity
EXU	excretory urogram
F*	Fahrenheit
F*	female
FAE	fetal alcohol effects
FAS	fetal alcohol syndrome
FB	foreign body
FBR	foreign body removal
FBS	fasting blood sugar
Fe	iron

FEV	forced expiratory volume
FFP	fresh frozen plasma
FH	family history
FHR	fetal heart rate
FHT	fetal heart tone
fl	fluid
flex	flexion
fluoro	fluoroscopy
FNA	fine needle aspiration
FOB	foot of bed
FOT, TF	flow of thought
FROM	full range of motion
FSBS	fingerstick blood sugar
FTD	formal thought disorder
FTN	finger to nose
FTND	full term normal delivery
FTSG	full thickness skin graft
FTT	failure to thrive
f/u, FU	follow up
FUO	fever of unknown origin
FVC	forced vital capacity
FWB	full weight bearing
Fx	fracture
G*	gallop
g*	gram
GA	gastric analysis
GAF	global assessment of functioning
gav	gavage
GB	gallbladder
GC	gonorrhea
GDM	gestational diabetes mellitus
GERD	gastroesophageal reflux disease
GFR	glomerular filtration rate
GGT	gamma glutamyl transferase
GGTP	gamma-glutamyl transpeptidase
GI	gastrointestinal
gm	gram
GP	general population
Gr	grain

grav	# of pregnancies
GSR	galvanic skin response
gsw	gunshot wound
gt	drop/drops
GTT	glucose tolerance test
GU	genitourinary
GXT	graded exercise test
gyn	gynecology
H*	heart
H*	hour
H2O	water
H2O2	hydrogen peroxide
HA	headache
HAA	hepatitis associated antigen
HaAb	hepatitis A antibody
HaAg	hepatitis A antigen
HAT	hemagllutination test
HaV	hepatitis A virus
HbA1C	hemoglobin A1C
HbAb	hepatitis B antibody
HbAg	hepatitis B antigen
HbcAb	hepatitis B core antibody
HBO	hyperbaric oxygen
HBP	high blood pressure
HbsAb	hepatitis B surface antibody
HbsAg	hepatitis B surface antigen
HbV	hepatitis B virus
HCG	Human Chorionic Gonadatropin
HCM	hypertrophic cardiomyopathy
HCV	hepatitis C virus
HCVD	hypertensive cardiovascular disease
HDL	high density lipoprotein
HEENT	head, eyes, ears, nose, and throat
Hep B	hepatitis B
Hep C	hepatitis C
Hgb	hemoglobin
HGH	human growth hormone
HIV	human immunodeficiency virus

HJR	hepatojugular reflux
HNP	herniated nucleus pulposus
h/o	history of
HOB	head of bed
HOH	hard of hearing
HORF	high output renal failure
HP/H&P	history and physical
HPI	history of present illness
HPV	human papilloma virus
HR	heart rate
HRT	hormone replacement therapy
HS	bedtime, hour of sleep
HSV/HSV-1/HSV-2	herpes simplex virus/type 1/type 2
ht	height
HTN	hypertension
Hx	history
I&D	incision and drainage
I&O	intake and output
IA	intra-arterial
IABC	intra-aortic balloon counterpulsation
IABP	intra-aortic balloon pump
IBS	irritable bowel syndrome
IBW	ideal body weight
ICF	intermediate care facility
ICH*	intracranial hemorrhage
ICH*	intracerebral hemorrhage
ICP	intracranial pressure
ICS	intercostal space
ICT	intermittent cervical traction
ICU	intensive care unit
ID	infectious disease
IDA	iron deficiency anemia
IDC	institution disciplinary committee
IDDM	insulin dependent diabetes mellitus
IDH	ischemic heart disease
IgG	immunoglobulin G
IHSS	idiopathic hypertrophic subaortic stenosis
I/J	insight & judgement

