Contents

Authorization of Staff Members Making Entry into Medical Records Chart (File) 1
Retention of Medical Record 2
Confidentiality of Medical Records 3
Security of Medical Records 4
ICD -10 Coding and Data Abstracting 6
Medical Records Tracking System 8
Patient Medical Record Identification 9
Medical Alert 9
Entering Laboratory Results into Patient Records 10
Medical Record Analysis and Completion 11
Storage of Old Inactive Records 13
Approved and Prohibited Abbreviations 14
Abbreviations & Meaning 15
Foetal position and Presentation 20
Abbreviation for use on the abstracts (Medical Records) 21
Dental Abbreviations 23
Abbreviation NOT to be used 25
INDEX 26

Authorization of Staff Members Making Entry into Medical Records Chart (File)

PURPOSE: It provide the hospital with authorized staff to make entries in the medical record

POLICY: Only authorized staff members shall be allowed to make entries in Medical Record. Such staff members include physicians' nurses and other paramedical staff involved in the patients' medical care.

PROCEDURES: The following criteria shall be observed:

1. There is a unique identifier (Name and Employee Number) for each staff member.
2. Physicians shall be expected to have a stamp bearing both (Name and Employee Number)
3. Nursing and other staff members shall be expected to have a stamp or may use their name and employee number (handwritten) in signing entries into medical records.
4. All entries into the Medical Records by Staff Members have to be signed and authenticated with a stamp whenever applicable, dated and timed.
5. All the entries in the file should be in English Language.
6. All results from Radiology and Laboratory have to be signed by a member of the medical team before being inserted into the medical records.
7. Each entry must be dated according to Gregorian calendar in day-month-year sequence.
8. Time entries are made using 12 hours clock system.

Authorized Staff Members to make Entries: The following Medical and Health Care Professionals are authorized to make entries in the Medical Records of MGMC&RI with the coordination of Medical Records Staff Members:

- All physicians.
- Nurse.
- Physiotherapists.
- Dietitian.
- Medical Records Technicians.
- Other Health Care Providers sharing in patient's care.

Procedures in Making Entries:

- Responsible Medical or Health Care Providers are required to complete the spaces provided for the date, patient's name, age and sex.
- Detailed clinical assessments shall be entered in a legible manner.
- After the entry of each clinical assessment the responsible medical or health care providers must place their name or number, signature, date and time.

Retention of Medical Record

PURPOSE: To retain and preserve the Medical Records for a time period as specified by NABH standards for medical, legal, administrative, educational and other purposes.

POLICY: It is the policy of the Medical Records Department to comply with NABH Medical Records Retention schedule as mentioned in the NABH policies and manual.

PROCEDURES:

- Medical Records are retained as per the following medical retention schedule stated in NABH policies/procedures manual.
- Approval from Dean, MGMC & RI would be taken before destroying any medical record.

Preservation of Records:

1. All medical records including patients files, register books, etc., relating directly to patient care have to be maintained by the medical Records Department.
2. The old files, register books, are to be preserved in a secure place for a prescribed period. Later the records have to be disposed off as per the "Record Retention Schedule" procedures mentioned in the NABH manual.
3. Special care has to be taken to reserve the safety of records. Records have to be protected from insects, termites and prevent them from being exposed to heat, fire, dampness and dust. Adequate fire extinguishers should be available in the filling area.

Confidentiality of Medical Records

PURPOSE: To maintain confidentiality of all types of information. This includes medical records diseases, operation index.

POLICY: It is the policy of the department to set forth procedures to maintain all types of information in utmost confidentiality in compliance with MGMC & RI Hospital policy and ethical rights of patients and hospital staff

PROCEDURES:

1. Persons working in the Medical Records, persons directly involved in patient care and other authorized persons who have access to patient medical records must not under any circumstances disclose any type of patient information to unauthorized persons . Disclosures of any information contained in the medical records are a breach of confidentiality. Anyone found to have disclosed any information to unauthorized persons would be subject to disciplinary action and possible termination.
2. Authorized persons, who need to obtain any kind of patient information, should adhere to guidelines in policy and procedures for the "Release of Information ".
3. Medical Records in the department are kept secured and in strict confidentiality .No unauthorized persons are allowed to have access to patient medical records or any type of patient data information.

