МИНИСТЕРСТВО ЗДРАВООХРАНЕНИЯ РЕСПУБЛИКИ БЕЛАРУСЬ
БЕЛОРУССКИЙ ГОСУДАРСТВЕННЫЙ МЕДИЦИНСКИЙ УНИВЕРСИТЕТ
КАФЕДРА ПРОПЕДЕВТИКИ ВНУТРЕННИХ БОЛЕЗНЕЙ

ОФОРМЛЕНИЕ МЕДИЦИНСКОЙ ДОКУМЕНТАЦИИ

FULFILLED MEDICAL DOCUMENTATION

Методические рекомендации

Минск БГМУ 2025

УДК 614.2:005.92(083.13)
ББК 53.5
О-91

Рекомендовано Научно-методическим советом университета в качестве методических рекомендаций 20.11.2024 г., протокол № 3

Авторы: канд. мед. наук, доц. Г. М. Хващевская; канд. мед. наук, доц. М. В. Шолкова; ассист. Т. П. Новикова; ассист. Е. И. Сасинович; ассист. Ю. В. Репина

Рецензенты: канд. мед. наук, проф., зам. гл. врача 11-й городской клинической больницы г. Минска В. В. Груша; каф. внутренних болезней, гастроэнтерологии и нутрициологии с курсом ПКиП Белорусского государственного медицинского университета

О-91 **Оформление** медицинской документации = Fulfilled medical documentation : методические рекомендации / Г. М. Хващевская, М. В. Шолкова, Т. П. Новикова [и др.]. – Минск : БГМУ, 2025. – 32 с.

ISBN 978-985-21-1859-0.

Подробно изложены сведения о медицинской документации приемного и терапевтического отделений стационара. Представлены правила заполнения медицинской документации.

Предназначены для студентов 2-го курса медицинского факультета иностранных учащихся, обучающихся на английском языке, по дисциплине «Медицинский уход и манипуляционная техника».

УДК 614.2:005.92(083.13)
ББК 53.5

Учебное издание

Хващевская Галина Михайловна
Шолкова Мария Владимировна
Новикова Татьяна Петровна и др.

ОФОРМЛЕНИЕ МЕДИЦИНСКОЙ ДОКУМЕНТАЦИИ
FULFILLED MEDICAL DOCUMENTATION

Методические рекомендации

На английском языке

Ответственный за выпуск Э. А. Доценко
Компьютерная вёрстка М. Г. Миранович

Подписано в печать 02.05.25. Формат 60×84/16. Бумага писчая «Снегурочка».
Ризография. Гарнитура «Times».
Усл. печ. л. 1,86. Уч.-изд. л. 1,34. Тираж 70 экз. Заказ 316.

Издатель и полиграфическое исполнение: учреждение образования
«Белорусский государственный медицинский университет».
Свидетельство о государственной регистрации издателя, изготовителя,
распространителя печатных изданий № 1/187 от 24.11.2023.
Ул. Ленинградская, 6, 220006, Минск.

ISBN 978-985-21-1859-0

MOTIVATIONAL CHARACTERISTICS OF THE TOPIC

Theme of lesson: Medical documentation.

Total class time: for 2 year students the general medicine faculty is 3 hours.

Goals of lesson: to acquaint students with the rules of medical documentation filling out.

Student should know:

– the medical documentation types;

– principles of medical records management.

Student should be able to:

– fill out the medical documentation.

Requirements for initial level of knowledge: to get acquainted with the relevant sections of the main, additional and legal literature covering the features of medical records management.

Control questions from related disciplines:

1. Main public policy principles of healthcare in Belarus.
2. The healthcare structure in Belarus.
3. Organisation of medical care the principles of patient care with self-care deficiencies.

Control questions on the theme of lesson:

1. Types of medical documents, rules for recording in hospital medical documentation.
2. Medical e-documents.
3. Personal medical case record.
4. Patient's prescription list.
5. Statistics card of the discharged patient.
6. Basic documentation of the Therapeutic department.
7. Rules for recording in medical documents.

DOCUMENTING THE MEDICAL INFORMATION

The collected information must regularly be checked for assessment of accuracy and reliability. The medical nurse must be sure:

– that the information is complete;

– the subjective and objective information complement each other;

– no information was skipped.

