A. V. YAKAULEVA, R. V. KHURSA,
V. V. DROSHCHANKA

FILLING IN OUTPATIENT MEDICAL CARD

Репозиторий БГМУ

Minsk BSMU 2016

МИНИСТЕРСТВО ЗДРАВООХРАНЕНИЯ РЕСПУБЛИКИ БЕЛАРУСЬ
БЕЛОРУССКИЙ ГОСУДАРСТВЕННЫЙ МЕДИЦИНСКИЙ УНИВЕРСИТЕТ
КАФЕДРА ПОЛИКЛИНИЧЕСКОЙ ТЕРАПИИ

Е. В. Яковлева, Р. В. Хурса, В. В. Дрощенко

ОФОРМЛЕНИЕ МЕДИЦИНСКОЙ КАРТЫ АМБУЛАТОРНОГО БОЛЬНОГО

FILLING IN OUTPATIENT MEDICAL CARD

Учебно-методическое пособие

Минск БГМУ 2016

Репозиторий БГМУ

УДК 616-08-039.57-071 (811.111)-054.6 (075.8)
ББК 53.4 (81.2 Англ-923)
Я47

Рекомендовано Научно-методическим советом университета в качестве учебно-методического пособия 20.04.2016 г., протокол № 8

Р е ц е н з е н т ы: канд. мед. наук, доц. Т. П. Павлович; канд. мед. наук, доц. А. М. Борис

Репозиторий БГМУ

Яковлева, Е. В.

Я47 Оформление медицинской карты амбулаторного больного = Filling in outpatient medical card : учеб.-метод. пособие / Е. В. Яковлева, Р. В. Хурса, В. В. Дрощенко. – Минск : БГМУ, 2016. – 24 с.

ISBN 978-985-567-490-1.

Содержит рекомендации по оформлению учебной медицинской карты амбулаторного больного.

Предназначено для студентов 4-го курса медицинского факультета иностранных учащихся, обучающихся на английском языке.

УДК 616-08-039.57-071 (811.111)-054.6 (075.8)
ББК 53.4 (81.2 Англ-923)

ISBN 978-985-567-490-1

© Яковлева Е. В., Хурса Р. В., Дрощенко В. В., 2016
© УО «Белорусский государственный медицинский университет», 2016

INTRODUCTION

Practical skills in filling in medical documentation and consolidation of these skills is one of the main directions of the educational process at the Department of Outpatient Internal Medicine.

The most important document of outpatient practice physician is “Outpatient medical card” (“Outpatient medical card” also often unofficially referred to as an “outpatient card”, “patient’s card” or simply “the card”) approved by the Ministry of Health of the Republic of Belarus as form # “025/y-07”.

This document is a medical passport reflecting state and dynamics of patient’s health over a long period of time. It provides a holistic view of the patient and allows doctors of various specialties, who manage this patient during his life, make appropriate medical decisions. Outpatient practice doctors, especially district therapists/general practitioners, are those who are responsible for the correct filling in and management of the “Outpatient medical card”.

“Outpatient medical card” as an approved (mandatory, single) form has the following sections: passport data part, final (verified) diagnoses list, additions to anamnesis; periodic examinations, sheets for physician’s records.

However, the time passed since the date of approval of the form # “025/y-07” showed the need of addition of new sections that would meet actual practical health care needs. Therefore, now the “Outpatient Medical card” has the following structure:

– passport data part;
– final (verified) diagnoses list;
– periodic (annual) examinations;
– examination results;
– vaccination record;
– gynaecological examinations record (gynaecologist) for women;
– temporary disability record;
– X-ray examinations record;
– anamnesis;
– additions to anamnesis;
– physician’s records.

Results of laboratory (full blood count, urinalysis, blood chemistry etc.) and other diagnostic tests (ECG, pulmonary function tests, ultrasound, etc.), consultative clinics and diagnostic centres specialist consultations conclusions, hospital epicrises (hospital discharge records) are pasted in at the end of the outpatient card or together with the physician’s records.