IM*	internal medicine
IM*	intramuscular
inc	incision
inf	inferior
inj	injection
INR	international normalized ratio
INS	Immigration and Naturalization Service
int	internal
IOL	intraocular lens
IOP	intraocular pressure
IP	interphalangeal
IPD	intermittent peritoneal dialysis
IPPB	intermittent positive pressure breathing
IPT	intermittent pelvic traction
IQ	intelligence quotient
IS	incentive spirometry
IT	intrathecal
ITP	idiopathic thrombocytopenic purpura
IUD	intrauterine device
IV	intravenous
IVCD	intraventricular conduction delay
IVDA	intravenous drug abuse
IVF	IV fluids
IVH	intraventricular hemorrhage
IVP	intravenous pyelogram
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
JODM	juvenile onset diabetes mellitus
JVD	jugular venous distention
JVP	jugular venous pressure
K	kilo
K+	potassium
Kcal	kilocalorie
kg	kilogram
KJ	knee jerk
KO	keep open
KOR	keep open rate
KUB	kidneys, ureters, bladder
KVO	keep vein open

l*	liter
L*	left
L&W	living and well
LA	left atrium
lab	laboratory
lac	laceration
LAD	left anterior descending
LAFB	left anterior fascicular block
lap	laparoscopy/laparoscopic
lat	lateral
LAVH	laparoscopic assisted vaginal hysterectomy
LB	leg bag
LBBB	left bundle branch block
LBP	lower back pain
lbs	pounds
LCL	lateral collateral ligament
LDH	lactic dehydrogenase
LE	lower extremity
LEEP	loop electrocautery excision procedure
LFA	left forearm
LFT	liver function test
LGA	large for gestational age
LHF	left heart failure
lido	lidocaine
liq	liquid
LKS	liver, kidneys, spleen
LLC	long leg cast
LLE	left lower extremity
LLL	left lower lobe
LLQ	left lower quadrant
LLSB	left lower sternal border
LMN	lower motor neuron
LMP	last menstrual period
LN	lymph node
LOC	loss of consciousness
LOF	loss of function
LOM	limitation of movement
LOS	length of stay

LP	lumbar puncture
LPM	liters per minute
LPN	Licensed Practical Nurse
LR	lactated ringer solution
LRA	least restrictive alternative
LRE	least restrictive environment
L/S*	logical and sequential
L-S*	lumbosacral
LSB	left sternal border
LTC	long term care
LTG	long term goal(s)
LUE	left upper extremity
LUL	left upper lobe
LUQ	left upper quadrant
LV	left ventricle
LVA	left ventricular aneurysm
LVH	left ventricular hypertrophy
lymphs	lymphocytes
lytes	electrolytes
M*	male
M*	murmur
M1	mitral first sound
M2	mitral second sound
MAOI	monoamine oxidase inhibitor
MAP	mean arterial pressure
MBC	maximal breathing capacity
MBD	minimal brain dysfunction
MC	metacarpal
mcg	microgram
MCL*	medial collateral ligament
MCL*	midclavicular line
MCP	metacarpophalangeal
MCV	mean corpuscular volume
MD*	muscular dystrophy
MD*	Medical Doctor
MD*	manic depression
MD*	myocardial disease
MDD	major depressive disorder
mec	meconium

med/surg	medical/surgical
meds	medications
mEq	millequivalent
mets	metastasis
MH	mental health
MI*	mitral insufficiency
MI*	mental illness
MI*	myocardial infarction
MIC	minimum inhibitory concentration
min*	minimum
min*	minute
mix	mixture
MJ	marijuana
ML*	midline
ml*	milliliter
mm	millimeter
MMPI	Minnesota Multiphasic Personality Inventory
MMR	measles, mumps, rubella
MOM	milk of magnesua
mono*	mononucleosis
mono*	monocyte
MPD	multiple personality disorder
MR*	mental retardation
MR*	mitral regurgitation
MRA	magnetic resonance angiography
MRG	murmurs, rubs, gallops
MRI	magnetic resonance imaging
MRSA	methicillin resistant staph aureus
MS*	mitral stenosis
MS*	multiple sclerosis
M/S	medical/surgical
MSE	mental status examination
MSL	mean sleep latency
MSLT	multiple sleep latency testing
MSR	muscle stretch reflex
MTP	metatarsophalangeal
MVA	motor vehicle accident
MVR	mitral valve regurgitation