Security of Medical Records

PURPOSE: To ensure that all Medical Records (Data Information) are kept safe and secured in the Medical Records Department and protection of Medical Records from loss, theft or deliberate alteration / tampering

POLICY: To establish responsibilities and procedures for safeguarding Medical Records (data and information).

PROCEDURES:

1. Medical Records originated in the hospital are the property of MGMC & RI Hospital and are maintained for the benefit of patients and hospital staff.
2. In accordance with MGMC & RI Hospital's policies, medical records shall not be removed from the hospital except by court of Ministry of Health.(Only copy)
3. Medical Records can be taken out of Medical Records Department only by authorized persons
4. If the file/s are required for a purpose, other than patient appointment, the persons requesting the file/s should fill up a "file request form within the organization", available from Medical Records Department.
5. For emergency patient the medical records staff will promptly deliver the file to ER nurse or the ER staff can collect the file from Medical Records Department with proper identification.
6. To ensure maximum security against loss, defacement, tampering and from use by any unauthorized individual:
    - No unauthorized persons are allowed to enter Medical Records Department or to have access to patient Medical records out of the department.
    - All medical records taken from the Medical Records department during working hours by any outpatient department /ER or by any authorized persons/unites should be returned on the same day. No records are to be kept overnight in any unit other than inpatients.
    - Patients or their relatives will not be allowed to carry the patient files or to keep them in their possessions.
7. authorized allowed
8. The main door of the Medical Records Department should be kept locked after working hours.
9. All persons who need to enter Medical Records Department after 4:30 pm should contact Medical Record staff on duty through reception counter or by phone Ext.
10. No records /files should be left unattended.
11. Medical record staff should always be available. No staff should leave the department without handing over.
12. Any misconduct made by any of the authorized and responsible staff members against this policy requires immediate notice from the head of medical records with the approval of the

chief medical director for prompt initiation of penalty depending on the signification of offense/s and elaborated as follows:

- First offense requires a warning letter signed by the medical director stating the consequence if the same misconduct is repeated and he is trained further not to repeat his mistake again.
- Second offense necessitates a three not to seven–days salary deduction depending upon the type of fault along with a written memorandum duly signed by the chief medical director and the administrative manager.
- Third offense is subject to termination of contract.

ICD -10 Coding and Data Abstracting

PURPOSE: To correctly and accurately assign Standards Disease, Operation and /or Procedure Codes to all discharged Inpatients Medical Records and to enter the data in the computer for future reference.

POLICY: It is the policy of the Medical Records Department to code all inpatient discharges.

PROCEDURES:

1. Receive medical recodes from the Medical Record Technician who have analyzed the file for completeness.
2. Discharged inpatient medical records will be coded daily against the discharge census and at the end of each month, the medical record technician will refer to their list of discharges for all files that are not yet coded.
3. Review the medical record Inpatient Admission Sheet, Discharge Summary, History and Physical, Physician Progress Notes, Consultation Notes, Operation and Procedure Notes and all Investigations (if present).
4. Compare the final diagnosis of the Inpatient Admission sheet to the one recorded on the Discharge Summary, History and Physical and progress report, plus the Operative and Pathology Reports to ascertain that there are no discrepancies in information. If there are, ask first the physician for clarification of the diagnosis before putting the code.
5. Determine that the primary (final) diagnosis has been listed first and any secondary codes are listed in correct coding sequence.
6. Code the identified Diagnosis, Operations and Procedures, listed them in pencil on the Inpatient Admission sheet in correct sequence, in the column marked “ICD-10”
7. Place your initial next to those of the analyst in the blank box next to the column marked ICD Code Numbers on the Inpatient Admission sheet.

CODING GUIDELINES:

The following basic steps in coding should be followed:

- Locate the main term in the Alphabetic Index.
- Refer to any notes under the main term.
- Refer to any modifiers of the main term.
- Refer to any sub terms indented under the main term.
- Follow any cross–reference instructions.
- Read and be guided by any instruction, terms, symbols, etc which may further qualify the code.
- Assign the Code Number thus obtained.
    a. Code all operative procedure, all invasive procedures and all diagnostic procedures, which are invasive.

