U.S. Department of Justice
Federal Bureau of Prisons

P R O G R A M S T A T E M E N T
OPI HSD/HSB
NUMBER 6090.04
DATE March 2, 2015

Health Information Management

/s/
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1. PURPOSE AND SCOPE

To provide guidelines and procedures for health information management in support of the Bureau's mission; ensure the health record contains the information needed to justify the inmate's care, treatment, and services; and provide continuity of care among providers.

a. Summary of Changes

Policy Rescinded
P6090.03 Health Information Management (7/31/12)

This reissuance incorporates the following modifications:

- Signature log no longer required.
- Medical Referral Centers will have a credentialed health information professional on staff or contract those services (see Section 2.a.).
- Each facility will have a copy of the most recent version of the International Classification of Diseases, Clinical Modification (see Section 2.b.).
- Description of the Bureau's system of records is referenced in Section 2.c.
- Applicability of the Health Insurance Portability and Accountability Act (HIPAA) is described in Section 4.
- Copies of applicable inmate health records (in lieu of originals) will be taken on escorted medical trips (see Section 5.b.).

- Institutions will have an Institution Supplement regarding interruptions to information processes (see Section 6.).
- Facilities will use only approved abbreviations in Appendix C.
- Health record entries will be timely (see Section 7.d.).
- Procedure for correction of electronic health records is described in Section 7.e.2.
- Definition of co-signature and review is provided in Section 7.f.1 and 2.
- All staff-generated forms filed in the record will be in English (see Section 8.a.).

b**. Program Objectives**. Expected results of this program are:

- To provide ease of access and availability of information to appropriate health care staff for persons in the custody of the Bureau.
- To provide for the maintenance and release of records concerning the medical, mental, and dental health of persons in the Bureau's custody.

c. **Institution Supplement Required.** Implementation of this Program Statement requires development of an Institution Supplement specifying procedures to manage interruptions to information processes. Institution Supplement requirements are in Section 6.

2. HEALTH INFORMATION MANAGEMENT

Each institution will designate one or more individuals, appropriately trained in processing and maintaining health information, to manage the health record system. These designated staff will be allowed two hours per quarter for BEMR training. New staff will be trained in these processes during Introduction to Correctional Techniques and will not receive BEMR access until this training is complete. Responsibilities include, but need not be limited to:

- Managing a separate and complete health record for each inmate in an organized, standardized health record format. Scanning and/or filing results and other required documentation in medical records and assembling patient charts in the required ordering sequence.
- Maintaining the confidentiality, security, and integrity of all health records and health-related data.
- Ensuring the availability and prompt accessibility of the health record to appropriate Health Services and Psychology Services staff at all times.
- Participating in quality management/quality improvement activities and functions. This includes monthly chart audits.
- Scheduling appointments for patients with other medical services.

a. **Medical Referral Centers.** Medical Referral Centers will have a credentialed health information manager on staff or have quarterly audits by a credentialed health information

manager. Acceptable credentials are to be current through the American Health Information Management Association (Registered Health Information Technician or Registered Health Information Administrator) or the Health Information and Management Systems Society (Certified Professional in Health Information Management Systems).

b. **Minimal Equipment Requirements.** Each institution must provide sufficient space, equipment, and supplies to Health Information Management (HIM) staff to enable them to meet their responsibilities efficiently:

- Photocopier.
- Facsimile machine.
- Desktop computer connected to the LAN with SENTRY access.
- Scanner with TWAIN driver.
- Copy of the most recent version of the International Classifications of Diseases, Clinical Modification.
- Copies of all applicable Health Services policies.
- Medical dictionary.

c. **System of Records**. The Privacy Act of 1974, 5 U.S.C. § 552a, requires the Bureau to give public notice of the systems of records by publication in the *Federal Register*. 28 CFR part 16 §51336 specifies, "(a) No Bureau component may contract for the operation of a record system by or on behalf of the Bureau without the express written approval of the Director or the Director's designee."

Effective January 1, 2009, all available processes within the electronic health record (EHR) are required for use when documenting patient care, treatment, and services. Records prior to January 1, 2009, may be documented on paper and filed in a yellow, six-part BOP health record folder. Contracts with privately managed secure facilities will specify if they are to use the Bureau's EHR or the former paper-based records system (see Appendix A).

Medical Referral Centers will maintain a secondary health data index, to include a diagnostic and operative index. The diagnoses and operations will be coded using the current International Classification of Diseases, Clinical Modification (ICD-9-CM or ICD-10-CM). The ICD-9-CM [ICD-10-CM] Official Guidelines for Coding and Reporting will be used for proper code selection. The index will be maintained (or reviewed quarterly) by a certified professional in health information. The index will be forwarded to the Chief, Health Information, quarterly.

(1) **Filing System for Authorized Paper Records**. The health record must be managed so it is readily available to medical staff at all times.

Records are filed on open shelves 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.

An appropriate charge-out system will be maintained when a record is removed from the shelf. The charge-out system will contain:

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

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

(2) **Labels.** All authorized paper health record folders must use color-coded numbers affixed to the right reinforced margin with the following standard Ames® filing colors:

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

- The size of the labels must be 1 7/8" x 1 7/8" large digit reverse block.
- Only the last two digits of the first five digits of the register number will be color coded and placed on the record. For example, register number 12345-678 would have color labels for 45.
- 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.

The only additional labels (when necessary) that may be used either on the front cover or within the health record include:

- "Allergic to:…" centered beneath BOP Health Record heading.
- "Advance Directives On File" centered beneath BOP Health Record and allergy label (if applicable).
- "Sensitive But Not Classified" on the lower left corner on front cover.
- Multiple volume labels 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 the label containing identifying information (i.e., Volume I of II).

