



ORIGINAL

DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
1100 PLYMOUTH BOULEVARD
BEAUFORT, SOUTH CAROLINA 29902-6148

IN REPLY REFER TO:

NAVHOSPBFTINST 6150.1Q

23C
18 APR 2000

NAVHOSP BEAUFORT INSTRUCTION 6150.1Q

Subj: MEDICAL RECORDS

Ref: (a) Joint Commission on Accreditation of Healthcare Organizations, Accreditation Manual for Hospitals
(b) Manual of the Medical Department, Chapter 16
(c) SECNAVINST 5211.5D
(d) BUMEDINST 6010.13
(e) BUMEDINST 6010.17A
(f) NAVHOSPBFTINST 5213.1G
(g) Nursing Policy and Procedure Manual

Encl: (1) Standards for Inpatient Medical Records
(2) Standards for Outpatient Medical Records
(3) Medical Records Committee
(4) List of Approved Medical Abbreviations and Symbols

1. Purpose. To provide guidelines for the preparation, maintenance, review and retirement of inpatient and outpatient medical records per references (a) through (g).

2. Cancellation. NAVHOSPBFTINST 6150.1P

3. General Information

a. The standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires a medical record function that documents the evaluation, diagnosis and treatment for all patients provided care at Naval Hospital, Beaufort (NHB).

b. The medical record serves as a communication link between health care providers and consultants and protects the legal interests of the patient, provider, NHB and the Federal Government. The medical record is a medico-legal document and it is essential that proper clinical documentation, administrative management, accountability and security of records is maintained.

c. The medical record is the property of the government and it is the responsibility of the NHB to safeguard the record and its contents against loss, defacement, tampering and unauthorized use. Per references (b) and (c), patient privacy, medical confidentiality and medical record security will be respected and implemented.

d. The Privacy Act Statement (DD Form 2005) will be signed by each patient and filed in their medical record.

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4. Records Categories

a. Inpatient Medical Records document inpatient care provided to all patients. References (a) and (b) set forth the methods and procedures for the maintenance of inpatient medical records. The minimum standards for inpatient medical records required by NHB are contained in enclosure (1).

b. Outpatient Medical Records document outpatient medical care provided to all patients. References (a) and (b) provide the methods and procedures for the maintenance of outpatient medical records. The minimum standards for outpatient medical records required by NHB are contained in enclosure (2).

5. Medical Records Committee (MRC) will assess the quality of medical care documentation as well as the procedures developed for their establishment, maintenance, and disposition. The MRC will base their appraisal on the assessment of whether the requirements of Navy directives, JCAHO standards, and local instructions have been met. Refer to enclosure (3) for complete committee guidelines.

6. Abbreviations. The use of abbreviations, sign, and symbols in the medical records are restricted to those authorized by the medical staff per enclosure (4). Each abbreviation or symbol should have only one meaning. Abbreviations should not be used for recording the final diagnoses on cover sheets, narrative summaries, or operation reports.

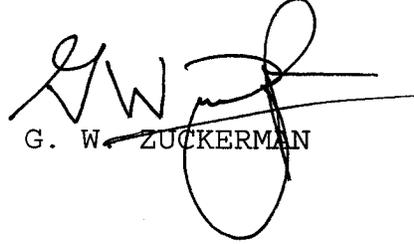
7. Record Entries. All entries will be legible and in black ink or typewritten. All signatures must be identifiable. Signatures must be accompanied by typed, stamped, or printed identification data immediately below the signature. The minimum required information: the signer's name, grade, profession or corps (e.g., MD or MC). Use of preprinted master signature lists is an acceptable method of meeting the signature identification requirement. Use of signature stamps is strictly prohibited.

8. Authorized Forms. Any new, revised, overprinted standard forms or preprinted instructions to the patient to be incorporated in the medical record must be approved by the Medical Records Committee. Medical documentation from civilian sources will be interfiled with the SF 600s and other similar forms.

9. Storage and Retirement of Medical Records. All medical records shall be maintained and retired per reference (b).

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10. Action. Minimum standards for inpatient and outpatient medical records at NHB are contained in enclosures (1) and (2). All Medical Department personnel shall have a working knowledge of this instruction. Directors and Department Heads are responsible for ensuring specific compliance, as applicable, by personnel assigned to their area of responsibility.



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Distribution:
"A"

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STANDARDS FOR INPATIENT MEDICAL RECORDS

1. Preparation of the Inpatient Medical Record. An inpatient medical record will be established for every individual receiving inpatient care at NHB. A comprehensive, well documented and complete inpatient medical record is a mandatory requirement in the practice of good clinical medicine. Each record provides a means of communication between professional staff, documents the course of a patient's illness and serves as a basis for evaluation of quality of care. A complete medical record with appropriate entries is also utilized as a medico-legal document.