It is mandatory that the information is complete and double checked before the next step of nursing care is followed through. Any diagnoses or treatment plans can only be implemented once all of the chief complaints are collected and the full physical examination is done, because it is between these steps, where mistakes are often made.

Checking the information

Some of the collected information may require a second examination, for example pulse may be counted several times.

Additional questions may be asked by the nurse to confirm the information that was collected. For example, if the patient is holding his hand behind his head, the nurse might make a conclusion that the patient is experiencing headaches. However, upon asking the patient if he is having headaches, it might turn out that he was just holding his head because he is upset over the diagnosis.

The collected medical information must also be double checked by another medical personnel. For example, if the nurse has doubts about the accuracy of the blood pressure measurement because it seems too low, she may ask a colleague to recheck the blood pressure to either confirm or disprove the concern.

Cross evaluation of subjective and objective information should be carried out. For example, if a patient with edema says that his water intake is low, but on his bedside table there are several empty water bottles, the nurse must confirm the actual volume of fluids he ingested, and then do an assessment on the water balance in the body.

The collected patient information may be documented straight into the patient's medical card. There are two types of medical cards: out-patient (ambulatory) and clinical medical cards. They differ in structure and in volume of information. The ambulatory medical card records information over several years, whereas clinical cards may only record a week or several months' worth of information. In the clinical card the patient is examined daily (several times throughout the day), whereas the ambulatory medical card may have breaks in time where patient did not come in to see the doctor. Both versions of medical cards may be in paper form or electronic format.

Rules of documenting medical information

The documentation of medical information must be accurate, grammatically correct and should implement the proper medical abbreviations. For every entry into the medical history, the date and time must be stated, as well as the nurse's or doctor's full name and specialty. The documentation should be precise and interpretations of the information should be avoided, only the facts should be present in the medical card. In the medical card such adjectives such as «norm», «normal» should be avoided and the information should be as accurate as possible. For example, the following should be inputted «the body temperature is 36,7 degrees Celsius» instead of writing «body temperature is in norm». All of the collected information should be fixed and stated clearly.

All medical documentation is completed by the nurse of the admission department after the doctor has examined the patient and decided on the patient's hospitalization in this medical institution. The nurse:

– measures the patient's body temperature and records it in the "Patient Admission and Refusal of Hospitalization Log" (Form No. 001 U);

– completes the title page of the "Inpatient Medical Record" (Form No. 003 U) or the medical history;

– fills out the passport and left side of the "Statistical Record of a Patient Discharged from the Hospital (Form No. 066 U). If additional instrumental and laboratory clinical studies or consultations are required, she calls all the necessary specialists. At the end of her shift, information about all hospitalized patients and those in the diagnostic wards of the admission department.

MEDICAL DOCUMENTATION

The most frequently used (Appendix 2):

1. Journal or notebook of appointments.
2. Journal of receiving and transferring shifts.
3. Sheet of registration of patient movement and hospital bed capacity.
4. Portioner. Portioner — the ward nurse, checking the appointment sheet, makes a portioner daily (if there is no dietary nurse). The portion list must contain information on the number of different dietary tables and types of fasting and individual diets. For patients admitted in the evening or at night, the portion list is compiled by the nurse on duty.
5. Journal of registration of medicines of lists A and B.
6. Summary of the condition of patients for the information desk.
7. Journal of registration of expensive and acutely shortage drugs.
8. Journal of dressings.
9. Journal of write-off of materials and alcohol.
10. Journal of disinfection treatment of instruments.
11. Journal of pre-sterilization treatment of instruments.
12. Sterilization journal.
13. Journal of general cleaning.
14. Quartzization journal.
15. Journal of registration of post-injection complications.
16. Statistical coupon, form No. 30.
17. Journal of emergency tetanus prophylaxis.
18. Journal or notebook of appointments. The nurse writes out the prescribed medications, as well as the tests that the patient needs to undergo, in the prescription notebook, where the patient's last name, first name, patronymic,

room number, manipulations, injections, laboratory and instrumental tests are indicated. She duplicates these entries in the prescription sheet. Dates and the nurse's signature are required.

19. Duty Acceptance and Transfer Log. Duty transfer is most often done in the morning, but can also be done during the day if one nurse works the first half of the day and the other — the second half of the day and at night. The nurse accepting and handing over the duty goes around the wards, checks the sanitary and hygienic regime, examines seriously ill patients and signs the duty acceptance and transfer log, which reflects the total number of patients in the department, the number of seriously ill and feverish patients, patient movements, urgent appointments, the state of medical equipment, care items, and emergencies. The log must contain clear, legible signatures of the nurse accepting and handing over the duty.