3. 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/or copies of his/her health records must complete an Inmate Request to Staff (BP-A0148) in order to review or receive copies of the record. The BP-A0148 will be addressed to the HSA or his/her designee.

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.

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.

The HSA/Designee will make the copies in a reasonable amount of time and give them to the inmate. An administrative note in the EHR or paper chart 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.
- Signature.

The original BP-A0148 will be filed in section 6 of the paper health record or EHR document manager.

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

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

If the inmate makes a FOIA request, a copy of the records withheld and the administrative note will be forwarded to the Regional Office. The Regional Counsel's Office will conduct a review of the document(s) that the institution has indicated on the administrative note were not released.

Regional Counsel staff, 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.

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.
- Fee, if any.

The Bureau has limited facilities to reproduce copies of x-ray, xerography, and ultrasonography films. Therefore, when copies are requested, the HSA/designee will estimate 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 Residential Reentry Centers (RRCs)**. 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 RRC.

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 3.a. 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.

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 RRC 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.

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 RRC; 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.

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.

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

Pages 1-240 = No charge.
Pages 241 and above = 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

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.

Consult the institution's Trust Fund Manager regarding processing of fees.

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. Requests from the Social Security Administration (SSA) will not be forwarded to the OGC's FOIA section. SSA requests will be processed at the institution level.

e. **Copying of Health Records**. The Bureau monitors the copying of health records because it is time-consuming for 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 HIM 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.

4. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

While the Bureau is not a HIPAA covered entity, most community-based healthcare providers with which the bureau contracts are HIPAA covered entities. However, 45 CFR § 164.512, *Uses and disclosures for which an authorization or opportunity to agree or object is not required*, permits those contracted providers to disclose protected health information without the written authorization of the inmate when the disclosure is for a specialized government function. Section 164.512(k)(5) specifically provides:

> A covered entity may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual protected health information about such inmate or individual, if the correctional institution or such law enforcement official represents that such protected health information is necessary for
>
> (A) The provision of health care to such individuals.

Therefore, an inmate does not need to sign a release of information form or otherwise give consent in order for Bureau health services staff to obtain copies of his/her medical records.

5. TRANSFER AND DISPOSITION OF RECORDS

a. **Federal Prisoners In Transit**. An exit summary will be generated and hard copy sent with the inmate upon any transfer. Any paper health record, including all volumes, will be transferred with the designated inmate. The health records of inmates on writ or other temporary release will remain at the parent institution. When inmates transfer to a privately operated secure adult correctional facility under Bureau contract where the EHR is not available, a printed copy of the previous year's records will be made and sent with the inmate.

b. **Escorted Medical Trips**. The paper record does not accompany the inmate during escorted medical trips. Copies of applicable records may be made and/or a medical record in transit form generated. These records will be placed in a sealed envelope and transferred with the inmate. The institution will have a procedure ensuring that upon completion of the escorted medical trip, records given to the escorting staff by the healthcare facility will be sent to the Health Services department. Note: from PATIENT CARE: Section 18. Replaced use of BP-A0659 (Medical Summary of Federal Prisoner/Alien In Transit) with EMR Exit Summary for Inmate Intra-system Transfer.

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

A SENTRY inmate history transaction is performed at the receiving institution to determine each institution where the inmate was housed. An e-mail message will be sent to each institution that housed the inmate in transit stating the inmate arrived without his/her record or portions of it.

Each notified institution will search its files for the missing records. This includes checking with the institution Case Management Coordinator. 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.

d. **Retention and Disposition of Records**

(1) **Paper Records**. Paper health records are retained in original form after the inmate is released from the Bureau. HIM staff will ensure health records of released inmates are transferred to the Correctional Systems (CS) Department. The CS Department will maintain consolidated inactive records until they are sent to the regional Federal Records Center. Refer to the Program Statement **Correctional Systems Manual** for a schedule of retention.

(2) **Electronic Records**. Electronic health records are maintained by Central Office Information Systems until they are archived in accordance with the Bureau's policy.

6. **MANAGEMENT OF INTERRUPTIONS TO INFORMATION PROCESSES**

Regardless of whether a facility uses a paper-based system or electronic, a plan to address the process for information continuity should be in place. The goal of the information continuity process is to return the Health Services unit to normal operations as soon as possible with minimal downtime and no data loss. The Health Services Administrator (HSA) and Clinical Director (CD), in consultation with their Associate Warden (AW) and Captain, will create an Institution Supplement that includes: the various types of interruptions and disasters that might impair the operation of the facility; scheduled and unscheduled interruptions of electronic health information systems; and a list of the Health Services Department's core information processes (providing access to records and the ability to document urgent and chronic care, medication administration, etc.). The Institution Supplement will be tested annually in conjunction with an institution mock drill (Article 3 may apply).

Please see Appendix B for Institution Supplement template.

7. **DOCUMENTATION GUIDELINES**

The health record will contain information needed to: support the inmate's diagnosis and condition; justify and document the course and result of care, treatment, and services; and provide continuity of care among providers.

a. **General Guidelines**

- All health record entries will be legible.