N/V	nausea and vomiting
Na	sodium
NA	not applicable
NAD	no apparent distress
NCPR	no cardiopulmonary resuscitation
NEC	necrotizing enterocolitis
NED	no evidence of disease
neg	negative
neuro	neurological
NG	nasogastric
NGT	nasogastric tube
NGU	nongonoccoccal urethritis
NIDDM	non-insulin dependent diabetes mellitus
NKA	no known allergies
NKDA	no known drug allergies
nl	normal
NMS	neuroleptic malignant syndrome
noc	night
nos	not otherwise specified
NP	Nurse Practitioner
NP-CPAP	nasopharyngeal continuous positive airway pressure
NPH	normal pressure hydrocephalus
NPO	nothing by mouth
NS	normal saline
NSAID	nonsteroidal anti-inflammatory drug
NSR	normal sinus rhythm
NSS	normal saline solution
NST	nonstress test
NSVB	normal spontaneous vaginal bleeding
NSVD	normal spontaneous vaginal delivery
NT	nasotracheal
NTG	nitroglycerin
NWB	no weight bearing
o:	objective
O&P	ova and parasites
O2	oxygen
OA	osteoarthritis
OAG	open angle glaucoma

OB	obstetrics
OB/GYN	obstetrics and gynecology
OBS	organic brain syndrome
OC	occipital circumference
OCD	obsessive compulsive disorder
OCG	oral cholecystogram
OCP	oral contraceptive pill
OD	right eye
oint	ointment
OM	otitis media
OMF	oromaxillofacial
OMT	osteopathic manipulation therapy
OOB	out of bed
Op	operation/operative
OPD	outpatient department
OPV	oral polio virus vaccine
OR	operating room
ORIF	open reduction internal fixation
oris	mouth
ortho	orthopedics
OS	left eye
OSA	obstructive sleep apnea
OSM	osmolality
OT	occupational therapy
OTC	over the counter
OTD	organ tolerance dose
OU	each eye, both eyes
OV	office visit
oz	ounce
p:*	plan
P*	pulse
P&A	percussion and auscultation
P&PD	percussion and postural drainage
PEEP	positive end expiratory pressure
P2	pulmonic second sound
PA-C	Physician Assistant- Certified
PA*	Physician Assistant
PA*	posteroanterior

PAC	premature atrial contraction
PACU	post anesthesia care unit
Pap*	papanicolaou test
PAP*	pulmonary artery pressure
par	parenteral
PAT	paroxysmal atrial tachycardia
path	pathology
pc	after meals
PCA	patient controlled analgesia
PCG	phonocardiogram
PCL	posterior cruciate ligament
PCP	pneumocystic carini pneumonia
PCR	polymerase chain reaction
PD	personality disorder
PE*	physical examination
PE*	pulmonary embolism
PEG	percutaneous endoscopic gastrostomy
PEN	parenteral and enteral nutrition
PERLA	pupils equal, react to light and accommodation
PET	positron-emission tomography
PF	plantarflexion
PFSHx/PFSH	past, family, and social history
pH	potential of hydrogen
PI	present illness
PICC	peripherally inserted central catheter
PID	pelvic inflammatory disease
PIP	proximal interphalangeal joint
PKU	phenylketonuria
plt	platelet
pm	after noon
PME	post mortem exam or autopsy
PMHx/PMH	past medical history
PMI	point of maximum intensity
PMS	premenstrual syndrome
PND	paroxysmal nocturnal dyspnea
PNS	peripheral nervous system
PO	by mouth
POD	post operative day