2. Contents of the Inpatient Medical Record. The following forms constitute the minimum requirements for an inpatient medical record. Each form will be the original and will contain patient-identifying information utilizing the patient's addressograph card or the computer generated equivalent.

a. Inpatient Admission/Cover Worksheet. Physicians will record all final diagnoses and surgical procedures on this form when the patient is discharged or transferred to another hospital. All diagnoses established during the period of hospitalization will be listed. Abbreviations and symbols will not be used to record final diagnoses.

b. Narrative Summary (502), a concise clinical resume included in the medical record at discharge, provides important information to other caregivers and facilitates continuity of care. It is required for all patients whose hospitalizations exceed 48 hours. The summary will contain the reason for hospitalization, significant findings, procedures performed and treatment rendered, the patient's condition at discharge, and instructions to the patient and family. For patients hospitalized less than 48 hours with only minor problems, a final progress note may substitute for the narrative summary.

c. History and Physical Examinations (SFs 504, 505, and 506) must be completed by a physician or oral surgeon within 24 hours after admission. When a patient is readmitted within 30 days for the same or a related condition, the physician may review the previous history and physical and document any interval changes in a progress note in lieu of completing new SFs 504, 505, and 506.

d. Abbreviation Medical Record (SF539) may be used to document the history and physical examination for those admissions of a minor nature which are anticipated to require less than 48 hours of hospitalization. When the SF 539 is used, the narrative summary may be replaced by a final progress note.

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When a short stay extends to more than 48 hours, a narrative summary must be prepared. In such cases, SFs 504, 505, and 506 need NOT be completed in addition to the SF 539. The reason for the extended stay will be recorded fully in the progress notes.

e. Doctor's Orders (SF 508). A patient shall not be admitted or given medication, special diet, or treatment except upon the orders of a physician, dentist, or other authorized provider. All orders must be dated and signed by the registered or licensed nurses. Each verbal order is dated and is identified by the names of the individuals who gave it and received it, and the record documents who implemented it. Verbal orders will be cosigned by a licensed independent practitioner within 24 hours.

f. Progress Notes (SF 509) give a chronological picture and analysis of the clinical course of the patient and will be kept current at all times. The frequency with which entries are made is determined by the condition of the patient, but must be made at least daily. The Disposition Planning Guide (NHBFT 6011/1) may be used as the final progress note. This form is completed in triplicate; the original will be filed in the inpatient record, one copy will be given to the patient, and one copy will be filed in the outpatient record.

g. Laboratory and Radiographic Reports. Cumulative reports are generated from Composite Health Care System (CHCS) and will be filed in the record upon receipt.

h. Nursing Assessments will be completed on all patients. See Nursing Policy and Procedure Manual for specific requirements.

i. Nursing Notes (SF 510) are a record of all nursing care given and the patient's reaction to this care. Nursing notes will be kept current at all times.

j. Other forms as required

(1) Autopsy Protocol (SF 503). When an autopsy is performed, a complete report of the findings shall be made a part of the medical record within 90 days.

(2) Authorization for Autopsy SF 523). When an autopsy is performed, the completed authorization will be included in the medical record.

(3) Consultation Sheet (SF 513). All consultations must be recorded, signed by the consultant and included in the medical record per reference (b). Physicians requesting internal consultations must utilize the CHCS generated SF 513.

Enclosure (1)

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(4) Tissue Examination (SF 515). A CHCS generated form required any time surgically removed tissue specimens are sent to the laboratory for pathological examination.

(5) Operation Report (SF 516) must be dictated immediately after surgery and contain a description of the findings, the technique used and the tissue removed. The signed original is filed in the medical record as soon as possible. A comprehensive progress note, including preoperative and post operative diagnoses will be entered in the medical record immediately following surgery to provide pertinent information for use by any practitioner who is required to attend the patient.

(6) Anesthesia Report (SF 517). The pre-anesthesia evaluation of the patient must be made and authenticated by an anesthesiologist or nurse anesthetist. The events taking place during the duration of all anesthetic agents, other drugs, intravenous fluids and blood or blood components, must be recorded. The original report is filed in the medical record.

(7) Blood Transfusions (SF 518). The original signed report becomes part of the medical record.

(8) Electrocardiographic Reports (SF 520). The original signed report is made a part of the medical record.

(9) Authorization for Anesthesia and for Performance of Operations and Other Procedures (SF 522). The requirements for informed consent and the completion of subject form are outlined in reference (d).

(10) Labor Record (SF 534). The Physician performing the delivery must sign this form.

(11) Newborn Record (NHBFT 6300/14). This form will be signed by both the Obstetrician and Pediatrician.

3. Completion of Clinical Record. After the patient has been discharged, the record will be assembled in the prescribed sequence per reference (b). The record must be dictated, signed, and coded within 30 days following discharge. Continuous monitors of inpatient medical record deficiencies and delinquencies are performed by medical record technicians and the findings are reported monthly and quarterly to the Performance Improvement Board and Medical Record Committee.

Enclosure (1)

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4. Security and Control. Medical Records are kept in locked shelving on the Inpatient Medical Records Branch. No original inpatient records may leave the premises. Healthcare providers are to work on medical records only on the premises of the Military Treatment Facility (MTF). After normal working hours the Officer of the Day (OOD), Mate of the Day (MOD), and the Patient Administration Watch are authorized to check out medical records if they are needed for patient care purposes. Patients being transferred to a local hospital for further care shall have a copy of pertinent parts of the record accompany them to the receiving hospital. The ward is responsible for ensuring that a copy of the record is sent with the patient. The original inpatient record will remain in the custody of NHB.

5. Outpatient Health Records will be retained on the ward while the patient is receiving inpatient care if requested by the ward.