- Paper record entries will be made in blue or black ink.
- Military time (0700, 1200, 1400, etc.) will be used for all entries in the health record.

b. **Abbreviations**. Abbreviations are generally to be avoided. Standard abbreviations are listed in Appendix C.

c. **Authentication**

- Electronically generated health records will automatically record provider name and credentials, ensure legibility, and assign the date and time to entries.
- In paper records, health care providers will sign their name and credentials and use a block stamp or printed name and credentials.
- Only authorized individuals make entries in the record.
- Staff members will document in the electronic health record when logged in under their own account. At no time will staff allow others to document under or otherwise use their EHR account.
- Staff will personally document care, treatment, and services that they provide. When dictation is approved in advance by the Chief of Health Information, documentation may be transcribed for signature of the care provider. These requests will be made via annual exception to policy memorandum to the Health Services Division.

d. **Timeliness of Entries**. To ensure integrity of the record, documentation of patient encounters and treatments will be completed as soon after the event as possible. Documentation is expected to be completed no later than the end of the shift. When this is not possible, the documentation will be labeled as "LATE ENTRY" with a brief explanation of the delay following. Documentation of on-call contacts will be co-signed or documented on the staff member's next business day. At no time will late entries exceed 30 days after the encounter. After 30 days, an administrative note can be made to add information regarding an encounter.

e. **Correction of Errors and Amendments**

(1) **Correction of Errors in Paper Records**. A neat line will be drawn through the incorrect information with an explanatory note (i.e. error, wrong chart). The date of the correction and the person's initials will be added to the corrected documentation.

(2) **Electronic Records**. When available, the amendment process will be used to correct mistakes in documentation in the electronic record (left versus right, missing documentation of a body system, etc.). When amending a note, the provider will state the reason for the amendment.

Entry error should generally be reserved for instances where staff documented on the wrong patient/in the wrong record.

f. **Co-signatures and Review**

(1) **Co-signature**. Co-signing documentation is the act of a licensed independent provider validating and taking responsibility for the content and orders he/she gave to those authorized to accept orders. When errors are found, the cosignatory should write a subsequent note simply correcting the order or clarifying the information in a professional manner.

(2) **Review**. Signing as a reviewer of a document should be limited to instances where the reviewer precepts a student or new employee; or provider review of scanned documentation (i.e., scanned consultation or laboratory report). It implies the reviewer's responsibility for the content of the document. It is not to be used to only to notify someone about the existence of the documentation.

8. **FORMS**

a. Form Language. All official forms filed in the record will be in English. Form versions available on Sallyport in other languages will be for reference only.

b. **Outpatient Forms**. All forms used in the outpatient record (with the exception of outside consultant forms) will have Health Services Division, Chief of Health Information, approval to provide a systematic, integrated record and eliminate unapproved forms from being used in health record. The Chief of Health Information will receive all requests for revised or new forms from the field. Forms will be submitted in final format to the Forms Manager, Policy and Information Management Branch. Once approved, the form will be incorporated into the appropriate health record filing format.

c. **Inpatient Forms**. Inpatient forms at Medical Referral Centers will be handled locally. See Appendix D for the discharged chart order. Forms generated for ancillary services (physical therapy, radiation therapy, social work, etc.) at Medical Referral Centers that are also used in outpatient settings are authorized to be handled locally. Copies of any new and updated Medical Referral Center forms will be sent to the Chief of Health Information for informational purposes.

d. **Availability**. Bureau forms are available on Sallyport.

9. ADVANCE DIRECTIVES

An advance directive is "a written document, such as a living will that states the patient's preferences for care. It also can be in the form of a durable power of attorney for healthcare in which the patient names another person to make medical decision on his or her behalf in the event he or she is incapacitated" (LaTour and Eichenwald-Maki 2006). Laws governing advanced directives are state-specific. There is no standard Bureau advance directive form. Advance directives are state-driven.

Ordinarily, an inmate will initiate and provide the advance directive to HIM staff to file/scan into the record. The HSA will be responsible for providing the form if the inmate cannot obtain the form on his/her own. An alert will be placed on the EHR notifying staff of the document's existence.

Advanced directives may be changed or rescinded. Health Services staff must ensure when an inmate updates or rescinds an advanced directive, this information is filed in the document manager and the alert updated or removed.

Any time an inmate with an advance directive is admitted to an outside healthcare facility, a copy of the advance directive will accompany the patient to inform the receiving facility of its existence.

10. HEALTH RECORD REVIEW

a. **General**. 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 issues which need to be corrected.

b. Monthly Review. Each facility will review at least 15 records each month. The records to be reviewed will be selected to cover all services provided. The outpatient health record audit worksheet (Appendix E) may be used; however, local modification may be made to meet the institution's needs and comply with Joint Commission standards. Records will be reviewed, audit worksheet completed, results discussed, and worksheet kept for at least one year.

11. AGENCY ACA ACCREDITATION PROVISIONS

- Standards for Adult Correctional Institutions, 4th Edition: 4-4396M, 4-4413, 4-4414, and 4-4415

- Performance-Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-4D-13M, 4-ALDF-4D-14M, 4-ALDF-4D-26, and 4-ALDF-4D-27, and 4-ALDF-4D-28

REFERENCES

Program Statements

1222.06 Forms Management (9/17/1997)
1240.05 Records and Information Management Programs (9/21/2000)
1351.05 Release of Information (9/19/2002)
5800.14 Correctional Systems Manual (1/1/2009)
6031.04 Patient Care (6/3/2014)

Other References

Department of Health and Human Services (n.d.). **Classification of Diseases, Functioning, and Disability**. Retrieved from Centers for Disease Control and Prevention: www.cdc.gov

"Inmate Physical and Mental Health Record System, JUSTICE/BOP – 007," 67 *Federal Register* 51 (15 March 2002), pp. 11712 - 11714.

The Joint Commission (2011). **Standards for Ambulatory Care**. Oakbrook Terrace, IL: Joint Commission Resources.

LaTour, Kathleen M., and Shirley Eichenwald-Maki (2006). **Health Information Management: Concepts, Principles, and Practice**. Chicago: American Health Information Management Association.