POR	problem oriented record
pos	positive
pp*	postprandial
PP*	post partum
PP*	placenta previa
PPD	purified protein derivitive (TB skin test)
PPH	postpartum hemorrhage
PPM	permanent pacemaker
PPT	partial prothrombin time
PR*	per rectum
PR*	pulse rate
PR*	per return
PRBC	packed red blood cells
prn	as needed
PROM*	passive range of motion
PROM*	premature rupture of membranes
prox	proximal
PSA	prostate specific antigen
PSG	polysonogram
PSVT	Paroxysmal Supraventricular Tachycardia
PT*	physical therapy
pt*	patient
PTA	prior to admission
PTB	pulmonary tuberculosis
PTCA	percutaneous transluminal coronary angioplasty
PTH	parathyroid hormone
PTHC	percutaneous transhepatic cholangiography
PTSD	posttraumatic stress disorder
PTT	partial thromboplastin time
PTU	Propylthiouracil
PUD	peptic ulcer disease
PVC	premature ventricular contractions
PWB	partial weight-bearing
px	prognosis
q	every
qd	once daily
qid	four times a day
QNS	quantity not sufficient

QS	quantity sufficient
R*	rub
R*	respirations
R*	right
RA*	right atrium
RA*	rheumatoid arthritis
rad	radiation absorbed dose
RAIU	radioactive iodine uptake
RAO	right anterior oblique
RAFB	right anterior fascicular block
RBBB	right bundle branch block
RBC	red blood cell
RBOW	ruptured bag of water
RCD	relative cardiac dullness
RCT	rotator cuff tear
R&D	Receiving and Discharge
RDS	respiratory distress syndrome
REM	rapid eye movement
rep, reps	repititon, repititons
resp	respiration/respiratory
rev	revision
RF	right flank
Rh	Rhesus
RHD	rheumatic heart disease
RHF	right heart failure
RHIA	Registered Health Information Administrator
RHIT	Registered Health Information Technician
RIA	radioimmunoassay
RLE	right lower extremity
RLL	right lower lobe
RLO	right lateral oblique
RLQ	right lower quadrant
RN	Registered Nurse
RNA	ribonucleic acid
r/o	rule out
ROM*	range of motion
ROM*	rupture of membranes
ROS	review of systems

RPO	right posterior oblique
RPR	rapid plasma reagin
RR*	respiratory rate
RR*	recovery room
RRE	round, reactive, equal
RRR	regular rate and rhythm
RRRsM	regular rate and rhythm without murmur
RSS	rapid strep screen
RSV	respiratory syncytial virus
RT	Respiratory Therapist
RTC	return to clinic
RTW	return to work
RTX	radiation therapy
RU	roentgen units
RUE	right upper extremity
RUL	right upper lobe
RUQ	right upper quadrant
RV	right ventricle
RVF	right ventricular failure
RVH	right ventricular hypertrophy
Rx	prescription
Rxn	reaction
s:	subjective
S1	1st heart sound
S2	2nd heart sound
SACH	sloid ankly cushion heel
SAD	seasonal affective disorder
SAH	subarachnoid hemorrhage
SB	sinus bradycardia
SBE*	self breast exam
SBE*	subacute bacterial endocarditis
SBFT	small bowel follow through
SBO	small bowel obstruction
SC	sternoclavicular
SCD	sickle cell disease
SCDT	schizophrenia, chronic, disorganized type
SCI	spinal cord injury
SCPT	schizophrenia, chronic, paranoid type