2. It is imperative that both the alphabetic indices and the tabular indices be used when locating and assigning a code. Do not try to code directly from the alphabetical indices because the tabular indices may provide additional information. Such as exclusion terms, 5th digit codes(in the case of diagnostic coeds) or instructions to use more than one code for any given diagnosis or procedure.
3. Each individual diagnosis or procedure must be assigned a correct and complete coed. If the physician had not given specific information, search the history and physical, doctors progress notes, operative reports and pathology reports for more information. If not clearly defined, as the concerned physician for clarification.
4. The principle diagnosis and the principle procedure must be coded first, because the categories in which patients are grouped for the purpose of evaluating the utilization of Health Record facilities are based on principle diagnosis and principle procedure. Secondary codes must be sequenced in the order of importance and their effect in the principle diagnosis.

   NOTE: CODING IS AN IMPARTENT ASPECT OF RESEARCH IN THE MEDICAL RECORDS DEPARTMENT AND IT MUST BE DONE ACCURATELY.
5. After each coding procedure has been completed for a discharged Inpatient Medical Record, put a highlight in each appropriate medical record number from the correct discharge census list . The file may then be put in the pre-filing area or give to the Transcriptionist for typing of Discharge Summary if necessary.

Medical Records Tracking System

PURPOSE: To provide a system to facilitate and ensure easily tracking of medical record.

POLICY: Patient records are only released out of Medical Records according to a policy approved by the hospital.

PROCEDURES:

1. Records can be released to the nurses in the outpatient clinics.
2. Records can be released to the Emergency Room nurses for a patient in Emergency Room.
3. Records are released to medical committee and he signs for it.
4. Approval by the medical director for all other requests for release of the medical record.
5. Releases and Return of Files(Medical Records Tracking System):
   - Any Medical Record files sent from the filing area will have the Records Transfer Card written and the kept in its place.
   - A retrieval register should be maintained in Medical Records Department for all requests for files. Date, Medical Record Number, Dr. Name, Time Department, name and time requested should be entered in the logbook with the signature of the medical record staff.
   - A logbook should also be maintained for all outgoing patient medical record, clinic, receiving the files should be entered in the PIN with date, time, and signature.
   - All Medical Records sent out must be returned to the filing area on the same day
   - Filing for OPD appointments are prepared according to the appointment list the previous day.
   - All the files from the OPD clinic are collected at 12.00 to 01.00 pm and 8.00 to 9.00 pm as routine.
   - If any files are not returned to the Medical Records Departments on the same day from the clinic the files are sent for admission or to another clinic in case the patient had two different appointments on the same day.
   - The Medical Records staff who is operating the file Movement will check each morning to ensure that all the files sent out the previous day are returned to the filing area on the same day.
   - If there are unreturned files, the Medical Records staff the person responsible as to who borrowed these files, make enquiries and take action to collect them at the earliest.
   - The Medical Records tracer card should be updated in cases of unreturned files after ensuring the location.
   - If a Medical Record cannot be located by the borrower or the Medical Records staff after 3 days, it will be informed to medical director Medical Record file is missing.
   - A list of the missing files should be presented to the Medical Records MCI committee.

Patient Medical Record Identification

PURPOSE: It provide a process for identification of patient data in the medical file.

POLICY: Every patient shall have a medical record created in his /her name

PROCEDURES:

1. All form in the patients file shall have the adhesive label including(PIN Number, name,Date of Birth) or filled up daily by the nurse
2. Information concerning next of kin including address, telephone number.

Medical Alert

PURPOSE: It provide medical record staff by a system to complete the patient serious data.

POLICY: Essential information about the patients shall be legible and located in the face-sheet, and shall include.

PROCEDURES:

1. Allergies.
2. Code Status.

Entering Laboratory Results into Patient Records

PURPOSE: It provides a mechanism for entering laboratory result in medical file.

POLICY: All Laboratory results shall be signed & authenticated by a physician prior to placement into Medical Records.

PROCEDURES:

1. As soon as a Laboratory result is received on the ward the nurse shall inform the Attending Physician.
2. If should junior staff members not be able to attend, the Consultants should be informed of the Presence of laboratory result.

Medical Record Analysis and Completion

PURPOSE: To Complete all Medical Records of in-patient discharges in compliance with the hospital's standards.

POLICY: It is the policy of the Medical Records Department to ensure that all Medical Records are completed according to established criteria and contains complete documentation relating to treatment and progress during hospitalization.