U.S. Office of Personnel Management (2001). Job Family Position Classification for Assistance with Technical Work in the Medical, Hospital, Dental, and Public Health Group, GS—0600.

Records Retention

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.

Appendix A. Paper-Based Health Record Organization Used at Privately Operated Secure Adult Correctional Facilities under Bureau Contract Where the EHR Is Not Available

1. Registration Number. The register number is a unique inmate identification number assigned to each inmate. The number is loaded into SENTRY with other inmate data. Health records are maintained permanently by the register 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 of 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. The electronic record automatically marks the records with the patient's name, register number, and institution where the inmate was when the record was generated. Forms that require continuing use from institution to institution will not be stamped or labeled with the institution's name. These include:

- Laboratory Backing Sheet (SF-514).
- Radiographic Backing Sheet (SF-519).
- Patient Problem List (BP-A0620).
- Immunization Record (BP-A0619).

2. Organization of the Health Record. The content and format of health records will be maintained uniformly. Paper-based records are managed as follows until manual documentation is replaced by an electronic process, or the record is archived upon the inmate's release. All outpatient healthcare records pertaining to a sentenced inmate will be filed in a yellow, six-part, hardback, press sport jacket. The health records of unsentenced prisoners, holdovers of less than 90 days duration, will be maintained in a two-part folder.

3. Health Record Format

a. 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 the 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-A0659).
- SF-600 (most recent on top).
- 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 that BP-A0659 created for this particular inmate movement. Any BP-A0659 created at an institution is to be filed beneath the current SF-600 (examples: to and from court, admissions to local hospitals). In the 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.

ii. **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).

iii**. X-Ray/Diagnostic Reports Divider.** All diagnostic imaging studies, including MRIs, CT scans, and ultrasounds (excluding evaluation of female breasts, uterus, and ovaries) are to be filed chronologically with the most recent on top. It's 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/EKG's.
- Stress Tests.
- Holter Monitors.
- EEGs.
- EMGs.
- NCVs.
- Doppler Studies.

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

b. Medication and Treatment Divider

- Psychotropic Medication Consents (BP-A0689 through BP-A0698).
- Medication Administration Records (most recent on top).
- Tuberculosis Preventative Treatment Program monitoring form (optional).
- Monthly INH Side Effect Interview and Monitoring form (after completion of treatment) (BP-A0652).
- 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 PFT's).
- Speech and Language.
- Activities.
- Other Therapies.

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

- Patient Problem List (BP-A0620).
- Chronic Medication/Summary Sheet (sheets that are outdated or from previous institutions will be moved to section 1).
- Immunization Record (BP-A0619).
- Tuberculosis Chemoprophylaxis Record (BP-A0636).
- Monthly INH Side Effect Interview and Monitoring form (BP-A0652). Move to section 1, medication's divider after completion of treatment.
- Flow sheets/Graphics.
- HIV Chronic Care Flowsheet (BP-A0637).

a. History and Physical Divider

- Reported Medical Examination or dictated history and physical (SF-88). File all physicals with the most recent on top.
- Anatomical Figure (SF-531) (optional).
- Health Intake Assessment/History (BP-A0360). All history forms filed with most recent on top.
- Intake Screening (Medical)(BP-A0354). Forms filed with most recent on top.
- Outpatient Assessments (Pain, Nursing, Abnormal Involuntary Movement Scale, Social Work, Addiction Research Foundation Clinical Institute Withdrawal Assessment − Alcohol (BP-A0708), 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 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 breast, uterus, ovaries, etc.

- Flowsheets **(**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 that consultant providers recommend.

5. **Section 3 − Dental Section**. All forms are separated by institution except dental radiographs.

- All Dental Radiographs.
- Dental Treatment Record.
- Clinical Dental Records (BP-A0618).
- Health Questionnaire.
- Consultation Form.
- Consent Form for Oral/Maxillofacial Surgery.
- Other pertinent dental information records (i.e., tissue reports, dental laboratory form, inmate property record).

6. **Section 4 − Inpatient and Death Records**. Autopsy reports and got summaries for other than indications are to be filed at the top of the section.

Inpatient records from the institution and community facilities during the inmate's incarceration in Bureau custody will be filed in the 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 1 and treatment refusals will be filed in section 5.

7. **Section 5.** Forms will be filed with the most recent on top.

- Medical Duty/Idle Form.
- Inmate Injury Assessment and Follow-Up (Medical)(BP-A0362).
- Medical Treatment Refusal.
- Wound and Evidentiary Photographs (outpatient).

a. Advanced Directives Divider. Advance Directive.

b. Civilian Records Divider. "Non-Bureau" records (records from county jails, records prior to incarceration, copies of D.C. Department of Corrections records, etc.).

c. 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-A0489).
- Inmate Request to Staff Member (BP-A0148).
- Institution Administrative Remedy Appeal Copies (BP-229).
- Authorization for Release of Medical Information (BP-A0621).
- HIV Classifications (BP-A0638)(optional).
- Vaccine Consent – Inmates (BP-A0808).
- Nicotine Replacement Therapy Approval.
- Nicotine Therapy Consent Form.
- Photographic Consents.
- General Correspondence.
- Legal Papers.
- Other Non-Medical Forms.

Appendix B.

FEDERAL CORRECTIONAL INSTITUTION _____
HEALTH SERVICES POLICY AND PROCEDURE
SUBJECT: Health Information Continuity and Disaster Recovery
APPROVED BY:
Date: _____
_____, Health Systems Administrator

Purpose:

Should the health information department experience a disaster, the following plan will be implemented to protect health information from further damage, minimize disruption, ensure stability, and provide for orderly recovery of lost data and records. The plan will be tested annually. Documentation of testing will be maintained by the Health Services Administrator or designee. This policy supplements and supports institution correctional contingency plans.