РЕПОЗИТОРИЙ БГМУ

PASSPORT DATA PART

Patient’s name.
Sex, date of birth.
Phone number (home, work).
Patient’s address.
Place of employment, name and nature of manufacture.
Occupation.
Group of Dispensary surveillance. Indicate diagnosis for groups III and IV.

Data that is indicated on this page should include: allergic anamnesis, history of viral hepatitis, whether the patient belongs to the group of citizens who are eligible for benefits (e. g. military actions handicapped, patients with 1st 2nd 3rd group of disability, prisoners of concentration camps, etc.) with the certifying document number, series and batch; in case of an elderly patient living alone — contact information of the nearest relatives, acquaintances or assigned social service worker should be indicated.

FINAL (VERIFIED) DIAGNOSES LIST

In this part the exact date (day, month, year) of the patient’s visit is specified, the final (specified) diagnoses is briefly formulated and confirmed by physician’s signature.

First-time diagnoses (diagnoses established for the first time) are marked with “+”, chronic diagnoses are repeatedly indicated every year, acute conditions (e. g. acute upper respiratory tract infections) are marked with “+” every time.

The data given here allows the physician to know the patient’s pathology and the reason of the patient's visit, decide whether filling of a statistical coupon is required (remember that statistical coupon is filled in all cases of acute illness , and only once a year in case of chronic pathology).

PERIODIC EXAMINATIONS QUESTIONNAIRE RESULTS AND EXAMINATION RESULTS

In this section the results of patient interview are written down in the first part and the results of patient examination are written down in the second part specifying the date (at least once a year).

This section allows physician to control consistency and regularity of preventive examinations patient undergoes and helps not to lose awareness, especially cancer awareness for early detection of cancer.

Репозиторий БГМУ

If physical examination reveals no abnormalities (e. g. skin examination, oral mucosa examination) — "N" (meaning "normal") is written in, in case organs and/or organ systems cannot be examined directly during physical (e. g. lungs, gastrointestinal tract) — "N/C" or "NC"(meaning "no complaints") is used.

Remember to examine the thyroid (it is included into the "other").

VACCINATION RECORD AND GYNAECOLOGIAL EXAMINATIONS RECORD (GYNAECOLOGIST) FOR WOMEN

This section includes information about vaccines done against tetanus and diphtheria. Data about other vaccinations can also be indicted here.

Indicate the date of vaccination and revaccination, dosage and medication name, series and batch, local and general vaccination reaction. The fact of vaccination is marked in the outpatient card by a nurse, in case of vaccination reaction this fact is reflected by a physician with description of this reaction.

For women: examination results are written down — examination date, diagnosis, cytology results, doctor's or midwife's signature.

TEMPORARY DISABILITY RECORD

This part reflects all cases of the patient's temporary disability (date of issuing and date of closing of a temporary disability certifying document (a temporary disability certificate and/or a sick leave (may also be called a leaflet of disability, or LD), diagnosis). Number of days of each case is counted and indicated.

Addition of this section (despite the fact that issuing of a temporary disability certifying document is mandatory to be reflected in physician's record), allows doctor to make a rapid overview, get information and assess frequency and duration of the patient's temporary disability, makes referral to MREP (if required) and compiling a temporary disability report easier.

X-RAY EXAMINATIONS RECORD

Information about all of the X-Ray examinations patient has been exposed to is noted here (the exact date, type of the x-ray test, radiation dose are specified) and confirmed by physician's signature. This is necessary to address the issue of multiplicity and possibility of further repeated X-ray tests taking into consideration the cumulative radiation dose the patient has already received.

РЕПОЗИТОРІЙ БДМУ

ANAMNESIS AND ADDITIONS TO ANAMNESIS

Past medical history, family history and other significant information should be noted in this part: the patient's present and suffered diseases, past surgery, family history and allergic reactions, risk factors present (smoking, excessive alcohol consumption. substance abuse, insufficient physical activity, dyslipidemia, psychoemotional stressors, etc.), professional anamnesis (workplace, occupational hazards), and brief information about "major" disease (since when patient considers he has had the disease, its possible causes, frequency of exacerbations and precipitating factors, treatment and it's effectiveness, frequency of hospitalizations, frequency of sanatorium and resort treatment, weather the patient is under dispensary surveillance because of this disease and since when).