6. Confidentiality of Medical Records/Information. Information contained in the medical record of individuals who have undergone medical examinations or treatment is personal to the individual and is considered to be of a private and confidential nature. Consequently, information from such medical records, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, will not be made available to the public. Such information is exempt from release under the Freedom of Information Act. Medical information is seen by clerical and administrative support personnel in the course of performing their jobs. These individuals have a professional, ethical, and legal obligation to keep medical information confidential and private. Unauthorized disclosure of medical information is grounds for disciplinary action against the informant.

7. Release Against Medical Advice (AMA). When a patient other than an active duty member, elects to leave the hospital against the advice of their physician, the following procedures apply:

a. During regular working hours:

(1) Notify the patient's physician

(2) Notify Head, Patient Administration Department or their designee, who will discuss the matter with the patient, witness the patient or patient's agent sign the Hospital Release Form, and then sign the form. The AMA Form (NHBFT 6320/5) is prepared in triplicate; the original copy placed in the chart, one copy is forwarded to the Patient Administration Department and one copy is given to the patient.

(3) The ward nurse will make appropriate entries in the Nursing note (SF 510).

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b. After regular working hours:

(1) Notify in-house and/or emergency room physician and the patient's primary physician.

(2) Notify the OOD who will discuss the matter with the patient and perform the Patient Administration functions as described above.

(3) The ward nurse will make appropriate entries in the Nursing Notes.

c. Active duty patients are considered to be in an Unauthorized Absence status if they leave without being properly discharged. Notify the Patient Administration Department or OOD as applicable.

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STANDARDS FOR OUTPATIENT MEDICAL RECORDS1. Preparation of the Outpatient Medical Record

a. General. An outpatient medical record (NAVMED 6150/21-30) will be established and maintained for every patient who receives ambulatory care services at NHB. All significant clinical information pertaining to the patient will be incorporated into the medical record. Documentation of visits will include:

- (1) Patient Identification
- (2) Date
- (3) MTF Name
- (4) Clinical Department or Service
- (5) Provider's name, grade or rate, profession, and SSN
- (6) Chief complaint or purpose of visit
- (7) Objective findings
- (8) Diagnosis or medical impression
- (9) Studies ordered
- (10) Therapies administered
- (11) Disposition, recommendations, and instructions to patient
- (12) Signature of Provider

b. When surgical services are provided on an ambulatory basis, an accurate and complete description of the techniques and findings of every operative procedure performed will be dictated or written immediately following surgery and authenticated by the individual who performed the procedure.

c. Non-active duty patients will not be allowed to handcarry their outpatient medical records or maintain them on a routine basis. Patients who report for appointments carrying their medical record, other than patients in transit, will not have their record returned to them. Only when patients are receiving care at another military or government MTF or care from a civilian provider may have possession of the outpatient medical record. Patients who have walk-in appointments within the NHB will be allowed to hand-carry their record on a case by case

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basis. The record will be signed out to the patient and it will be annotated in CHCS that the record is in the patient's possession. The record should be returned to the custody of the NHB following the clinic visit. Medical information required for a bona fide medical emergency will be released by the most expedient method.

d. Active duty members may hand-carry their medical records for appointments but may not have custody of them. Active duty records will be retained by the MTF having responsibility for the record.

e. All records will be maintained in a locked area, room, or file to ensure safekeeping, unless there is a 24 hour watch in the records office. Copies of medical records will be released only with authorization from the patient and will be restricted to the amount of information necessary to accomplish the purpose for which it is requested.

2. Contents of the Outpatient Medical Record. The following forms constitute the minimum requirement for an outpatient medical record at NHB:

a. Summary of Care (NAVMED 6150/20). All outpatient medical records will contain a summary list of relevant conditions and medications that significantly affect the patient's medical status, including information relative to health surveillance and health maintenance. All physicians and other licensed independent health care practitioners providing care to patients bear responsibility for ensuring the Summary of Care form is continuously updated following reference (b).

b. Chronological Record of Medical Care (SF600) is a record of all routine outpatient visits and treatment recorded in chronological order.

c. Privacy Act Statement (DD Form 2005). Should be signed and filed in the outpatient medical record when it is established.

d. Laboratory, Radiology, and EKG results.

3. Maintenance of the Outpatient Medical Record

a. Record Tracking

(1) Medical records will be charged out to the custody of the appropriate clinic for outpatient appointments. CHCS will be utilized to track the record. When patients have subsequent appointments at other clinics, the initial clinic will re-charge

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out the record to the next clinic in order to track the record properly.

(2) Charge out cards will be placed in the file to show the location of the record.

b. Responsibilities of the Outpatient Records Section

(1) Each patient will be registered in CHCS along with the established and maintenance of the outpatient medical record. All medical reports received will be processed into the medical record following the guideline in reference (b).

(2) Records will be transferred following the guidelines in reference (b).

c. Secondary Records

(1) Certain outpatient clinics are authorized to initiate a secondary medical record to document sensitive medical information. The health care provider creating a secondary record should write a note stating the nature of the secondary record, the patient's diagnoses, the clinic or department name, address, and telephone number on the Summary of Care (NAVMED 6150/20) of the patient's primary record.

(2) Prenatal records on patients for whom delivery is expected to be performed at Beaufort Memorial Hospital (BMH) will be maintained in the OB Clinic or the Blue Teams until delivery occurs. Clinic staff will prepare a complete copy of the prenatal record at 28 weeks and update copies at 36 weeks and at the time of delivery. Patient Administration Department will arrange delivery of the copies to BMH. Physicians handcarry copies of BMH medical records back to NHB so they can be incorporated into NHB Outpatient Records.