Threats that might occur in the health information department include but are not limited to: fire, water damage, inmate riot and destruction of government property, and computer server crash or network failure. In the event of any of these disasters, the department must be able to make an orderly inventory of records and data. A systematic approach to recovery of lost data and records must be followed. Finally, the department must continue to function in support of the medical staff.

Procedure:

I. **Physical Damage to Paper Records** (from fire, water damage, inmate riot, or natural disaster).

A. The Safety and Correctional departments will notify the Health Systems Administrator after the immediate threat or emergency has been resolved and the Health Information department has been deemed safe for staff.

B. A Health Information Technician will print a current SENTRY roster of inmates at the institution. If SENTRY is not available, a sister institution will be contacted and asked to fax the roster to the institution.

C. The medical records will be inventoried:

1. A copy of the roster will be given to all staff available to help with records inventory.

2. The Health Services Administrator or designee will divide up the affected area into search sections. He/she will keep a log of which staff member was assigned to each search area.

3. As records are found, they will be marked on the individual roster as follows:

- W– whole record intact (charts that are in an official, yellow BOP Health Record folder and appear to have no damage).
- P – partial record (loose records not in a folder but that do not appear damaged).
- WD – whole record that is damaged (i.e., burned or wet).
- PD – partial records that are damaged (loose paperwork) that were damaged (i.e., burned or wet).
- CW – whole record that appears to be contaminated with blood, body fluid, or other unknown substance (other than obvious water damage).
- CP – partial record that appears to be contaminated with blood, body fluid, or other unknown substance (other than obvious water damage).

4. After search, rosters will be returned to the Health Services Administrator to be kept permanently on file.

5. Whole and partial medical records that are not damaged or contaminated will be taken to a designated temporary storage area. The area will be divided into terminal digit numbers 00 – 99 and records will be kept in these groupings.

6. Damaged and contaminated records will be brought to the attention of the Health Services Administrator and Safety Administrator. The HSA will also notify the Chief, Health Information, Health Services Division. A determination of salvageability will be made. The HSA will keep a log of partial and whole records that were not salvageable, along with the method of disposal. A copy of the log will be given to the institution Correctional Services Manager and the Chief of Health Information, Health Services Division.

D. The health information department will be returned to working order:

1. The area will be cleaned and necessary repairs made.

2. Whole, undamaged records will be taken from temporary storage and returned to permanent terminal-digit filing.

3. For inmates with partial paper records recovered, a new six-part yellow BOP Health Record folder will be made. Any available paper records will be put in the new folder and placed in permanent, terminal digit filing.

II. **Interruption to Access of Electronic Records**. Bureau-wide electronic health information systems are maintained by the Central Office in Washington, D.C. The Central Office maintains contingency plans for these systems. These systems include (but are not limited to): the Bureau Electronic Medical Record (BEMR), SENTRY (used as a master patient index), and Orchard Copia Laboratory Information System.

A. **Planned Downtime**. Every electronic information system requires periodic maintenance that affects availability of the system to end users. Maintenance is scheduled by the Central Office and communicated to the institution by e-mail and within the application's log-in banner. Contingency plans described in section II.B. of this Appendix will not be used for planned downtime unless directed by the Chief, Health Information, Health Services Division. Staff will plan work accordingly in advance of the scheduled electronic information system maintenance.

B. **Unplanned Downtime**. When institution staff cannot access these electronic records, they will first contact institution computer services staff to determine if the problem is due to a local cause. Institution staff will contact the Health Services Division Informatics Section by telephone or e-mail when the issue is not due to a local cause. If the issue occurs during evening or morning watch, weekend or holiday, institution staff will contact the BOPNet Support Line. The e-mail and telephone contact information is posted in the health services area, where it can be easily accessed by staff but not viewable by inmates.

1. The following table outlines procedures to be followed during a short-term loss of more than one hour and less than 24 hours.

Process	Short-term loss
Call-out entry into SENTRY	If SENTRY is down at the time call-outs should be entered, the health information technician will obtain advice from the HSA as to whether or not nonessential call-outs should be postponed. Call-outs that are to take place the following day will be printed on paper and delivered to the housing units by the health information staff.
Medical duty status (MDS) Entry	Contingency MDS paper form will be completed. Three copies will be made (one copy each for inmate, detail supervisor, and later data entry). The practitioner writing the MDS assignment will key the entry into the electronic record when available. HIT staff will update SENTRY.

Exit Summary	If inmates are not scheduled for immediate institution departure, exit summaries will be delayed until the electronic record is available. **When the electronic record is not available due to a local issue**. A sister institution, the regional HSA, regional CD, or Central Office health informatics section will be contacted to obtain information from the electronic record. Review of exit summary information will be conducted via telephone between inmate's current institution provider and the staff accessing the electronic record information on the first party's behalf. Exit summary will be faxed to inmate's institution and physical co-signature will be added to paper document by health services staff. A copy will be made to scan into the electronic record when it becomes available. The original will be routed per regular institution procedures. **When the electronic record is not available due to Central Office/national issue**. The exit summary contingency form will be completed with as much information as is known. A copy will be made to scan into the electronic record when it becomes available. The original will be routed per regular institution procedures.
Misc. Documentation and Information[1]	**When the electronic record is not available due to a local issue**. For emergency information needs, a sister institution, the regional HSA, regional CD, or Central Office health informatics section will be contacted to obtain information from the electronic record. **When the electronic record is not available due to a Central Office/national issue**. For emergency information needs, the provider will gather as much information as is available at the time (patient verbal history, stored medication summary, etc.) New entries/notes will be documented on paper by the practitioner and entered into the electronic record when it becomes available. The practitioner making the late entry will back-date and time the documentation and make note that it was due to the electronic record being inaccessible.
Order Processing[2]	The HSA may postpone non-emergency order processing until the electronic record becomes available. Otherwise, the designated health services staff member will contact a sister institution, the regional HSA, regional CD, or Central Office health informatics section to obtain information necessary to process the orders. Changes to this information will be maintained on paper and updated when the electronic record becomes available.