This part is filled in and signed by a physician specifying the date of taking the anamnesis.

Additions to the anamnesis are filled if new data emerges over time and in case of newly discovered circumstances (allergic reactions, change in working and living conditions, etc.). It is mandatory to indicate the date the additions were made.

PHYSICIAN'S RECORDS

The number of sheets for writing down physician's records (so-called diaries) differs from patient to patient and depends on the frequency of patient's visits, duration of each case of disease, etc.

The structure of the physician's record assumes specifying the date of patient's visit (day, month, year), name of specialty of physician performing examination, type of examination (home visit, ambulatory), primary or repeated (follow-up), description of patient's complaints, first — major complaints, then — other complaints (particularly significant symptoms are detailed precisely), duration of disease, its association with any factors, treatment and its effectiveness (non-drug treatments, procedures (including surgical), medications, complimentary and alternative medicine treatments, etc.).

Physical examination is performed in accordance with the propedeutics of internal diseases scheme, but in busy outpatient settings results of examination are written down in brief (but the examination itself has to be done thoroughly!).

In this section write down the results of physical examination; comment on every organ system with thorough and detailed description of findings in those organs and systems that are relevant to diagnosis; always list vitals: assess level of consciousness (whether patient appears alert, oriented and cooperative), body temperature, heart rate (HR) and pulse, blood pressure (BP),

Репозиторій БДМУ

respiratory rate (RR), if possible — pulsoxymetry (SpO_2). Also indicate height, weight, waist circumference. Noting the fact of smoking, excessive alcohol consumption and drug abuse here (though already noted in anamnesis) is not a mistake.

Diagnosis is formulated in accordance with current classifications and is based on anamnesis (careful history taking, etc.) and physical examination.

Patient management is specified: plan of laboratory and diagnostic tests if required, diet recommendations, regime (e. g. bed rest), medications (dosage, regimen) and non-medication treatment (rehabilitation, physiotherapy, complementary and alternative treatments, etc.), hospital or specialist referral, etc.

If issuing a temporary disability document is necessary, indicate it's series and batch, the exact date of issue, and the exact date of the next visit (during which the document and term (duration) of temporary disability might be prolonged or terminated (closed), this is also noted) in the end of the record. Physician's record is confirmed by physician's signature.

SOME USEFUL TIPS ON FILLING PHYSICIAN'S RECORDS AND SAMPLE PHYSICIAN'S RECORD OF A HISTORY AND EXAMINATION OF A HEALTH PATIENT

An approximate example of normal physical examination brief write up is given here.

Abbreviations are often used in busy outpatient settings to describe patient's complaints, physical findings, diagnostic tests, etc. Mind not to overuse them, though. It might be a good idea to use abbreviations to write indicated diagnostic tests, prescriptions or questioner results (e. g. FBC, MMSE or GDS), but it is really confusing when clinical diagnosis is fool of abbreviations, especially of those very specific so that even a GP can't guess.

List of some commonly used abbreviations is given below.

Be sure to write your abbreviations READABLY!

Some examinations, like thyroid, breast and gynaecological (genitourinary) examination, DRE, part of HEENT examination requiring devices (like ophtalmoscope), may not be written down (though may also be), if they are already described during periodic examinations in the above chapters or are not performed by a physician in case there are no devices required or they are performed by other specialists or patient if referred to specialists for such examinations (but note, that a general practitioner/outpatient internist can perform all these physical examinations).

Write down additional information in additions to anamnesis if you lack free space in physician's records.