Enclosure (2)

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MEDICAL RECORDS COMMITTEE

1. General. This enclosure provides guidelines for the organization and function of the Medical Records Committee. The review of medical records addresses the presence, accuracy, timeliness, legibility, and authentication of the data and information specified in JCAHO standards and Navy directives.

2. Committee Membership. To ensure that membership remains ongoing and representative, the Chairman will seek replacement nominees from the respective Director upon a particular member's departure from the Committee. Nominees shall be approved by the Commanding Officer and appointment letters prepared by Manpower Management Department. The Medical Records Committee will meet at the call of the Chairman or at least quarterly. The Medical Records Committee will include the following members:

a. Chairman, (a Medical Officer appointed by the Commanding Officer).

b. One Medical Officer from a Medical subspecialty.

c. One Medical Officer from a Surgical subspecialty.

d. One Medical Officer from an Ancillary subspecialty.

e. Medical Staff Representatives from Branch Medical Clinic, Marine Corps Recruit Depot and Branch Medical Clinic, Marine Corps Air Station, Beaufort , SC.

f. One Nurse Corps Officer.

g. Head, Patient Administration.

h. Medical Records Representative.

i. Other members as needed.

3. Action

a. Employing the criteria set forth in references (a) and (b), the medical records staff will conduct a 100% review of inpatient records and a representative sample review of outpatient records. The results of all record reviews will be presented to the Medical Record Committee. Measures recommended to correct any deficiencies and follow-up will be documented in the Committee minutes.

b. The committee shall review departmental record evaluation results and make recommendations for improvements.

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c. The committee shall identify opportunities and make recommendations to improve the quality, accessibility, confidentiality and security of medical records and the data maintained and processed in medical records systems.

4. Reporting Requirements. Written reports and minutes shall be submitted to the Performance Improvement Board.

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LIST OF APPROVED MEDICAL ABBREVIATIONS AND SYMBOLS

A.....assessment
 A2.....aortic 2nd sound
 a.....before
 AAS.....acute abdominal series
 AB.....abortion
 ab.....antibody
 abd.....abdomen
 ABG.....arterial blood gas
 ACDU, AD.....Active Duty
 ACTH.....adrenocorticotropic hormone
 a.c.....before meals
 AC.....abdominal circumference
 AD.....right ear
 ADH.....antidiuretic hormone
 ADL.....activities of daily living
 Adm.....admission, admitted
 ad lib.....as desired
 AF.....anteflexed
 AF.....Air Force
 AFB.....acid fat bacillus
 AFEB.....afebrile
 AFP.....alphafetoprotein
 A/G.....albumin/globulin
 AG.....antigen
 AGA.....appropriate gestational age
 AIDS.....Acquired Immunodeficiency Syndrome
 AJ.....ankle jerk
 AK.....above knee
 AKA.....above the knee amputation
 A-line.....arterial line
 Alb.....albumin
 alk phos.....alkaline phosphatase
 ALRI.....anterolateral rotary instability
 A.M.....morning
 AMA.....against medical advice
 AMINO.....aminophylline
 AMINO.....amniocentesis
 amp.....ampule
 amt.....amount
 anes.....anesthesia
 ant.....anterior
 AODM.....adult onset diabetes mellitus
 AOW.....admitted from other ward
 APPT.....appointment
 APPY.....appendectomy
 A&P.....auscultation and percussion
 Ao.....aorta
 AoA.....aorta aneurysm
 A&P Repair.....anterior and posterior repair

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ag.....aqueous
APV.....Ambulatory Procedure Visit
APU.....Ambulatory Procedure Unit
ARC.....AIDS related complex
ARD.....Alcohol Rehabilitation Department
ARDS.....adult respiratory distress
 syndrome
AROM.....artificial rupture of membrane
AS.....left ear
ASA.....aspirin
ASAP.....as soon as possible
ASCVD.....atherosclerotic cardiovascular
 disease
ASD.....atrial septal defect
ASHD.....arteriosclerotic heart disease
ASMI.....anteroseptal myocardial infarction
ASO.....antistreptolysin O titer
ASYM.....asymmetric
ATN.....acute tubular necrosis
AU.....both ears
AV.....arteriovenous
av.....anteverted
AWE.....acetowhite epithelium
A&W.....alive ann well
Ax.....axillary

Ba.....barium
BBB.....bundle branch block
BBT.....baby's blood type
BCP.....birth control pills
BE.....barium enema
BF.....black female
BH.....Braxton Hicks
b.i.d.....twice a day
Bili.....bilirubin
Bin x cyl.....binocular cross cylinder
BK.....below knee
BKA.....below knee amputation
BM.....bowel movement
BOM.....bilateral ottis media
BOW.....bag of waters
BOWI.....bag of waters intact
BP.....blood pressure
BPD.....biparietal diameter
BPH.....benign prostatic hypertrophy
BR.....bed rest
B.R.B.....bright red blood
BRP.....bathroom privileges
BRRB.....bright red rectal bleeding