PROCEDURES:

- All newly discharged and expired records will be analyzed within two (2) working days of discharge.
- Verify that all discharged records for the day are collected or present.
- Use a Physician Incomplete Checklist from for each physician having medical records deficiencies in any record.
- Use Nursing Deficiency Checklist form for each Nursing Unit having deficiencies.
- Nursing Deficiency Checklist form used will then be distributed as follows:
    - Top copy will be given to each nursing unit in the ward with backed copy signed by any of the nursing staff from the ward.
    - Backed copy will then be given to the Doctors' Completion In-charge for her list of Nursing Deficiency.
- Physician's Checklist will be attached to the right side of the medical record with the Most recent checklist on top.
- All deficiencies requiring signatures will be tagged with colored locator tags.
    - The appropriate colored tags will be placed on each deficiency checklist.
    - The following information will be recorded on the Physician Deficiency checklist:
        - Patient Name.
        - Patient Medical Record Number.
        - Unit.
        - Date of Deficiency.
        - Type of Deficiency.
    - One Medical Record Control Card will be prepared for each medical

      Record having physicians' deficiency.
    - For each Medical Record having discharge summary and/or operation report that needs to be typed, Medical Record Control Card with copy will be prepared and then divided and distributed as follows:
        - Top copy given to the Doctor's completion In- charge.

  - Back-up copy given to the Transcriptionist.

- Mortality Records:
  - If the patient has expired, record all the information in Death Registry (patient name, date of death, medical record number, ward/unit, sex and treating physician).
  - Ensure mortality records are completed such as death summary, diagnosis or cause of death.
  - Write to each top face side of folder “EXPIRED” with date and time of death.
  - Keep the expired files in separate filing shelves filed in numeric order.
  - An out-guide will be prepared with the following information written in Block form to be placed in the main filing area:
    - Medical Record Number.
    - EXPIRED.
    - Date and time of expiration.
- Complete the down part corner of the In-patient Admission sheet by writing the date of discharge or date of expired, time and write the initials and the date the file was analyzed.
- Analyzed files will be passed on to the person (s) responsible for Coding.

Storage of Old Inactive Records

PURPOSE: To store old medical records (which are inactive and less likely to be needed) in such a manner that they could be retrieved if required.

POLICY: It is the policy of the Medical Records Department to make available sufficient space in the filing area for newly opened files.

PROCEDURES:

- Patient records (In-patient and Out-patient):

  All patient files in which the patients has not attended OPD Clinic or were not treated, as inpatient for the last 2 years shall be removed from the main filing area.

- These files shall be stores in a place in close proximity to the Medical Records Department so that they could be retrieved quickly.
- These records will be arranged properly in shelves in numeric order to facilitate easy retrieval when required.
- ER Records:
  - ER Records for the current year shall be kept inside the Medical Records Department.
  - All the ER records of previous years will be removed from the filing area and stored in the old records store room.
  - According to the availability of shelves and space in the storeroom, old ER Records shall be arranged properly in shelves in chronological order to’
  - Facilities easy retrieval when required.
  - Old ER records will be arranged in chronological order by bundle of 100 records each and filed in a special filing shelf chronologically.

Mortality Files:

Mortality files belonging to the current year shall be kept in special shelves. All previous Mortality files shall be transferred to the old records storeroom and arranged in shelves in chronological order to enable easy retrieval.

General Instruction for Storing Old Records:

- Old records should be stored in a safe and secured place.
- An “old Records Register” will be maintained and all the old records removed From the filing area must be entered in this register.
- All the old and inactive records have to be retained until they are disposed off, as per the rules laid down by MOH for “Record Retention”, (Please see policy and procedures on Retention of Medical Records).

Approved and Prohibited Abbreviations

PURPOSE: To establish a system in the hospital to utilize only the approved and comprehensive list of abbreviations approved by the medical records committee.

POLICY: It is the policy of the Hospital to use approved and standard abbreviations list which givens guidance for documentation in patient records in accordance with the MRQP standards.