20. Patient Movement and Hospital Bed Stock Record Sheet — filled out by the nurse handing over the duty in the morning, form No. 007 U. The senior nurse of the department summarizes the information from the ward nurses on the number of diets, they are signed by the head of the department, and then transferred to the food block.

Inpatient medical record (case history) form No. 003/u-80

Definition of the case history. The medical history or a case history is a structured assessment conducted to generate a comprehensive picture of a patient's health problems (Appendix 1). It includes the assessment of:

– the patient's complaints;

– the patient's current and previous health problems;

– the patient's current and previous medical treatment;

– factors which might affect the patient's health and their response to the prevention or treatment of health problems (e. g. risk factors, occupational conditions, lifestyle issues);

– the patient's family health;

– the patient's health in general.

Taking together the history, information from the physical examination and any investigations or tests should provide all the information necessary to make a diagnosis (i.e. to identify the nature of a health problem).

This training instruction allows medical students to have a clear view of the scheme of examining a patient and the rules of case history writing. Besides it helps to acquire such skills as a correct interviewing the patient, gathering data about patient's complaints and both present and past history, carrying out patient's physical examination, planning and assessment of laboratory and instrumental studies.

The students will learn to formulate the final clinical diagnosis as a conclusion point of patient's clinical examination, and also gets a notion about medical diaries

and epicrisis. All sections of the medical case history which are presented in the text is a scheme which the student must follow while writing his/her own educational case history.

Rules for maintaining medical documentation

The inpatient medical record is a legal document, so all entries in it must be clear and easy to read. Information entered into the medical record must be reliable, fully reflecting the facts and results of the activities of medical workers, accurate and in chronological order, and not subject to changes. Corrections are possible in exceptional cases, but whitening agents cannot be used — incorrect information is crossed out and the correct one is written next to it with the signature of the official and the instruction "believe the correction".

Passport section. Upon admission of the patient, the admission department staff writes down the passport data on the front side of the medical record. All lines of the first and second pages of the medical record must be filled in (marked). The medical record must contain the date and exact time of admission to the emergency room, hospitalization, discharge, and death of the patient. Data on the blood type, Rh factor, and drug intolerance are entered by the attending (receiving) physician during the first examination of the patient, except for cases when this data cannot be obtained. The data on the expert-labor history must be indicated: since what time the patient has had a continuous certificate of incapacity for work, the number of the certificate of incapacity for work. The record of the issuance of a document certifying the fact of temporary incapacity for work is made by the attending physician according to the established rules.

Registration of the diagnosis. The diagnosis of the referring institution is indicated in the medical record; the diagnosis upon admission is entered on the front side of the card immediately after the patient is examined (the diagnosis is completed in full, indicating the concomitant pathology without abbreviations). The clinical diagnosis is recorded on the front side of the medical record within three working days from the moment the patient is admitted to the hospital. If the clinical diagnosis has changed during the patient's treatment, this should be reflected in the medical history, preferably in the form of a stage epicrisis. The final diagnosis is recorded upon discharge of the patient, in expanded form, indicating the ICD-10 code. It is necessary to try to identify one main disease that determines the severity and prognosis of the disease. The second main (combined) disease is established only in the case of another disease that is no less significant for assessing the severity and prognosis than the main one. The diagnosis should include all complications and concomitant diseases that are important for patient management.