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BS.....bowel sounds
 B.S.O.....bilateral salpingo-oophorectomy
 BSOM.....bilateral serous otitis media
 B.T.B.....breakthrough bleeding
 BTL.....bilateral tubal ligation
 BUN.....blood urea nitrogen
 BUS.....Bartolin's, urethral, Skene's
 glands
 Bx.....Biopsy

c.....with
 C.....centigrade
 CA.....cancer
 Ca.....calcium
 cap.....capsule
 cath.....catheterize, catheter
 CABG.....coronary artery bypass graft
 CAD.....coronary artery disease
 CAL.....calorie
 Cauc.....Caucasian
 CBC.....complete blood count
 CBC with diff.....complete blood count with
 differential
 cc.....cubic centimeter
 CCE.....cyanosis, clubbing, exudate
 CDO.....Command Duty Officer
 CF.....cystic fibrosis
 CG.....Coast Guard
 CHF.....congestive heart failure
 CHLAM.....chlamydia
 CHO.....carbohydrate
 chol.....cholesterol
 CHORIO.....chorioamnionitis
 CI.....cephalic index
 CIRC.....circumcision
 CKC.....cold knife conization
 C.L.....corpus luteum
 CMAA.....Chief Master-At-Arms
 CMP.....chondromalacia patellae
 CNS.....central nervous system
 CO.....Commanding Officer
 CO2.....carbon dioxide
 c/o.....complaining of
 COLP.....colposcopy
 cond.....condition
 cont.....continue
 COPD.....chronic obstructive pulmonary
 disease
 COR.....heart (coronary)

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CP.....cardiopulmonary
CPD.....cephalopelvic disproportion
CPK.....creatinine phosphokinase
CPP.....chronic pelvic pain
CPR.....cardiopulmonary resuscitation
Cr.....creatinine
CRYO.....cryotherapy
C-spine.....cervical spine
C/S.....Cesarean section
C&S.....culture and sensitivity
CSF.....cerebrospinal fluid
CSR.....central supply room
CST.....contraction stress test
CT.....Computerized Tomography Scan
CTM.....chlorthrimeton
CTX.....contractions
CV.....cardiovascular
CVA.....cerebrovascular accident
CVAT.....costovertebral angle tenderness
CVP.....central venous pressure
cx.....cervix
CXR.....chest x-ray
Cyl.....cylinder
cysto.....cystoscopy
C1-C7.....cervical vertebrae

DC.....discharge
d.....day
d/c.....discontinued
D&C.....dilatation and curettage
Dec.....deceased
DEPT.....department
Derm.....Dermatology
DIC.....disseminated intravascular
 coagulation
DIG.....Digitalis
disp.....dispense
DIP.....distal interphalangeal joint
DJD.....degenerative joint disease
D.M.....diabetes mellitus
DNEPTE.....did not exist prior to enlistment
DOA.....dead on arrival
DOB.....date of birth
DOD.....day of delivery
DOE.....dyspnea on exertion
DOS.....day of surgery
DP.....dorsalis pedis
DPG.....disposition planning guide
DPT.....diphtheria pertussis tetanus

Enclosure (4)

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Dr.....doctor
 DRSG.....dressing
 DSD.....dry sterile dressing
 DSPH.....diopter sphere
 DT.....delirium tremens
 DTR.....deep tendon reflex
 D.U.B.....dysfunctional uterine bleeding
 DVO.....distance vision only
 DVOD.....distance vision right eye
 DVOS.....distance vision left eye
 Dx.....diagnosis
 D5NS.....dextrose 5% in normal saline
 D5 1/2 NS.....dextrose 5% in 1/2 normal saline
 D% RL.....dextrose 5% in Ringer's Lactate
 D5W.....dextrose 5% in water
 D/W.....dextrose in water

ea.....each
 EBL.....estimated blood loss
 ECC.....endocervical curettage
 E. Coli.....Escherichia coli
 ECF.....extracellular fluid
 ECG or EKG.....electrocardiogram
 ECHO.....echocardiogram
 EDC.....estimated date of confinement
 EEG.....electroencephalogram
 EENT.....eye, ear, nose and throat
 EFM.....external fetal monitor
 EGD.....Esophagogastroduodenoscopy
 ELF.....elective low forceps
 elix.....elixir
 EMS.....emergency medical services
 EOMI.....extra ocular movements intact
 ENT.....ear, nose, throat
 E.O.....expected outcome
 EOM.....extraocular movements
 EOS.....eosinophils
 EP.....esophoria
 EPI.....epinephrine
 EPIS.....episiotomy
 EPITH.....epithelial
 EPTE.....existed prior to enlistment
 ER.....Emergency Room
 ERT.....estrogen replacement therapy
 ES.....extra sound
 ESR.....erythrocyte sedimentation rate
 EST.....exercise stress test
 ET.....endotracheal
 etc.....etcetera

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ETR.....Emergency Treatment Report
 ETH.....elixir terpin hydrate
 ETH/C.....elixir terpin hydrate with codeine
 ETOH.....ethyl alcohol
 E.U.A.....examination under anesthesia
 exam.....examination
 Ex.....excisional
 EXAC.....exacerbation
 EXP.....expiration
 EXSERMAT.....exservice maternity
 EXT.....extremity