PROCEDURE:

1. The Pharmacy will not accept orders and prescriptions from In-Patient which includes non approved abbreviations and symbols.
2. Orders containing non-approved abbreviations and symbols are clarified with the physician.
3. Medication orders containing Abbreviations of Medications, will not be filled unless the Abbreviation is universally accepted, i.e P.P.D (purified Protein Derivative) and listed in the current edition of Medical Records Abbreviations Booklet.
4. Non-universally accepted abbreviations of Medications, in the approved hospital listings are intended for use in medical records etc, and will not be accepted for use in medication orders.
5. A listing of selected Abbreviations of Medications, orders can be found in the current edition of the Formulary.
6. The abbreviations shall be reviewed yearly or whenever new additions and deletions are required.
7. The uniformity of abbreviations among the Hospital staff would be maintained.
8. Any suggested additions / deletions shall be submitted to the Medical Director for review and approval.
9. The abbreviation list is reviewed by the Medical Records Committee and the approved abbreviation list is circulated to all the departments of the Hospital to be followed.
10. The prohibited abbreviation list is also forwarded to the departments to confirm the use of appropriate abbreviation list is followed and not the prohibited list.
11. The listed out prohibited abbreviations should never be used by the departmental staff and which was approved by the medical records committee.

Abbreviations & Meaning

ABBREVIATION		MEANING
a.m		Before Midday, Morning
AB		Apex beat
ABG		Arterial blood gas
AGA		Appropriate for gestational Age
AIDS		Acquired Immunodeficiency Syndrome
AP & Lat		Anteroposterior & lateral
AP Chest		Antero - Posterior
APH		Antepartum haemorrhage
ARM		Artificial rupture of membranes
ASAP		As soon as possible
ASD		Atrial septal defect
AXR		Abdominal x -ray
b.i.d		Two Times a Day
BCG		Bacillus Calmett - Guerin
BE		Base excess
BIL		bilateral
BILI		bilirubin
BILI C		Conjucated bilirubin
BILI D		Direct bilirubin
BMR		Basal Metabolic Rate
BP		Blood pressure
BPD		Bronchopulmonary dysplasia
BUN		Blood Urea Nitrogen
BW		Birth Weight
C & S		Culture and Sensitivity
C.S.S.D		Central Sterilization & Supplies Department
C.S.T		Continue Same Treatment
C.T. Scan		Computerized Tomography Scan
Ca++		Calcium
CBC		Complete Blood Count
IDDM		Insulin dependent diabetes mellitus
IDM		Infant of Diabetic Mother
IE Ration		Inspiratory/expiratory
IM		Intramuscular
IMV		Intermittent mandatory ventilation
Inc		Incubator
IPPV		Intermittent positive pressure ventilation
IT		Inspiratory time
IUD		Intrauterine Contraceptive Device
IUFD		Intrauterine fetal death
IUGR		Intrauterine growth restriction

IV		Intra Venous
ABBREVIATION		**MEANING**
IVH		Intraventricular haemorrhage
IVP		Intra Venous Pyelogram
IVU		Intra Venous Urogram
IWL		Insensible water loss
K++		Potassium
KCL		Potassium chloride
Kg (Kgms)		Kilogram(s)
KUB		Kidney, Ureter, bladder
L & D		Labour and Delivery
Lab		Laboratory
Ib		Pound
LBW		Low Birth Weight
LDH		Lactic Acid Dehydrogenase
LGA		Large for gestational age
LMP		Last menstrual period
LP		Lumbar Puncture
LSCS		Lower segment caesarean section
LT		Left
M		Minimum
MAP		Mean Arterial Pressure
CCN		Clinical charge Nurse
CDH		Congenital diaphragmatic hernia
CHD		Congenital heart disease
CLD		Chronic lung disease
Cm		Centimeter
CMV		Cytomegalovirus
CNS		Central Nervous System
CO		Carbon monoxide
Co2		Carbon Dioxide
COPD		Chronic Obstructive Pulmonary Disease
CPAP		Continuous positive airway pressure
CVA		Cerebro Vascular Accident
CVL		Central venous line
CVP		Central venous pressure
CXR		Chest X- ray
D & C		Dilation and Curettage
D 10w		Dextrose 10% in water
D 5w		Dextrose 5% in water
DDH		Developmental dysplasia of the hips
DIC		Disseminated intravascular coagulation
DOA		Dead on Arrival
DPT		Diphtheria Toxoid, pertussis Vaccine Tetanus Toxoid
DR		Delivery room
EBM		Expressed Breast Milk