Abbreviations:
A&O × 3 — Awake and oriented to person, place and time
A/O — Alert and oriented
AF, AFIB — atrial fibrillation
AFB — acid-fast bacilli
ALT — Alanine Transaminase
ANA — Antinuclear Antibody
AST — Alanine Aminotransferase
ATPO, also TPOA — Antibodies to Thyroid Peroxidase Antibodies
AXR — abdominal X-ray
BAC — Blood Alcohol Concentration
bd — two times daily
BNP — Beta Natriuretic Peptide
BP — blood pressure
BPH — benign prostatic hyperplasia
bpm — beats per minute
BUN — blood urea nitrogen
C/O — complains of
CHF — congestive heart failure
CI — contraindications
CK MB — heart CK
CK (sometimes CPK) — creatine(phospho)kinase
CN — cranial nerves
Cr — creatinine
CRP — C-reactive protein
CT — computer tomography
CVD — cardiovascular disease
CXR — chest X-ray
DM — diabetes mellitus
DQS — dementia quick screen
DVT — deep venous thrombosis
EGD, EGDS, OGDS — (o)esophagogastroduodenoscopy
ESR — erythrocyte sedimentation rate
FBC — fool blood count, the same as CBC – common, or complete, blood count.
FH — family history
FM — Family Medicine
FOBT — faecal occult blood test
FT4 — free T4
GDS – geriatric depression scale
GFR — glomerular filtration rate
GGT — gamma-glutamyl transferase

Репозиторий БГМУ

GP — General Practice, General Practitioner
GU — genitourinary
HBSAg — hepatitis B surface antigen
HSV — herpes simplex virus
HDL — high-density lipoproteins
HEENT — head, ears, eyes, neck, throat examination
HPI — history of present illness
HPV — human papillomavirus
HR — heart rate
HTN — hypertension, sometimes also AH — arterial hypertension
CHD, IHD, ASCVD — coronary heart disease, ischemic heart disease, atherosclerotic heart disease
OEM/EOM — orbital eye muscles/extraocular muscle — basically the same.
IM — intramascular
INR — international normalized ratio
IV — intravenous
JVP — jugular venous pressure
KUB — kidney, ureters, bladder (X-ray)
LAD — lymphoadenopathy
LD — lactate dehydrogenase
LDL — low-density lipids
LFT — liver function tests
LIF — left iliac fossa
LLQ — left lower quadrant (of abdomen)
LOC — level of consciousness
LUQ — left upper quadrant (of abdomen)
LV — left ventricle of the heart
MC&S — microscopy, culture, and sensitivity (investigations of microbiology samples)
MMSE — mini mental state examination
MRI — magnetic resonance imaging
MSU — midstream urine
MVP — mitral valve prolaps
N&V — nausea, vomiting
NAD — nothing abnormal detected
NBM — nil by mouth
NKDA — no known drug allergies
NR — normal range
O&P — ova and parasites (stool test)
O/E — on examination
OGTT — oral glucose tolerance test

Репозиторий БГМУ

P&A — percussion and auscultation
PAP — Papanicolau (e. g. pap smear).
PE — pulmonary embolysm
PERLA — pupils equal and reactive to light and accommodation
PFT — pulmonary function tests
PMH — past medical history
PO — per os, by mouth, orally
PR — per rectum, rectally
PRN — as needed, per need
PSA — prostate specific antigen
PT — prothrombin time
PV — per vaginum
qd — every day, once daily
qHS — before sleep, before bedtime
qid — for times daily
QoL — quality of life
RF — rheumatic factor
RIF — right iliac fossa
RLQ — right lower quadrant (of abdomen)
ROM — range of motion
RR — respiratory rate
RUQ — right upper quadrant (of abdomen)
Rx — recipe (Latin for treat with)
AP — alkaline phosphotase
S1, S2, S3, S4 — 1st, 2nd, 3rd, 4th heart sounds
SC — subcutaneous
SE — side-effect(s)
SG — serum glucose
SL — sublingual
SOB — Shortness of Breath
SpO_2 — peripheral oxygen saturation (%)
STD(I) — sexually transmitted disease (infection)
TC, Chol — total cholesterol, cholesterol
TD — transdermal
TG, Trig — triglycerides
tid — three times daily
TM — eardrum (tympanum)
TORCH — toxoplasmosis, other infections (like chlamydia), rubella, cytomegalovirus, herpes simplex virus
TSH — thyroid stimulating hormone
U&E — urea (or blood urea nitrogen), creatinine and electrolytes, generally means kidney function test

Репозиторий БГМУ

UA — urinalysis
ULN — upper limit of normal
ULN — upper limit of normal
URTI — upper respiratory tract infection
US — ultrasound
UTI — urinary tract infection