Hospitalization. An emergency patient is examined by the doctor on duty immediately after admission, indicating the date and time of the examination, the doctor's name. A planned patient must be examined by the attending physician within 3 hours from the moment of admission to the hospital. In case of planned hospitalization, a referral must be available, properly completed, which is pasted into the medical record. For planned patients, the admission status is recorded during the current working day, for emergency patients — during the examination. Entries in the admission status must be informative, contain data of clinical significance. The patient's complaints and medical history are recorded in detail, indicating the essential signs important for establishing a diagnosis and developing a treatment plan. The medical history reflects factors related to establishing a diagnosis, assessing the severity and prognosis of the disease, or influencing the patient's management tactics. The anamnesis of life includes information about the presence of allergic reactions, specific infectious diseases (tuberculosis, sexually transmitted diseases, viral hepatitis, HIV infection, etc.), previous blood transfusions, previously suffered diseases and operations. It is mandatory to indicate since what time the patient has had a continuous certificate of incapacity for work. In case of an unfinished case of temporary incapacity for work and the patient has an unclosed certificate of incapacity for work, indicate the number of the primary certificate of incapacity for work and its duration; extension of the certificate of incapacity for work for more than 15 days is carried out with the permission of the medical commission. If the patient has a disability group, it is specified whether he works or not, the reason that caused the disability, the date of establishment of the group and the dates of the next re-examination are indicated. If it is impossible to collect an anamnesis (including allergic) on the day of admission due to the patient's condition, then at the first opportunity, additions to the anamnesis are made to the medical history, drawn up separately with an indication of the date or as part of the diary entry of the attending physician. The data of the initial examination are filled in briefly for all organs and systems available for examination. The revealed pathological changes are described in detail, indicating the characteristic symptoms and syndromes. In cases of injuries that may require a forensic medical examination, all injuries the patient has are described in detail. At the end of the admission status, a clinical diagnosis, examination plan and treatment are necessarily formulated indicating the trade name of the drugs in Latin, doses, frequency and route of administration. When transferring a patient from one department to another within the same hospital, a transfer epicrisis is drawn up containing a brief anamnesis, the treatment and diagnostic measures taken, and the purpose of the transfer.

Informed consent. A necessary preliminary condition for medical intervention is the informed voluntary consent of the citizen, which is drawn up in writing in accordance with the established procedure and signed by the patient.

In cases where the citizen's condition does not allow him to express his will, and the intervention is urgent, the issue of its implementation in the interests of the citizen is decided by a council, and if it is impossible to assemble a council, directly by the attending (duty) physician with subsequent notification of the administration of the medical institution, confirming this with an entry in the medical record. Consent to medical intervention in relation to persons under the age of 15 and citizens recognized as incompetent in accordance with the procedure established by law is made by their legal representatives. In the absence of legal representatives, the decision on medical intervention is made by a council, and if it is impossible to assemble a council, directly by the attending (duty) physician with subsequent notification of officials of the medical institution and the legal representatives of the patient. Information about the upcoming medical intervention is provided to the patient in a form accessible to him. The patient is informed about the existing disease, methods and purposes of treatment, possible risks, side effects and expected results. Based on the information provided, an entry is made in the medical record. Consent for transfusion of biological fluids is also issued: blood, plasma and their components. In this case, the patient must be informed about possible complications and the risk of contracting HIV infection, viral hepatitis, syphilis in the seronegative period. In the case of surgical intervention and (or) anesthesia, the patient's consent is additionally issued. In case of refusal of medical intervention, the citizen, one of the parents or other legal representatives of the person must be explained the possible consequences of such refusal in a form accessible to him, which information is entered in the medical record. Refusal of medical intervention is recorded in the medical record in any form and signed by the patient and the attending physician, indicating the date.

Maintaining a medical record. Entries in the medical record must be made in chronological order, indicating the date and time. The doctor keeps diaries daily, unless otherwise specified. For patients in a serious or moderate condition, as well as for patients requiring daily dynamic observation, diary entries are made daily, and if necessary — several times a day. The diaries reflect the dynamics of the patient's condition, objective status, laboratory indicators that are essential for the prognosis and management tactics, and substantiate changes in the examination and treatment plan.

The medical record must contain original laboratory tests indicating the date and time of their performance (namely: the time of sampling the material for the test and the time of issuing the result), basic electrocardiograms (upon admission, discharge, important for assessing the dynamics of the condition), Holter monitoring data with ECG, daily blood pressure with drawings/graphs reflecting the existing deviations, and calculated parameters. The record of the radiologist, endoscopist, functional diagnostics doctor must reflect the full picture of the organ or system being examined, pathological changes, functional state and the course of the study. The conclusion must reflect the changes found or the suspected diagnosis.

Prescription sheets

The prescription sheet is an integral part of the medical record (Fig. 1). The attending physician writes down the prescriptions clearly, in detail, in a form that excludes dual or arbitrary interpretation, indicates the date of the prescription and the date of cancellation of the drugs. The nurse carries out the execution on the day of the prescription, certifies with her signature and indicates the date of the prescription. Medicines are written in Latin with the trade name of the medicine, dose, frequency and route of administration. Instead of a prescription sheet, the intensive care unit maintains an official form 01 1/u, where, in addition to the main vital parameters, all medical prescriptions are recorded and signed by a doctor and a nurse.