SCT	static cervical traction
SCUT	schizophrenia, chronic, undifferentiate type
sed rate	sedimentation rate
Seg	segregation
SEM	systolic ejection murmur
sg*	specific gravity
SG*	Swan-Ganz
SGA	small for gestational age
SHU	special housing unit
SHX	social history
SIADH	syndrome of inappropriate secretion of antidiuretic hormone
SI/HI/H's	suicidal ideation/homicidal ideation/ hallucinations
(A,O,V,T)H	(auditory, olfactory, visual, tactile) hallucinations
SIRS	Structured Interview of Reported Symptoms
sl, s/l	sublingual
SLC	short leg cast
SLE	systemic lupus erythematosus
SLR	straight leg raising
sm	small
SMI	sustained maximum inspiration
SNS	sympathetic nervous system
SOB	shortness of breath
sol	solution
S/P	status post
SPECT	single photon emmision computerized tomography
SPEP	serum protein electolysis
SPT	static pelvic traction
SQ	subcutaneous
SROM	spontaneous rupture of membranes
SSE	soap suds enema
SSEP	somato sensory evoked potentials
SSRI	specific serotonin reuptake inhibitor
SSS	sick sinus syndrome
ST	sinus tachycardia
staph	staphylococcus
stat	immediately
STD	sexually transmitted disease
STG	short term goal(s)

strep	streptococcus
STS	serologic test for syphillis
STSB	split thickness skin graft
SVC	superior vena cava
SVCS	superior vena cava syndrome
SVD	spontaneous vaginal delivery
SVT	supra-ventricular tachycardia
Sx	symptom
Sz	seizure
T	temperature
T1, T2	thoracic nerves or vertebrae by number
T&A	tonsils and adenoids
T&C	type and crossmatch
TID	three times daily
tab	tablet
TAH	total abdominal hysterectomy
TB	tuberculosis
TBA	to be arranged
TBI	total body irradiation
TBSA	total body surface area
TC	throat culture
TCDB	turn, cough, deep breathe
TD	tardive dyskinesia
temp	temperature
TENS	transcutaneous electrical nerve stimulation
TFM	transverse friction massage
TFT	thyroid function test
THA	total hip arthroplasty
THR	total hip replacement
TI	tricuspid insufficiency
TIA	transient ischemic attack
TKA	total knee arthroplasty
TM	tympanic membrane
TMJ	temporomandibular joint
TO	telephone order
toxo	toxoplasma
TP	total protein
TPN	total parenteral nutrition

TPR	temperature, pulse, respirations
TRUSP	transrectal ultrasound of prostate
TSD	Tay-Sachs disease
TSE	testicular self examination
TSH	thyroid-stimulating hormone
T-spine	thoracic spine
TSS	toxic shock syndrome
TTWB	toe touch weight-bearing
TUEVP	transurethral electrovaporization of prostate
TULIP	transurethral laser induced prostectomy
TURP	transurethral resection of prostate
TWB	touch weight-bearing
TWE	tap water enema
Tx*	traction
Tx*	treatment
UA	urinalysis
UCC	urine culture and colony count
UCG	urinary gonadotropin
UCHD	usual childhood diseases
UE	upper extremity
UFS	uroflowmetry, urine flow studies
UGI	upper gastrointestinal
UGIS	upper GI series
UMN	upper motor neuron
ung	ointment
URI	upper respiratory infection
US	ultrasound
UTI	urinary tract infection
UV	ultraviolet
V fib	ventricular fibrillation
V tach	ventricular tachycardia
VA	visual acuity
VBAC	vaginal birth after cesarean
VC*	vena cava
VC*	vital capacity
VD	veneral disease
VDH	valvular disease of the heart
VDRL	veneral disease research laboratories