Vaccines:
Hib — Haemophilus influenzae type b
IPV — inactivated poliovirus
MenACWY/MPSV4 — Meningococcal 4-valent conjugate/Meningococcal polysaccharide
MMR — measles, mumps, rubella
PCV13 — pneumococcal conjugate vaccine
PPSV23 — pneumococcal polysaccharide vaccine
RV — rotavirus
Td — Tetanus, diphtheria
Tdap — Tetanus, diphtheria, pertussis

RECOMMENDED RESOURCES FOR FURTHER READING

1. *John* Murtagh's General Practice. 6th Revised ed. McGraw-Hill Australia, 2015. 1603 p.
2. *Oxford* American Handbook of Clinical Examination and Practical Skills. Oxford University Press, USA, 2011. 720 p.
3. *Clinical* Examination : A Systematic Guide to Physical Diagnosis. 7 ed. Churchill Livingstone, 2013. 624 p.
4. *Sample* Written History and Physical Examination by University of North Carolina at Chapel Hill School of Medicine https://www.med.unc.edu/medclerk/files/UMNwriteup.pdf.

Репозиторий БГМУ

MINISTRY OF HEALTH OF THE REPUBLIC OF BELARUS

BELARUSSIAN STATE MEDICAL UNIVERSITY

DEPARTMENT OF OUTPATIENT INTERNAL MEDICINE

Head of Department

OUTPATIENT MEDICAL CARD
(academic)

Patient's name:

Superviser: name, group number, year, faculty

Teacher: position, name

Репозиторий БГМУ

MINISTRY OF HEALTH OF BELARUS

Clinic name, address

NMDC form code
NCOC form code
Medical Documentation
Form . . . 025/y

OUTPATIENT MEDICAL CARD

id or code

Patient's name ______________________________

Sex M / F Date of Birth __________ Phone: Home __________ Work __________

Address: region __________ settlement (city/town/village/other) name __________

district __________ street (lane) __________

house № __________ block № __________ apt. № __________

Place of employment __________ department __________

name and nature of manufacture

Occupation __________ dependant __________

Dispensarization

Dispensarization started	Reason	Dispensarization stopped	Reason

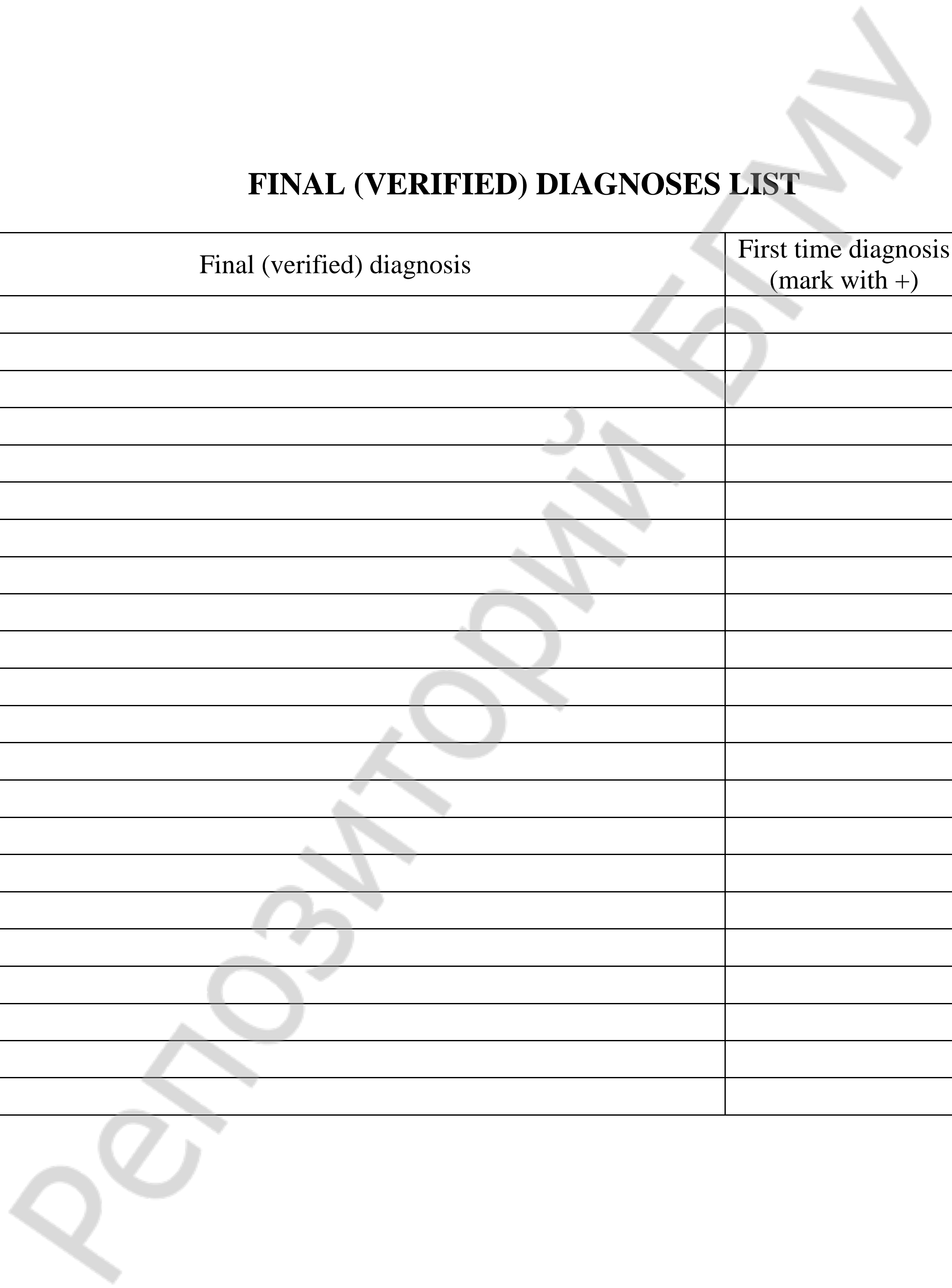
Address and workplace change

Date	New address (new workplace)

репозиторий БГМУ

FINAL (VERIFIED) DIAGNOSES LIST

Date (dd, mm, yyyy) of visit	Final (verified) diagnosis	First time diagnosis (mark with +)	Physician's signature (write surname readably)



PERIODIC EXAMINATIONS

QUESTIONNAIRE RESULTS (underline the relevant)	
1. Have you noticed any changes in the size and colour of moles and pigmented spots?	YES or NO?
2. Have you noticed any ulcerations, fissures, growths, lumps, exfoliations?	YES or NO?
3. Do you have difficulties swallowing?	YES or NO?
4. Do you notice general weakness, decrease of appetite, ongoing weight loss, constant vomiting, belching, nausea, sensation of abdominal heaviness, abdominal pain, constipation, diarrhoea?	YES or NO??
5. Have you noticed blood in your urine and/or feces, black "tarry" feces?	YES or NO?
6. Do you have cough, hemoptysis, chest pain, hoarse voice?	YES or NO?
7. Have you noticed hardenings, lumps of mammary (breast) glands, ulcers, fissures in the nipple area, nipple discharge?	YES or NO?
8. Have you noticed bloody vaginal discharge not related to menses?	YES or NO?
9. Other complaints	YES or NO?

Репозиторий БГМУ

EXAMINATION RESULTS

	20	20	20	20	20	20	20	20	20	20	20
Skin											
Lips											
Oral mucosa and tongue											
Oesophagus											
Stomach											
Rectum											
Lungs											
Breast											
Uterus											
Other											

Репозиторий БГМУ

Vaccination record

PLANNED VACCINATIONS							
Vaccination against		Date	Dose	Name of medication	Batch	Reaction	
						local	general
Tetanus and diphtheria	Vaccination № 1						
	Vaccination № 2						
	Revaccination № 1						
	Revaccination № 2						
	Revaccination № 3						
	Revaccination № 4						

Gynaecological examinations record (gynaecologist) for women

Date	Diagnosis	Cytology	Signature

репозиторий ВГМУ

TEMPORARY DISABILITY RECORD

Date of issue	Diagnosis (reason) of temporary disability	Date of sick leave closure	Duration of disability (number of days)