[1] Miscellaneous documentation includes: alerts, allergies, document manager, flow sheets, health problems, PPD, diet, clinical encounter, history and physical, intake, co-signature, sickle cell, vision screen, and medical forms.

[2] Order processing includes: consultation, laboratory, radiology, and miscellaneous non-medication order processing.

2. **Unplanned Downtime Lasting More than 24 Hours**

a. **Due to Local Cause**. The HSA will contact the Chief, Health Information, for assistance. Resources will be deployed to assist the institution until access to electronic records is restored.

b. **Due to National Cause**. The Central Office Information Systems section will implement national contingency plans. The Chief, Health Information, will disseminate information and guidance.

Appendix C. 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
ac	before meals
am, AM	morning
AA	Alcoholics Anonymous
AAA	abdominal aortic aneurysm
ABG	arterial blood gas
AC	acromioclavicular
ACE	angiotensin converting enzyme
ACL	anterior cruciate ligament
ACLS	advanced cardiac life support
AD	right ear
ADD	attention-deficit disorder
ADHD	attention-deficit hyperactivity disorder
ADL	activities of daily living
AF, A-fib	atrial fibrillation
AFB	acid fast bacillus
AFP	alpha feto protein
AG ratio	albumin/globulin ratio/anion gap
AICD	automatic inplanted cardiac defibrillator
AIDS	acquired immunodeficiency syndrome
AIMS	abnormal involuntary movement scale
AK	above knee
AKA	above knee amputation
ALL	acute lymphocytic leukemia
ALS	amyotrophic lateral sclerosis
ALT	alanine aminotransferase
AMA	against medical advice
AMI	acute myocardial infarction

AML	acute myelogenous leukemia
AMML	acute myelomonocytic leukemia
amp	ampule
ANA	antinuclear antibody
Ant	anterior
AODM	adult onset diabetes mellitus
A&O	admission and orientation
AP	anterior-posterior
Apt	appointment
approx	approximately
ARD	acute respiratory distress
ARDS	adult respiratory distress syndrome
ARF	acute renal failure
ARNP	Advanced Registered Nurse Practitioner
AROM	active range of motion
AS	left ear
ASA	aspirin
ASAP	as soon as possible
ASCVD	arteriosclerotic cardiovascular disease
ASHD	arteriosclerotic heart disease
AST	aspartate aminotransferase
AU	each ear
AV	atrioventricular
A-V	arteriovenous
AVSS	afebrile, vital signs stable
Ba	barium
Band	banded neutrophil
BBB	bundle branch block
BCC	basal cell carcinoma
BCP	birth control pill
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
BMT	bone marrow transplant

BOP	Bureau of Prisons
BP	blood pressure
BPH	benign prostatic hypertrophy
BR	bed rest
BS	blood sugar
BSE	breast self examination
BUN	blood urea nitrogen
BTL	bilateral tubal ligation
Bx	biopsy
C&S	culture and sensitivity
Ca	cancer
Ca++	calcium
C/S	cesarean section
c/o	complains of
CABG	coronary artery bypass graft
CAD	coronary artery disease
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
CCC	chronic care clinic
C-collar	cervical collar
CCPD	continuous cycling peritoneal dialysis
CCU	coronary care unit
CDC	Centers for Disease Control
CEA	carcino-embryonic antigen
CF	cystic fibrosis
CHB	complete heart block
CHD	coronary heart disease
chem	chemistry
chemo	chemotherapy
CHF	congestive heart failure
chol	cholesterol
CIN	cervical intraepithelial neoplasia
CIS	carcinoma in situ
Cl	chloride
CLD	chronic liver disease

CLL	chronic lymphocytic leukemia
cm	centimeter
cm2	square centimeters
CML	chronic myelogenous leukemia
CMV	cytomegalovirus
CN	cranial nerves
CNS	central nervous system
CO	carbon monoxide
CO2	carbon dioxide
COLD	chronic obstructive lung disease
comp	complication
cont	continue
COPD	chronic obstructive pulmonary disease
cp	chest pain
CPAP	continuous positive airway pressure
CPK	creatine phosphokinase
CPR	cardiopulmonary resuscitation
CrCl	creatinine clearance
crea	creatinine
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
CTRS	Certified Therapeutic Recreation Specialist
CTS	carpal tunnel syndrome
CV	cardiovascular
CVA	cerebrovascular accident
CVD	cardiovascular disease
CVL	central venous line
CVP	central venous pressure
CXR	chest x-ray
cysto	cystoscopy
DAT	diet as tolerated
D/C	discontinue
D&C	dilation and curettage
DDX	differential diagnosis
decub	decubitus
def	deficient/deficiency

DIC	disseminated intravascular coagulation
disp	disposition
DJD	degenerative joint disease
DKA	diabetic ketoacidosis
DM (I)(II)	diabetes mellitus(Type I)(Type II)
DME	durable medical equipment
DNA	deoxyribonucleic acid
DNKA	did not keep appointment
DNR	do not resuscitate
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
DTR	deep tendon reflex
DT	delirium tremens
DUB	dysfunctional uterine bleeding
DVT	deep vein thrombosis
Dx	diagnosis
Dz	disease
EBV	Epstein-Barr virus
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
EGD	esophagogastroduodenoscopy
EKG	electrocardiogram
EMG	electomyelogram
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
ENT	ear, nose, and throat
EOM	extraocular movement
ER	emergency room