F.....Fahrenheit
 FB.....foreign body
 FBS.....fasting blood sugar
 Fe.....iron
 FFP.....fresh frozen plasma
 FHx.....family history
 FH.....Fundal height
 F.H.T.....fetal heart tones
 FIB.....Fibrinogen
 Fl. oz.....fluid ounce
 FM.....Family Member
 fm.....fetal movement
 FMP.....family member prefix
 FP.....family practice
 freg.....frequent
 FRC.....functional residual capacity
 FROM.....full range of motion
 F.S.....frozen section
 ft.....foot, feet
 FT(M).....from transfer (Army, Air Force
 Other Naval Medical Facility)
 FT(O).....from transfer (other medical
 facilities)
 FTR.....father
 F/U.....follow-up
 FUO.....fever of undetermined origin
 FTT.....failure to thrive
 Fx.....fracture

Gm.....gram
 G.....gravida
 ga.....gauge
 GB.....gallbladder
 GC.....gonococcus
 G&D.....growth and development
 gen.....general
 Genit.....genitalia

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GERD.....gastroesophageal reflux disease
 GI.....gastrointestinal
 gr.....grain
 GSW.....gunshot wound
 GTT.....glucose tolerance test
 gtt.....drop/drops
 GU.....genitourinary
 GYN.....gynecology

HA.....headache
 HBP.....high blood pressure
 HC.....hydrocortisone
 H.C.....head circumference
 hct.....hematocrit
 HCL.....hydrochloric acid
 HEELP.....hepatic enzyme elevation and low
 platelet
 HEENT.....head, eyes, ears, nose and throat
 HFHL.....high frequency hearing loss
 HFlu.....Hemophilus influenzae
 Hgb.....hemoglobin
 H&H.....hemoglobin/hematocrit
 HIV.....human immunodeficiency virus
 HMD.....hyalin membrane disease
 HNP.....herniated nucleus pulposus
 H/O.....history of
 H2O.....water
 H&P.....history & physical
 hs.....at bedtime/on retiring
 H.S.G.....hysterosalpingogram
 HMS.....hepatosplenomegaly
 HSV.....herpes simplex virus
 ht or HT.....height
 HTLVIII.....human T lymphocyte virus type III
 HTN.....hypertension
 Hx.....history
 Hyst.....hysterectomy

IBD.....inflammatory bowel disease
 IBS.....irritable bowel syndrome
 ICH.....intracranial hemorrhage
 ICP.....intracranial pressure
 ICU.....intensive care unit
 ICS.....intercostal space
 I.D.....identification
 I&D.....incision and drainage
 ID.....intra dermal
 IDC.....indirect Coombs
 I/E.....inspiratory/expiratory ratio

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I.L.F.....indicated low forceps
 IM.....intramuscular
 I.M.B.....intramenstrual bleeding
 I.M.F.....indicated mid forceps
 IMF.....intermaxillary fixation
 IMI.....inferior myocardial infarction
 Imp.....impression
 in.....inch
 inc.....incision
 incr.....increased, increasing
 inf.....infusion/inferior
 ing.....inguinal
 INH.....isoniazid
 inj.....injection
 int.....intubate(d)
 I&O.....intake and output
 IOP.....intraocular pressure
 IPJ.....interphalangeal joint
 IPPB.....intermittent positive pressure
 breathing
 ITT.....internal tibial torsion
 IUD.....intrauterine device
 IUFD.....intrauterine fetal demise
 IUGR.....intrauterine growth retardation
 IUP.....intrauterine pregnancy
 IUPC.....intrauterine pressure catheter
 IV.....intravenous
 IVC.....intravenous cholangiogram
 IVCD.....intraventricular conduction delay
 IVP.....intravenous pyelogram
 IVPB.....intravenous piggy back

JP.....Jackson Pratt
 JVD.....jugular venous distention

K.....Potassium
 KCL.....potassium chloride
 kg.....kilogram
 KI.....potassium iodide
 KJ.....knee jerk
 KUB.....kidneys, ureters, bladder
 KVO.....keep vein open

L.....lumbar
 (L).....left
 LB.....live born
 L&D.....labor and delivery
 Lab.....laboratory

Enclosure (4)

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Lb.....pound
 Lac.....laceration
 LAD.....left axis deviation
 LAH.....left atrial hypertrophy
 LAP.....laparotomy
 LAT.....lateral
 LBBB.....left bundle branch block
 LBP.....low back pain
 LDH.....lactic dehydrogenase
 LE.....lower extremity
 LES.....lower esophageal sphincter
 LFT.....liver function test
 LGA.....large for gestational age
 L.H.....luteinizing hormone
 LIH.....left inguinal hernia
 LL.....left lateral
 LLE.....left lower extremity
 LLL.....left lower lobe
 LLQ.....left lower quadrant
 LMP.....last menstrual period
 L.N.....lymph node
 LNMP.....last normal menstrual period
 LOA.....level of activity
 LOC.....loss of consciousness
 LOE.....left otitis externa
 LOM.....left otitis media
 LOP.....left occipitoposterior
 LOT.....left occiput transverse
 LP.....lumbar puncture
 LPN.....Licensed Practical Nurse
 LSO.....left salpingo-oophorectomy
 LSOM.....left serous otitis media
 LSTC.....laparoscopic tubal cauterization
 LUE.....left upper extremity
 LUL.....left upper lobe
 LUQ.....left upper quadrant
 L-S.....lumbosacral
 LVH.....left ventricular hypertrophy
 lymps.....lymphocytes
 lytes.....electrolytes
 L1-L5.....lumbar vertebrae

m.....meter
 M.....murmur
 M1.....mitral first heart sound
 MAA.....Master-At-Arms
 mand.....mandible
 MAR.....medication administration record
 max.....maxilla
 MBT.....mother's blood type