NAME OF DRUG	PRESCRIBING DOCTOR	WHAT IS IT FOR?	START DATE	COLOR SHAPE	DOSE (mg)	DOSE (frequency)	INSTRUCTIONS FOR USE

Fig. 1. The prescription sheet

Temperature sheets

The temperature sheet is maintained by a nurse (Fig. 2). Temperature dynamics are recorded at least twice a day.

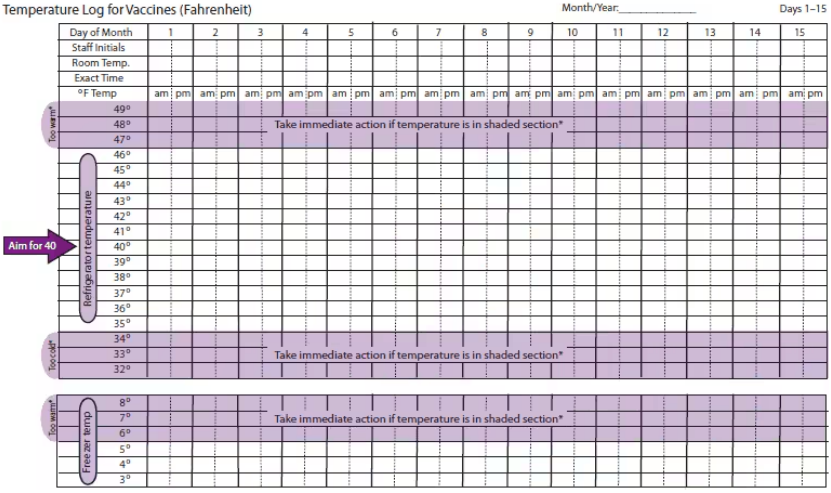

Fig. 2. The temperature sheet

Electronic medical record

Instruction 07.06.2021 No. 75 on the structure and procedure for the formation of an electronic medical record (EMR) of a patient, a personal electronic account of a patient EMR is a structured set , records about the patient's health status, facts of his/her request for medical care and other information about the patient.

The EMR is generated by a healthcare professional using the healthcare information system.

Section "Summary information about the patient". The section contains the basic personal data of the patient (his/her identification information), summary (key) information about the patient's requests for medical care, about being under medical supervision or receiving medical care.

Section "Document Owner". The section contains information about the healthcare organization.

Section "Patient's personal data". This section is intended for entering and storing the patient's personal data (last name, first name, patronymic (if any), identification number, date of birth, age, gender, information about the patient's identity documents, information about the place of residenceand (or) place of stay), his contact information, as well as information about the medical insurance contract (if any). The section consists of a subsection "Patient's representative", which includes information about the persons authorized by the patient or the persons specified in Part Two of Article 18 of the Law of the Republic of Belarus "On Health Care". Before determining the personal data of the newborn, the subsection "Patient's representative" shall contain information about the mother of the newborn.

Section "Patient's medical data". The section and its subsections are formed at the patient's birth or first visit to the health care institution and his registration in the Central Health Information System. The entered information is stored in the EHR and supplemented throughout the patient's life. The section consists of the following subsections: or another representative of the newborn; "Family history"; "Life history"; "Allergic history and drug intolerance" subsection; "Metric data" section; "Final (refined) diagnoses"; "Laboratory studies" section; "X-ray and radiological studies"; "Functional studies"; "Surgical interventions"; "Provision of medicines and provision of medical devices".

SELF-CONTROL OF TOPIC ASSIMILATION

1. What information does the doctor write in the medication record?

a) rout of medicine and time;
b) the name of medicine and dose;
c) the name of medicine;
d) the dose of medicine.

2. The patient was taken to the Admission Department by ambulance. He was examined by a doctor. The doctor treated the patient. The patient felt better. He refused to be hospitalized. What document should be written in the department?

a) Journal of the admission of patients and refusals in hospitalization;

b) Journal of Infectious Diseases, Food Poisoning, Complications after Vaccination;

c) Statistical card of discharged patient;

d) Medical card of a hospitalized patient.