ERCP	endoscopic retrograde cholangiopancreatography
ESR	erythrocyte sedimentation rate
ESRD	end stage renal disease
ESWL	extracorporeal shockwave lithotripsy
ET	endotracheal tube
ETOH	alcohol
Ex	examination
F	female
FB	foreign body
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
FROM	full range of motion
FSBS	fingerstick blood sugar
f/u, FU	follow up
FUO	fever of unknown origin
FVC	forced vital capacity
FWB	full weight bearing
Fx	fracture
g	gram
GAF	global assessment of functioning
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

gsw	gunshot wound
gt	drop/drops
GTT	glucose tolerance test
GU	genitourinary
gyn	gynecology
H	hour
H2O	water
H2O2	hydrogen peroxide
HA	headache
HaAb	hepatitis A antibody
HaAg	hepatitis A antigen
HaV	hepatitis A virus
HbA1C	hemoglobin A1C
HbAb	hepatitis B antibody
HbAg	hepatitis B antigen
HbcAb	hepatitis B core antibody
HBP	high blood pressure
HbsAb	hepatitis B surface antibody
HbsAg	hepatitis B surface antigen
HbV	hepatitis B virus
HCG	Human Chorionic Gonadatropin
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
HNP	herniated nucleus pulposus
h/o	history of
HOH	hard of hearing
/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
IBS	irritable bowel syndrome
IBW	ideal body weight
ICP	intracranial pressure
ICU	intensive care unit
ID	infectious disease
IDC	institution disciplinary committee
IDDM	insulin dependent diabetes mellitus
IDH	ischemic heart disease
IgG	immunoglobulin G
IM	intramuscular
inj	injection
INR	international normalized ratio
INS	Immigration and Naturalization Service
IOP	intraocular pressure
IQ	intelligence quotient
ITP	idiopathic thrombocytopenic purpura
IUD	intrauterine device
IV	intravenous
IVDA	intravenous drug abuse
IVP	intravenous pyelogram
JODM	juvenile onset diabetes mellitus
JVD	jugular venous distention
JVP	jugular venous pressure
K	kilo
K+	potassium
Kcal	kilocalorie
kg	kilogram
KUB	kidneys, ureters, bladder
KVO	keep vein open
l	liter
L	left
lab	laboratory
lap	laparoscopy/laparoscopic
lat	lateral
LBBB	left bundle branch block

LBP	lower back pain
lbs	pounds
LDH	lactic dehydrogenase
LE	lower extremity
LEEP	loop electrocautery excision procedure
LFT	liver function test
liq	liquid
LLE	left lower extremity
LLL	left lower lobe
LLQ	left lower quadrant
LMP	last menstrual period
LOC	loss of consciousness
LOF	loss of function
LOS	length of stay
LP	lumbar puncture
LPM	liters per minute
LPN	Licensed Practical Nurse
LR	lactated ringer solution
L-S	lumbosacral
LTC	long term care
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
M1	mitral first sound
M2	mitral second sound
MAOI	monoamine oxidase inhibitor
MC	metacarpal
mcg	microgram
MCL	medial collateral ligament
MCV	mean corpuscular volume
MD	Medical Doctor
med/surg	medical/surgical
meds	medications
mEq	millequivalent

mets	metastasis
MH	mental health
MI	myocardial infarction
MIC	minimum inhibitory concentration
min	minimum
ml	milliliter
mm	millimeter
MMPI	Minnesota Multiphasic Personality Inventory
MMR	measles, mumps, rubella
MOM	milk of magnesia
Mono	mononucleosis
mono	monocyte
MRA	magnetic resonance angiography
MRI	magnetic resonance imaging
MRSA	methicillin resistant staph aureus
MS	multiple sclerosis
MSE	mental status examination
MVA	motor vehicle accident
N/V	nausea and vomiting
Na	sodium
NA	not applicable
NAD	no apparent distress
neg	negative
neuro	neurological
NG	nasogastric
NGT	nasogastric tube
NIDDM	non-insulin dependent diabetes mellitus
NKA	no known allergies
NKDA	no known drug allergies
nl	normal
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
NTG	nitroglycerin
NWB	no weight bearing

o:	objective
O&P	ova and parasites
O2	oxygen
OA	osteoarthritis
OB	obstetrics
OB/GYN	obstetrics and gynecology
OBS	organic brain syndrome
OCD	obsessive compulsive disorder
OCP	oral contraceptive pill
OD	right eye
oint	ointment
OM	otitis media
OPD	outpatient department
OR	operating room
ORIF	open reduction internal fixation
ortho	orthopedics
OS	left eye
OT	occupational therapy
OTC	over the counter
OU	each eye, both eyes
oz	ounce
p:	plan
P&A	percussion and auscultation
PEEP	positive end expiratory pressure
PA-C	Physician Assistant-Certified
PA*	Physician Assistant
PAC	premature atrial contraction
PACU	post anesthesia care unit
Pap	papanicolaou test
PAT	paroxysmal atrial tachycardia
path	pathology
pc	after meaks
PCA	patient controlled analgesia
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