VEA	ventricular ectopic activity
VEP	visual evoked potential
VF*	visual field
VF*	ventricular fibrillation
vit	vitamin
VL	viral load
VO	verbal order
VP	voiding pressure
VPC	ventricular premature contraction
vs*	versus
VS*	vital signs
VSS	vital signs stable
VSD	ventricular septal defect
VT	ventricular tachycardia
WB	whole blood
WBAT	weight-bearing as tolerated
WBC	white blood count
WC	wheelchair
W/cm2	watts per square centimeter
WD*	well developed
W-D*	wet to dry
WFL	within functional limits
WN	well nourished
WNL	within normal limits
WPW	Wolff-Parkinson-White
wt	weight
w/u	workup
YBOCS	Yale-Brown Obsessive-Compulsive Scale
y/o	year old
yr	year
x	times
XRT	radiation therapy
SYMBOLS	MEANINGS
#	number
@	at
0	no information, none
∆	change
↑	increase/high

↓	decrease/low
♂	male
♀	female
1°	primary or first degree
2°	secondary or second degree
3°	third degree
c	with
s̄	without
p	after
−	negative
+	positive
>	greater than
<	less than

* denotes multiple meanings for the same abbreviation

DO NOT USE ABBREVIATIONS/SYMBOLS

The following abbreviations and dose expressions are most often associated with misinterpretation and patient harm as reported to the Institute for Safe Medication Practices and should not be used in the health record.

Abbreviation/ Dose Expression	Intended Meaning	Misinterpretation	Correction
Apothecary symbols	**dram** **minim**	**Misunderstood or misread (symbol for dram misread for "3" and minim misread as "mL")**	**Use the metric system.**
μg	**microgram**	**Mistaken for "mg" when handwritten.**	**Use "mcg."**
o.d. or OD	**once daily**	**Misinterpreted as "right eye" (OD—oculus dexter) and administration of oral medications in the eye**	**Use "daily."**
TIW or tiw	**three times a week.**	**Mistaken as "three times a day."**	**Don't use this abbreviation.**
per os	**orally**	**The "os" can be mistaken for left eye**	**Use "PO," "by mouth," or "orally."**
qn	**nightly or at bedtime**	**Misinterpreted as "qh" (every hour).**	**Use "nightly."**
qhs	**nightly at bedtime**	**Misread as every hour.**	**Use "nightly."**
q6PM, etc.	**every evening at 6 PM**	**Misread as every six hours.**	**Use 6 PM "nightly."**
q.o.d. or QOD	**every other day**	**Misinterpreted as "q.d." (daily)or "q.i.d. (four times daily) if the "o" is poorly written.**	**Use "every other day."**
sub q	**subcutaneous**	**The "q" has been mistaken for "every" (e.g., one heparin dose ordered "sub q 2 hours before surgery" misunderstood as every 2 hours before surgery).**	**Use "subcut." or write "subcutaneous."**
SC	**subcutaneous**	**Mistaken for SL (sublingual).**	**Use "subcut." or write "subcutaneous."**
U or u	**unit**	**Read as a zero (0) or a four (4),causing a 10?fold overdose or greater (4U seen as "40" or 4u seen as 44").**	**"Unit" has no acceptable abbreviation. Use "unit."**
IU	**international unit**	**Misread as IV (intravenous).**	**Use "units."**

cc	**cubic centimeters**	**Misread as "U" (units).**	**Use "mL."**
x3d	**for three days**	**Mistaken for "three doses."**	**Use "for three days."**
BT	**bedtime**	**Mistaken as "BID" (twice daily).**	**Use "hs."**
ss	**sliding scale (insulin) or ½ (apothecary)**	**Mistaken for "55."**	**Spell out "sliding scale."Use "one-half" or use "½."**
/ (slash mark)	**separates two doses or indicates "per"**	**Misunderstood as the number 1 ("25 unit/10 units" read as "110" units.**	**Do not use a slash mark to separate do Use "per." ses.**
Zero after decimal point (1.0)	**1 mg**	**Misread as 10 mg if the decimal point is not seen.**	**Do not use terminal zeros for doses expressed in whole numbers.**
No zero before decimal dose (.5 mg)	**0.5 mg**	**Misread as 5 mg.**	**Always use zero before a decimal when the dose is less than a whole unit.**