3. Who fills the patient's passport data in the "Medical card of a hospitalized patient"?

a) Admission department nurse;

b) Admission department doctor;

c) nurse in the treatment department;

d) doctor in the treatment department.

4. The title page of the medical card of a hospitalized patient should have:

a) information about the conducted examination and treatment;

b) passport data;

c) diagnosis;

d) results, time of medical examination;

e) information about relatives.

5. What information does the doctor write in the medical card of a hospitalized?

a) department of hospitalization;

b) transportation type;

c) performed sanitization;

d) inspection of pediculosis, skin diseases.

6. The nurse writes into documents patient's passport data:

a) true;

b) false.

7. In which departments of the hospital fill out the Statistics card?

a) therapeutic department;

b) admission department;

c) surgical department.

Answers: 1 — a, b; **2** — a; **3** — a; **4** — b, c; **5** — b; **6** — a; **7** — a, b, c.

LITERATURE

Basic

1. *Основы* медицинского ухода = Basics of medical care : пособие / Т. П. Пронько, Э. Э. Поплавская, Е. М. Сурмач [и др.]. – Гродно : ГрГМУ, 2019. – 206 с.

2. *Lunn, P.* Taylor's clinical nursing skills: a nursing process approach / P. Lunn. – 5th ed. – Philadelphia [etc.] : Wolters Kluwer, 2019. – 1095 p.

3. *Kovalyova, O. M.* Patient care (Practical Course) : textbook / O. M. Kovalyova, V. M. Lisovyi, S. I. Shevchenko. – 2nd ed., corrected. – Kyiv : AUS Medicine Publishing, 2018. – 320 p.

Additional

4. *Пронько, Т. П.* Основы ухода за больными = The basics of patient care : пособие / Т. П. Пронько, К. Н. Соколов, М. А. Лис. – 3-е изд. – Гродно : ГрГМУ, 2016. – 216 с.

5. *Шолкова, М. В.* Наблюдение за пациентом. Уход за пациентами с дефицитом самообслуживания = Follow up of patients. Patient care for individuals with self-care deficiency / М. В. Шолкова, Э. А. Доценко, Т. П. Новикова. – Минск : БГМУ, 2018. – 20 с.

6. *Об утверждении* форм первичной медицинской документации в организациях здравоохранения, оказывающих стационарную помощь : приказ М-ва здравоохранения Респ. Беларусь от 1 окт. 2007 г. № 792.

Appendix 1

HEALTH MINISTRY OF BELARUS
BELARUSIAN STATE MEDICAL UNIVERSITY
DEPARTMENT OF PROPAEDEUTICS OF INTERNAL DISEASES
Head of the Department of Propaedeutics of Internal Diseases,
M.D., Professor of Medicine, E. A. Dotsenko

CASE HISTORY

Patient's Surname, Name, Patronymic:_____

Clinical diagnosis: _____

1. Basic diagnosis _____

_____

_____

2. Complications of the basic diagnosis _____

_____

_____

3. Concomitant diagnosis (-es) _____

_____

_____

Student: _____

_____

(Surname, Name, Patronymic)

_____

(Group)

_____

(Year)

_____

(Faculty)

Teacher: _____

(position, scientific degree)

_____

_____

(Surname, Name, Patronymic)

Period of patient's observation: from «___»_____ 20__ to «___»_____ 20__

PATIENT'S PASSPORT DATA

(the student should fill in all the gaps)

1. **Surname, name, patronymic:**

_____

_____

_____

2. **Gender:** _____

3. **Age:** _____

4. **Marital status:** _____

5. **Full home address:**

_____

_____

_____

6. **Occupation** (*specify if the patient is a pensioner or the disabled worker*): _____

_____

_____

7. **Work place** (*name of establishment*): _____

_____

8. **Clinical diagnosis**:

1. The basic diagnosis:

_____

_____

_____

_____

2. Complications of the basic diagnosis:

_____

_____

_____

_____

3. Concomitant diagnosis (-es):

_____

_____

_____

_____

PATIENT'S COMPLAINTS

(the student should fill in all the gaps on this page)

1. Main complaints:

2. Additional complaints:

PRESENT HISTORY (ANAMNESIS MORBI)

(the student should fill in all the gaps on this page)

I. Onset, character and features of the basic disease course

II. Findings of the laboratory and instrumental tests carried out before <u>current</u> hospitalization

III. Previous treatment and its efficiency

PAST HISTORY (ANAMNESIS VITAE)

I. Patient's Physical and Intellectual Development.

Patient born the first (second, third and so on) child in the family:

_____

_____

Patient born in time (if the patient knows about it):

_____

_____

Patient get breast or artificial feeding (if the patient knows about it):

_____

_____

When did patient start to walk, speak (if the patient knows about it):

_____

_____

What was patient general health condition and development in childhood and youth (if the patient remembers about it):

_____

_____

Have patient ever lagged behind your peers physically or intellectually?