PERLA	pupils equal, react to light and accommodation
PET	positron-emission tomography
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
PMHx/PMH	past medical history
PMS	premenstrual syndrome
PNS	peripheral nervous system
PO	by mouth
pos	positive
pp	postprandial
PPD	purified protein derivitive (TB skin test)
PPT	partial prothrombin time
PR	pulse rate
PRBC	packed red blood cells
prn	as needed
PROM	passive range of motion
prox	proximal
PSA	prostate specific antigen
PSVT	Paroxysmal Supraventricular Tachycardia
PT	physical therapy
pt.	patient
PTH	parathyroid hormone
PTSD	posttraumatic stress disorder
PTT	partial thromboplastin time
PUD	peptic ulcer disease
PVC	premature ventricular contractions
px	prognosis
q	every
qd	once daily
qid	four times a day
R	right
RA	rheumatoid arthritis
RBBB	right bundle branch block

RBC	red blood cell
R&D	Receiving and Discharge
REM	rapid eye movement
rep, reps	repetition, repetitions
resp	respiration/respiratory
Rh	Rhesus
RHF	right heart failure
RHIA	Registered Health Information Administrator
RHIT	Registered Health Information Technician
RIA	radioimmunoassay
RLE	right lower extremity
RLL	right lower lobe
RLQ	right lower quadrant
RN	Registered Nurse
RNA	ribonucleic acid
r/o	rule out
ROM	range of motion
ROS	review of systems
RPR	rapid plasma reagin
RR	respiratory rate
RRE	round, reactive, equal
RRR	regular rate and rhythm
RSV	respiratory syncytial virus
RT	Respiratory Therapist
RTC	return to clinic
RTW	return to work
RUE	right upper extremity
RUL	right upper lobe
RUQ	right upper quadrant
Rx	prescription
Rxn	reaction
s:	subjective
SAD	seasonal affective disorder
SBE	self breast exam
SCD	sickle cell disease
sed rate	sedimentation rate
Seg	segregation
sg	specific gravity
SHU	special housing unit
SI/HI/H’s	suicidal ideation/homicidal ideation/ hallucinations

sl, s/l	sublingual
SLE	systemic lupus erythematosus
sm	small
SOB	shortness of breath
sol	solution
S/P	status post
SQ	subcutaneous
SSRI	specific serotonin reuptake inhibitor
SSS	sick sinus syndrome
ST	sinus tachycardia
staph	staphylococcus
stat	immediately
STD	sexually transmitted disease
strep	streptococcus
STS	serologic test for syphillis
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
TC	throat culture
TD	tardive dyskinesia
temp	temperature
TENS	transcutaneous electrical nerve stimulation
TFT	thyroid function test
THA	total hip arthroplasty
THR	total hip replacement
TIA	transient ischemic attack
TKA	total knee arthroplasty
TM	tympanic membrane
TMJ	temporomandibular joint
TO	telephone order
TP	total protein
TPN	total parenteral nutrition

TSH	thyroid-stimulating hormone
T-spine	thoracic spine
TSS	toxic shock syndrome
TULIP	transurethral laser induced prostectomy
TURP	transurethral resection of prostate
Tx	treatment
UA	urinalysis
UCC	urine culture and colony count
UCG	urinary gonadotropin
UE	upper extremity
UGI	upper gastrointestinal
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
VD	veneral disease
VDRL	veneral disease research laboratories
VF	visual field
VF	ventricular fibrillation
vit	vitamin
VL	viral load
VO	verbal order
Vs	versus
VS	vital signs
VSS	vital signs stable
VSD	ventricular septal defect
VT	ventricular tachycardia
WBC	white blood count
WC	wheelchair
WD	well developed
WFL	within functional limits
WN	well nourished
WNL	within normal limits
wt	weight
w/u	workup
y/o	year old

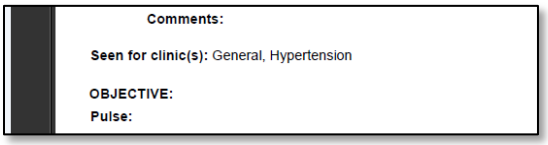
yr	year
x	times
XRT	radiation therapy
SYMBOLS	MEANINGS
#	Number
@	At
0	No information, none
△	Change
↑	Increase/high
↓	Decrease/low
♂	Male
♀	Female
1°	Primary or first degree
2°	Secondary or second degree
3°	Third degree
c̄	With
s̄	Without
p̄	After
-	Negative
+	Positive
>	Greater than
<	Less than

Appendix D. Discharged Chart Order for Medical Referral Centers

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 and 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).
- Doctor's 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.

Appendix E. Outpatient Electronic Health Record Audit Worksheet[3]
To be completed by health information department staff.
Review the past three months of documentation.

Health Record No.: Date: Reviewer: Institution:	**YES**	**NO**	**N/A**	**Provider Code# (if applicable)**
Scheduled activities are current to within 1-week of scheduled due date.				
Consultation requests, lab, x-ray, and other orders are processed in a timely manner according to institution policy.				
Clinical encounters generated 3-working days prior to review are completed (not left in-progress or pending co-signature).				
Administrative notes do not contain SOAP format.				
Injury assessment format is used for all injuries.				
Each chronic care clinic type (e.g., cardiac, diabetes) addressed in the clinical encounter note is listed under "Seen for clinic(s):"  **Comments:** **Seen for clinic(s):** General, Hypertension **OBJECTIVE:** **Pulse:**				
Co-signature of orders completed in a timely manner in accordance with institution policy.				
The health problem list is current and accurate.[4]				

[3] This form may be modified by the local institution to address local documentation issues or to support improving organizational performance.

[4] Specifically, inmates in a chronic care clinic will have a corresponding diagnosis. Comment boxes on the health problem list will further explain a problem but will not contain a list of multiple problems. (Note: HITs only address the accuracy of the code matching the diagnosis.)