ECG/EKG		Electrocardiogram
ABBREVIATION		**MEANING**
EDD		Estimated date of delivery
EEG		Electroencephalogram
ELBW		Extremely low birthweight
ENT		Ear, Nose, Thorat
ER		Emergency Room
ESR		Erythrocyte Sedimentation Rate
ET		Expiratory time
ETA		Estimated time of arrival
ETT		Endotracheal tube
FBS		Fasting Blood Sugar
FEBM		Fortified expressed breast milk
FFP		Fresh frozen plasma
FH		Fetal heart
FiO2		Fraction of inspired oxygen
FUO		Fever of unknown Origin
G.U.		Genito - Urinary
Gm		Gram
Gr I, II G		Gravida, pregnant indicating a woman of many pregancies
GTT		Glucose Tolerance Test
Gtt		Drops
GYN		Gynecology
H & P		History and Physical Exam
H.I.E		Hypoxic Ischemia Encephalopathy
H.M.D		Hyaline Membrane Disease
Het		Hematocrit
Hgb		Hemoglobin
HIE		Hypoxic ischaemic encephalopathy
HMD		Hyaline membrance disase
HPU		Has passed urine
HR		Hear rate
Hrs		Hours
I & D		Incision and Drainage
I & O		Intake and Output
IA		Intra-arterial
ICP		Intracranial pressure
ICU		Intensive Care Unit
MAS		Meconium Aspiration Syndrome
MAS		Meconium
mEq		Milliequivalent
Mg		Milligram
MI		Myocardial Infarction
Mm		Millimeter
Mv		Minute volume
N 10		Newborn intravenous nutrition 10% dextrose

N.PR		Nasal prongs
ABBREVIATION		**MEANING**
Na+		Sodium
NAD		No abnormality detected
NaHCo3		Sodium bicarbonate
NBM		Nil by mouth
NEC		Necrotising enterocolitis
NG		Nasogastric
NGT		Nasogastric Tube
NICU		Newborn intensive care unit
NND		Neonatal
NP		Nasophargyneal
NPO		Nothing per orally
NS		Normal Saline
NVD		Normal vaginal delivery
O2		Oxygen
OA		On admission
OB		Obstetric
OG		Orogastric
OR		Operating Room
OTT		Orotracheal tube
Oz		Ounce
P		Pulse
P.I.E		Pulmonary Interstitial Emphysema
p.m		After Midday
p.o (per orally)		Per Mouth
P.V		Per Vaginum
PA		Postero – Anterior
PA Chest		Poster anterior chest x- Ray
PaCO2		Partial pressure arterial carbon dioxide
PaO2		Partial pressure arterial oxygen
Pap Smear		Papanicolaou smear Test
Para I, II		Indicates the number of times a women has produced a viable Infant (over 500 grams and 20 weeks gestation)
Paw		Mean airway pressure
Pc		After Meals
PCO2		Carbon Dioxide pressure
PDA		Patent ductus arteriosus
PEEP		Positive and expiratory pressure
PH		Hydrogen ion Concentration
PID		Pelvic Inflammatory Disease
PIE		Pulmonary interstitial emphysema
PIP		Peak inspiratory pressure
Post-op		After Operation
PP		Post Partum
PPD		Purified protein derivative (TB test)

PPH		Postpartum haemorrhage
ABBREVIATION		**MEANING**
PPHN		Persistent pulmonary hypertension of the newborn
PPROM		Prelabour premature rupture of the membrances
Pre-op		Before Operation
PRN (prn)		As indicated, as necessary
PROM		Prolonged rupture of membrances
PSV		Pressure support ventiliation
PTU		Phototherapy unit
PVH		Periventricular haemorrhage
PVL or PVLM		Periventricular leucomalacia
Q		Every
Q2h		Every 2 Hours
Q 4 h		Every 4 Hours
Q d		Every Day
q.h		Every Hour
q.i.d		Four times a day
RBS		Random blood sugar
RDS		Respiratory distress syndrome
Resp		Respiration
RHT		Radiant heart table
ROP		Retinopathy of prematurity
RSV		Respiratory synctival virus
Rt		Right
RTA		Road Traffic Accident
SBR		Serum bilirubin
SFD		Small for dates
Sg		Specific Gravity
SGA		Small for gestational Age
SIMV		Synchronised IMV
SIPPV		Synchronised IPPV
SLE		Systemic lupus erythematosis
Spec		Specimen
SpO2		Oxygen saturation
SRM		Spontaneous rupture of membrances
SSG (S/C)		Split Skin Graft
STAT		At once
SVD		Spontaneous Vaginal Delivery
T & A		Tonsillectomy & Adenoidectomy
T or Temp		Temperature
Tabs		Tablets
TAPVD		Total anomalous pulmonary Venous
TB		Tuberculosis
TBW		Total body water
TE		Expiratory time
Tet		Tetralogy of Fallot