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MC.....Marine Corps
 MCAS.....Marine Corps Air Station
 mcg.....microgram
 MCL.....midclavicular line/medial
 collateral ligament
 MCP.....metacarpophalangeal joint
 MCDR.....Marine Corps Recruit Depot
 MEC.....meconium
 Meds.....medications
 MEq.....milliequivalent
 Mg.....magnesium
 mg.....milligram
 MgSO4.....magnesium sulfate
 MI.....myocardial infarction
 ml.....milliliter
 ML.....midline episiotomy
 min.....minute
 mm.....millimeter
 MMR.....measles, mumps, rubella
 MOM.....milk of magnesia
 Mon x cyl.....monocular cross cylinder
 M.S.....Morphine Sulfate
 MULTIP.....multiparous
 MVA.....motor vehicle accident
 MVP.....mitral valve prolapse
 MZ.....mosaicism

N.....navy
 N.....Nitrogen
 N/A.....not applicable
 Na.....sodium
 NaCl.....sodium chloride
 NAD.....no acute distress
 NaHCO3.....sodium bicarbonate
 NALS.....neonatal advanced life support
 N.E.....not examined
 neg.....negative
 NET.....nasal endotracheal tube
 NEURO.....neurology/neurologic
 NG.....nasogastric
 NGU.....nongonococcal urethritis
 NI.....not indicated
 NIS.....not in stock
 NKA.....no known allergies
 NKDA.....no known drug allergies
 NL.....normal
 N2O.....nitrous oxide
 NOC.....night
 NOD.....Nurse of the Day
 NOK.....next of kin

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NP.....nasopharynx
 NPC.....near point of convergence
 NPH.....neutral protamine hegedorn
 NPO.....nothing by mouth
 NR.....no refill
 NS.....normal saline
 NSVD.....normal spontaneous vaginal
 delivery
 NSR.....normal sinus rhythm
 NSSC.....normal size, shape, and
 consistency
 NSSTTW.....nonspecific S-T-T-wave changes
 NST.....nonstress test
 NSU.....nonspecific urethritis
 Nsy.....Nursery
 NT.....nasotracheal
 NTG.....nitroglycerin
 N&V.....nausea and vomiting
 NVO.....near vision only

O.....objective
 O.A.....occiput anterior
 OB.....obstetrical
 O2.....oxygen
 O2 SAT.....oxygen saturation
 occ.....occasional
 OCP.....oral contraceptive pill
 OCT.....Oxytocin Challenge Test
 OD.....right eye
 O.F.C.....occipitofrontal circumference
 OF.....Oriental female
 OFD.....occipital fontanel diameter
 OGM.....organomegally
 oint.....ointment
 OM.....otitis media
 OOB.....out of bed
 OOD.....Officer of the Day
 OP.....operation
 O.P.....occiput posterior
 O&P.....ova and parasites
 OPV.....oral polio vaccine
 OR.....Operating Room
 ORD.....orders
 ORIF.....open reduction and internal
 fixation
 ORTHO.....orthopaedic
 OS.....left eye
 OSD.....Osgood-Schlatter's Disease
 OT.....occupational therapy
 OU.....both eyes
 oz.....ounce

Enclosure (4)

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PPD.....post-partum day
 P.P.D.....purified protein derivative
 PPTL.....post-partum tubal ligation
 PR.....per rectum
 pr.....pair
 Preg.....pregnant
 Prem.....premature
 PREOP.....preoperative
 PREP.....prepare
 prn.....when necessary
 prob.....problem
 PROC.....procedures
 PROCTO.....proctosigmoidoscopy
 PROM.....premature rupture of membranes
 PSH.....post surgical history
 Pt.....patient
 PT.....Physical Therapy
 PT.....prothrombin time
 PTA.....prior to admission
 PTL.....preterm labor
 PTT.....partial thromboplastin time
 PUD.....peptic ulcer disease
 pud.....pudendal
 PUND.....pregnancy uterine not delivered
 pyelo.....pyelonephritis
 PVC.....premature ventricular
 contractions

q.....every
 qAM.....every morning
 q.d.....every day
 q.h.....every hour
 q2h.....every two hours
 q.i.d.....four times a day
 qns.....quantity not sufficient
 q.o.d.....every other day
 q.s.....sufficient quantity
 qual.....quality, qualitative
 quant.....quantity, quantitative
 R.....respiration
 (R).....right
 RADTX.....radiation treatment
 RAD.....reactive airway disease
 RAH.....right atrial hypertrophy
 RBBB.....right bundle branch block
 RBC.....red blood cell
 RDS.....respiratory distress syndrome
 Rec.....recommendation
 Reg.....regular
 Rehab.....rehabilitation