_____

_____

When did patient start to study? Was it easy or difficult to study?

_____

_____

What is patient education?

_____

_____

Have patient ever gone in for sports? Do patient have any sport category (rank)?

_____

_____

Additional questions for men:

Were patient in the army? (if not, what are the reasons of the deferment of military service):

_____

_____

Additional questions for women:

At what age did woman patient have her first menstrual period?

_____

What is the duration of each menstrual period?

_____

How many children have woman patient borne?

_____

Have woman patient had any abortion?

_____

Was patient pregnancy(-ies) normal?

_____

Habits. If the patient confirms that he smokes, and/or abuses alcohol, and/or uses narcotics:

SMOKING:

– at what age did patient begin smoking?

_____

– how many cigarettes do patient smoke a day?

_____

ALCOHOL ABUSING:

– at what age did patient start to take alcohol?

_____

– how often do patient take alcohol?

_____

NARCOTIC HABIT:

– what narcotic do patient use?

_____

– at what age did patient start to take narcotics?

_____

– how often do patient take narcotics and in what dose?

_____

II. Social History.

LIVING CONDITIONS:

– a flat, a private house, a hostel accommodation; conveniences (yes/no):

_____

– if the patient lives separately or with their family: _____

MARITAL STATUS:

– single, married: _____

BUDGET: wages and the general income of the family (it is unethical to specify the size of a salary, the correct question is: "Is your income sufficient for your needs?"):

_____

_____

NUTRITION HABITS:

– how often, when and what meal the patient usually has:

_____

– if he/she take food quietly or quickly: _____

– if it is masticated thoroughly: _____

– if hot food or drinks are consumed moderately hot or very hot:

_____

– is diet rich in fresh vegetables and fruits:

_____

DAILY REGIME:

– when the patient wakes up and goes to bed:

_____

– his/her keeping of personal hygiene:

_____

– what the patient does before going to work and after returning home (briefly):

_____

_____

– specify the distance from home to the place of work and means of conveyance (approximately):

_____

_____

III. Patient's Labor Activities (note the patient's labor activity in chronological order since its beginning).

Term of job or occupation: from _____ to _____.

Occupational hazard _____

_____

_____

Working day duration _____

Work schedule (at his last job place):

1) operation time _____ ;

2) breaks _____ ;

3) day or night shifts _____ ;

4) time or piece-work _____ ;

5) responsibility for the performed work (briefly) _____

_____ .

EXPERT MEDICAL ANAMNESIS:

– whether patient has the sick-list concerning current disease (yes/no): _____

– total duration of the patient's being on a sick-leave during the current year:

_____

– permanent disability (disability group, when it was appointed):

_____

IV. Allergological Anamnesis.

_____

_____

_____

_____

_____

V. Hereditary Anamnesis.

_____

_____

_____

_____

_____

Appendix 2

PERSONAL MEDICAL CASE RECORD

Приложение 1
к приказу
Министерства здравоохранения
Республики Беларусь
2008 №

Форма № 003/у-07

МИНИСТЕРСТВО ЗДРАВООХРАНЕНИЯ РЕСПУБЛИКИ БЕЛАРУСЬ

_____

_____

наименование организации здравоохранения

Виды транспортировки (подчеркнуть):
на каталке, на кресле, может идти

Требования службы чрезвычайных ситуаций

Носилочный (дата)	Ходячий (дата)

ВОДИТЕЛЬ	ДА	НЕТ	

КАТЕГОРИЯ

МЕДИЦИНСКАЯ КАРТА СТАЦИОНАРНОГО ПАЦИЕНТА
№ _____

Отделение _____ № _____ _____ № _____
_____ № _____ _____ № _____

Фамилия: _____

Имя: _____

Отчество: _____

ДИАГНОЗ основного заболевания (проставляется после выписки)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Код по МКБ 10