TGA		Transposition of the the great vessels
ABBREVIATION		**MEANING**
TI		Inspiratory time
TKVO or TKQ		To keep vein open
TOF		Tracheal oesophageal fistula
TPN		Total parenteral nutrition
TPR		Temperature, Pulse, Respiration
TTN		Transient tachypnoea of the newborn
TUR		Transurethral Resection
TV		Tidal volume
Type & X - match		Type and cross match
UAC		Umbilical arterial catheter
URTI		Upper Respiratory Tract Infection
UTI		Urinary Track Infection
UVC		Umbilical venous catheter
V/Q		Ventilation perfusion
VDRL		Venereal Disease Research Laboratory
VG		Volume Guarantee
VLBW		Very low birthweight
VSD		Ventricular septal defect
Vx		vertex
WBC		White blood count
Wt		Weight
ZIG		Zoster immune globulin

Foetal position and Presentation

ABBREVIATION		MEANING
LOA(ROA)		Left Occiput Anterior (right)
Lop(ROP)		Left Occiput Posterior (right)
LOT(ROT)		Left Occiput Transverse (right)
LSA(RSA)		Left Scrum Anterior (right)
LSP(RSP)		Left Scrum Posterior (right)
LST (RST)		Left Scrum Transverse (right)

Abbreviation for use on the abstracts (Medical Records)

ABBREVIATION		MEANING
Aband		Abandoned, Abandonment
-ve		Negative
+ve		Positive
ABD		Abdomen
ADM		Admission
AKA		Above knee Amputation
AMA		Against Medical advice
ANESTH		Anesthesia, Anesthetist
ASSESS		Assessment
BF		Blue Files, Burmper Files
BKA		Below Knee amputation
C		Centigrade, Celsius
CA		Cancer
Cardio		Cardiology
CCU		Coro nary care unit
CxR		Chest X- Ray
D.U		Duodenal Ulcer
Derma		Dermatology
Disc		Discharge
DOB		Date of Birth
DOD		Date of Discharge
EBL		Estimated Blood Loss
ER		Emergency Room
FH		Family History
FMW		Female Medical Ward
FRH		Female Rehabilittion
FS I		Female Surgical I
FS II		Female Surgical II
G.A		General Anesthesia
G.S		General Surgery
Gyne		Gynecology
HOSP		Hospital
HR		Heart Rate
ICU		Intensive Care unit
IM (int. Med)		Internal Medicine
Lab		Laboratory
LOS		Length of Stay
MM		Male Medical
MOH		Ministry of health
MR		Medical Record
MRH		Male Rehabilitation
MS I		Male Surgical I

MS II		Male Surgical II
ABBREVIATION		**MEANING**
N. Sur		Neurosurgery
NBN		Newborn
Nephro		Nephrology
NpN		Nursing progress note(s)
NSG		Nursing
O. Surg		Oral Surgery
O.T		Occupation Therapy
OB		Obstetrics
OH		Obstetrical History
Onco		Oncology
OPD I		Outpatient Department I
OPD II		Outpatient Department II
Ophthal		Ophthalmology
Ortho		Orthopedic
P & P		Policy & Procedures
PAT		Patient
Pedia		Pediatrics
Phar		Pharmacy
Pl. Surg		Plastic Surgery
PMH		Past Medical History
PPN		Physician progress Note(s)
PT		Physiotheraphy
Pulmo		pulmonary
Rehab		Rehabilitation
RX, TX, TRT		Treatment
SICU		Surgical Intensive Care Unit
Sur		Surgery
T0		Temp