репозиторий БГМУ

X-RAY EXAMINATIONS RECORD

Examination date	Type of examination	Dose	Physician’s signature

репозиторий БГМУ

ANAMNESIS

1. Past medical history: ____

____

____

2. Family history: ____

____

____

3. Medication allergy: ____

4. Risk factors: smoking, alcohol abuse, substance abuse, insufficient physical activity, psychoemotional stressors, dyslipidemia, diabetes mellitus, excessive weight, /underline/, hypertension

5. Workplace hazards: ____

6. Brief anamnesis: ____

____

____

____

____

____

____

____

____

7. Other notes: ____

____

8. Dispensarization started: ____

____

Date: ______________________ Physician's signature: ______________________________

репозиторий БГМУ

Additions to Anamnesis

Репозиторий БГМУ

PHYSICIAN'S RECORDS
(scheme)

Date:	**Patient seen during office visit/home visit**
t °	**Complaints, anamnesis (FH, PMH including allergies, HPI, etc.):**
BP	
Pulse	
HR	
RR	
SpO_2	
Physical examination:	
Diagnosis:	
Diagnostic tests and other indications:	
Treatment and recommendations:	
Temporary disability documents (if needed):	
	Supervising student's signature:

репозиторий БГМУ

PHYSICIAN'S RECORDS
(example)

Date: *01 Sep 2016*	**Patient seen during** **office visit**/**home visit**
t ° – *36.7 C*	**Complaints, anamnesis (FH, PMH including allergies, HPI, etc.):** *no complaints, PMH, FH unremarkable, NKDA,*
BP – *125/80*	non-smoker.
Pulse – *68*	
HR – *68*	
RR – *16*	
$\mathbf{SpO_2}$ – *98 %*	

Physical examination: *patient is alert, oriented and cooperative. Skin is normal. PERLA, EOM intact, sclera and conjunctiva normal, nasal mucosa normal, oral pharynx is normal without erythema or exudate. No abnormal adenopathy in the cervical, supraclavicular, axillary, inguinal areas. Thyroid WNL. Lungs are clear to auscultation and percussion bilaterally, no crackles or wheezing.*

Heart rhythm normal, no heart sound abnormalities.

The abdomen is symmetrical without distention, non-tender to palpation, bowel sounds are normal, no masses or splenomegaly; liver span is 8 cm by percussion. No peripheral cyanosis, clubbing or oedema are noted, peripheral pulses are normal.

The abdomen is symmetrical without distention; stool normal, normally coloured, no constipation or diarrhoea.

Urine normal, no disuria, diuresis normal. CN intact, motor and sensory examination of extremities is normal, cerebellar function and gait normal, reflexes are normal, symmetrical bilaterally. MSK system WNL.

Diagnosis: *healthy*

Diagnostic tests: *FOBT, Chol, SG. Urologist referral for routine chek-up, influenza vaccine, Td vaccine.*

Treatment and recommendations: *follow healthy living guidelines*

Temporary disability documents (if needed): –

Supervising student's signature:

Репозиторий БГМУ

Учебное издание

Яковлева Елена Викторовна
Хурса Раиса Валентиновна
Дрощенко Виталий Владимирович

ОФОРМЛЕНИЕ МЕДИЦИНСКОЙ КАРТЫ АМБУЛАТОРНОГО БОЛЬНОГО

FILLING IN OUTPATIENT MEDICAL CARD

Учебно-методическое пособие

На английском языке

Ответственная за выпуск Е. В. Яковлева
Переводчик В. В. Дрощенко
Компьютерная верстка Н. М. Федорцовой

Подписано в печать 20.04.16. Формат 60×84/16. Бумага писчая «Снегурочка».
Ризография. Гарнитура «Times».
Усл. печ. л. 1,39. Уч.-изд. л. 0,64. Тираж 50 экз. Заказ 379.

Издатель и полиграфическое исполнение: учреждение образования
«Белорусский государственный медицинский университет».
Свидетельство о государственной регистрации издателя, изготовителя,
распространителя печатных изданий № 1/187 от 18.02.2014.
Ул. Ленинградская, 6, 220006, Минск.

Репозиторий БГМУ