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RL.....religion
 REM.....rapid eye movement
 resp.....respiration
 RET.....retired
 RF.....retroflexed
 Rh.....rhesus factor
 RIH.....right inguinal hernia
 RL.....right lateral
 RL.....Ringer's lactate
 RLE.....right lower extremity
 RLF.....retrolental fibroplasia
 RLL.....right lower lobe
 RLQ.....right lower quadrant
 R&M.....routine and microscopic
 RML.....right middle lobe
 R.M.L.....right mediolateral
 RN.....Registered Nurse
 R/O.....rule out
 ROA.....right occiput anterior
 ROE.....right otitis externa
 ROM.....range of motion
 R.O.M.....right otitis media
 ROP.....right occiput posterior
 ROT.....right occiput transverse
 ROS.....review of systems
 RPR.....rapid plasma reagin
 RR.....Recovery Room
 RRR.....regular rate and rhythm
 RSD.....reflex sympathetic dystrophy
 RSO.....right salpingo-oophorectomy
 RSOM.....right serous otitis media
 RSR.....regular sinus rhythm
 RTC.....return to clinic
 RUE.....right upper extremity
 RUO.....right upper quadrant
 RV.....right ventricle
 rv.....retroverted
 RVH.....right ventricular hypertrophy
 Rx.....prescription
 rx.....reactive

s.....without
 s.....sacral
 S.....Subjective
 SA.....sinoatrial
 SA.....semen analysis
 SAA.....same as above
 S.A.....sacrum anterior
 Sat.....saturation

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S&A.....sugar and acetone
 SAB.....subarachnoid block
 SBE.....subacute bacterial endocarditis
 SF.....standard form
 SDS.....same day surgery
 sed. rate.....sedimentation rate
 SEM.....systolic ejection murmur
 SGA.....small for gestational age
 SGD.....straight gravity drainage
 SGOT.....Serum Glutamic Oxaloacetic
 Transaminase
 SH.....social history
 SIDS.....sudden infant death syndrome
 Sig.....label
 SIQ.....sick in quarters
 SL.....serious list
 sl.....slightly
 SLE.....systemic lupus erythematosus
 SLR.....straight leg raise
 SOB.....shortness of breath
 soln.....solution
 SOM.....serous otitis media
 SOME.....serous otitis media with effusion
 SOP.....Standard Operating Standard
 S.P.....sacrum posterior
 S/P.....status post
 spec.....specimen
 sp. gr.....specific gravity
 SROM.....spontaneous rupture of membrane
 SS.....saturated solution
 ss.....half
 S.S.E.....soap solution enema
 SSKI.....saturated solution of potassium
 iodide
 S.T.....sacrum transverse
 Staph.....staphylococcus
 stat.....immediately
 STD.....sexually transmitted diseases
 Strep.....streptococcus
 STS.....serological test for syphilis
 subcut.....subcutaneous
 SUI.....stress urinary incontinence
 sup.....superior
 Susp.....suspension
 sut.....suture
 surg.....surgical/surgery
 SVD.....spontaneous vaginal delivery
 SVE.....sterile vaginal exam
 Sx.....symptom
 SYM.....symphysis

Enclosure (4)

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Sym.....symmetrical
syr.....syrup

T.....tourniquet
T&A.....tonsillectomy and adenoidectomy
tab.....tablet
TAH.....total abdominal hysterectomy
TB.....tuberculosis
T/C or TC.....throat culture
T&C.....type and cross match
TCBD.....turn, cough, deep breath
tbsp.....tablespoon
T.E.D.....thrombo-embolic dressing
TECH.....technician
Temp.....temperature
TFT.....thyroid function tests
T&H.....type and hold
THEO.....theophylline
TI.....terminal ileum
TIA.....transient ischemic attack
TIBC.....total iron binding capacity
t.i.d.....three times a day
tinct.....tincture
TM.....tympanic membrane
T.max.....maximum temperature
TMJ.....temporomandibular joint
TNTC.....too numerous to count
TO.....telephone order
Tol.....tolerated
TOW.....transfer to other ward
T.P.....total protein
TPA.....tissue plasminogen activator
TPN.....total parenteral nutrition
TPR.....temperature, pulse, respiration
tsp.....teaspoon
TURP.....transurethral resection of
prostate
TV.....total volume
TVH.....total vaginal hysterectomy
TX.....treatment

UA.....urinalysis
UAC.....umbilical artery catheter
UC.....ulcerative colitis
UCHD.....usual childhood disease
UE.....upper extremity
UGI.....upper gastrointestinal series
UIC.....unit identification code
UIQ.....upper inner quadrant

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UNK.....unknown
 URI.....upper respiratory infection
 USO.....unilateral salpingo-oophorectomy
 UTI.....urinary tract infection
 UVC.....umbilical vein catheter

VA.....Veterans Administration
 VAB.....Veterans Administration
 Beneficiary
 Vag.....vaginal
 valg.....valgus
 var.....varus
 VAS.....vasectomy
 VBAC.....vaginal birth after cesarean
 VC.....vital capacity
 VD.....venereal disease
 VDRL.....Venereal Disease Research
 Laboratory
 VFIB.....ventricular fibrillation
 VIP.....voluntary interruption of
 pregnancy
 VMA.....vanillylmandelic acid
 VO.....verbal order
 vs.....versus
 VS.....vital signs
 VSD.....ventricular septal defect
 VSL.....very serious list
 VSS.....vital signs stable
 vtx.....vertex
 VV.....vesicovaginal

WBC.....white blood cell
 W/C.....wheelchair
 W/D.....well developed
 W/N.....well nourished
 WF.....white female
 WK.....week
 WNL.....weight

X.....multiplied by
 XRT.....x-ray radiation treatment
 x-ray therapy

yr.....year
 yrs.....years
 y/o.....year old

NAVHOSPBFTINST 6150.1Q

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"SYMBOLS"

@.....at
>.....greater than
<.....less than
#.....number