Dental Abbreviations

ABBREVIATION		MEANING
¾ GC		Three – quarter Gold Crown
Abg		Autogenous bone graft
Adh		Adhesive
AG		Attached gingival
Ag Pt		Silver point
AL		Attachment
Alg		Alginate
Amg		Amalgam
Ap Rep		Apically repositioned
B		Buccal
BAWON		Broken appointment without
Beh		Behavior
BL		Bone level/loss
BOP		Bleeding on probing
BL UP		Build up
BW		Bitewing radiograph
CA		Citric acid
CA(OH) 2		Calcium hydroxide
Carbo		Carbocaine
Cav		Cavitron
CR & BR		Crown and bridge
CU DET		Complete maxillary denture
CL DET		Complete mandibular denture
Cem		Cementation
ChX		Chlorhexidine
CL		Crown Length
CPTIN		Community based periodontal index of treatment needed
CR		Crown
CTG		Connective tissue graft
Cutt		curretage
Cx		Cancelled
D		Distal
DB		Disto - incise
DFDBA		Demineralized freeze drilled bone allogant
DI		Dsito - lingual
DO		Ditso - ligual
DPC		Direct pulp cap
DSK		Dry socket
E/IOE		Extraoral/infroaral examination
Epi		Epinephrine
ETB		Electric toothbrush
ETTB		End tuft tooth brush

EXT		Extract/extraction
ABBREVIATION		**MEANING**
F		Facial
FB		Fissure block
FB Imp		Full bony impaction
FG CR		Full gold crown
FGG		Free gingival graft
FI		Floss instruction
Fin & pol		Finish and polish
FL		Floride
FMX		Full mouth x -rays
FPCR		Full procelan
FPDET		Fixed patial Denture
GCR		Gold crown
GI		Glass lonomer
GP		Gutta percha
GTR		Guided Tissue Regulation
I		Incisal
IUC DET		Immediate Upper complete denture
ILU DET		Lowerimmediate complete denture
IE		Initial examination
Imp		Impression
IP		Initial preparation
IPE		Initial perodntal
IPX		Interproximal
IRM		Intermediated restrorative
KF		Kelac - f
Ks		Ketlac silver
L		L:ingual
L(cricted)		Left
LA		Local anesthesia
LHA		Lingual holding arch
Lido		Liocaine

Abbreviation NOT to be used

ABBREVIATION		MEANING
BT		Bed Time
D/C		Used in more than one sense of the word Discontinue. Discharge.
C.S.T		Continue Same Treatment
IJ		Injection
Mg		Microgram
SC, SQ, SUBQ		Subcutaneous
TIW		Twice or thrice times a week
U		Unit
IU		International unit
Q.D., Q.O.D		Every other day
X.O mg		Trailing zero
Ms, MSo4, MGSO4		Magnesium sulfate, Morphine Sulfate
H.S		Half strength or Latin abbreviation for bedtime
T.I.W		Three times a week
S.C. or S.Q.		Subcutaneous
D/C		Discharge
c.c.		Cubic centimeter
A.S., A.D., A.U.		Latin abbreviation for left, right, or both ears

INDEX

Sl. No.	TITLE	Policy No.
01	Registration of New patients	001
02	Authorization of Staff Members Making Entry Into Medical Records Charts (File)	002
03	Retention of Medical Records	003
04	Confidentiality of Medical Records	004
05	Security of Medical Records	005
06	ICD -10 AM Coding and Data Abstracting	006
07	Medical Records Tracking System	007
08	Patient Medical Record Identification	008
09	Recording By Various Health Care Providers In patients Medical Charts / File	009
10	Contents of Medical Records	010
11	Completion of Medical Records	011
12	Review of Medical Records For Quality	012
13	Physician Order – Telephone & Verbal Orders	013
14	Quantitative Analysis	014
15	Staffing of Medical Records Department	015
16	Filing And Retrieval of Medical Records	016
17	Transcription of Discharge/Death Summaries and Operative Reports	017
18	Release of Medical Records or Information	018
19	Executive Information about The patients Shall Be Located In the Face Sheet	019
20	Guidelines of Correction of Entries In the Medical Records	020
21	Entering Laboratory Results Into Patients Records	021
22	Participation of Medical Director In the Records Quality Management Program	022
23	Medical Record Analysis and Completion	023
24	Storage Record Analysis And Completion	024
25	Abbreviations	025