Дата поступления: ____ (день) _____ (месяц) _____ (год)

Дата выписки: (смерти) ____ (день) _____ (месяц) _____ (год)

Архив №
Год

Место подклеивания направления на госпитализацию

Информация	Подпись пациента Дата
Разрешаю предоставлять информацию о факте госпитализации, состояния здоровья, диагнозе заболевания, прогнозе, результатах обследования и лечения следующим лицам (Ф.И.О., степень родства): _____ _____ _____	
С правилами внутреннего распорядка стационара для пациентов ознакомлен, обязуюсь выполнять Предупрежден, что за нарушение запрета курения в зданиях больницы пациент подлежит выписке (приказ МЗ РБ № 603-А от 28 .12.2000г.) С порядком и путями эвакуации из здания при чрезвычайных ситуациях ознакомлен	

Сведения о передаче информации о пациенте

Куда передана	№№ телефонов	Дата и время передачи	Ф.И.О. принявшего информацию	Ф.И.О. и подпись передавшего информацию
МВД (РОВД, ГАИ)				
ГЦГиЭ				
Прокуратура				
БРНС				
Родители, родственники, соседи				

Вирусным гепатитом болел(а), не болел(а) (подчеркнуть)	Побочное действие лекарств (непереносимость) _____ _____ _____ _____ _____ _____ _____ название препарата, характер побочного действия
Группа крови: 0(I) A(II) B(III) AB(IV) Резус фактор: Rh - Rh+. Ф.И.О. врача _____	

Движение пациента в стационаре (включая приемное отделение):

Отделение	Дата, время поступления	Дата, время перевода	Дата, время выписки	Дата, время смерти

Медицинская карта стационарного пациента № _____

1. **ФИО** _____ **М / Ж**
_____ не идентифицирован

2. **Личный номер** _ _ _ _ _ _ _ _ _ _ _ _ _ _ без паспорта

3. **Возраст** _____ (полных лет, для детей: до 1 года – месяцев, до 1 месяца – дней)

4. **Домашний адрес** _____
адрес по паспортным данным: государство, область, район, населенный пункт; номер телефона, адрес родственников
_____

5. **Адрес места проживания** _____
адрес временного проживания: государство, область, район, населенный пункт; номер телефона, адрес родственников
_____
Адрес и фамилия ближайших родственников: _____
_____

6. **Вид оплаты:** за счет бюджетных средств, собственных средств, медицинского страхования (добровольного, обязательного) (нужное подчеркнуть). Страховой полис: серия_____, номер_____ Страховщик:_____

7. **Место работы, профессия или должность** _____
_____
для детей – название детского учреждения, школы; для учащихся – место учебы

8. **Инвалид или ветеран** войн; инвалид ВС; воин-интернационалист; пострадавший(ая) от катастрофы на ЧАЭС; ребенок-инвалид до 18 лет (нужное подчеркнуть), другое (указать)
_____
№ удостоверения _____

9. **Кем направлен** _____

10.**Доставлен в стационар** (нужное подчеркнуть) по экстренным показаниям: через___часов после начала заболевания, получения травмы; госпитализирован в плановом порядке

11. Диагноз направившей организации здравоохранении _____
_____

12. Диагноз при поступлении _____
_____
_____
_____
_____

13. Диагноз клинический (____._____.20____г.)
_____
_____
_____
_____
_____
_____
_____

14. Диагноз заключительный клинический:
основной_____
_____
_____
_____
_____ Код по МКБ-10
_____ | | | | . | |
_____
_____
осложнения основного_____
_____
_____
сопутствующие заболевания _____
_____
_____
_____

15. Госпитализирован в данном году по поводу данного заболевания: впервые, повторно (нужное подчеркнуть), всего _____раз

16. Хирургические операции и послеоперационные осложнения

Дата, время начала и окончания операции	Название операции	ФИО оперирующего хирурга	Осложнения	Вид анестезии (общая, местная)

17. Временная нетрудоспособность (в днях): до поступления _____, в стационаре _____, после госпитализации _____ (для продолжающих болеть при открытом больничном листе)

Отметка о выдаче листка нетрудоспособности номер строки по форме 16-ВН

№ _____ с _____ по _____ ; № _____ с _____ по _____;
№ _____ с _____ по _____ ; № _____ с _____ по _____.
(номер, число, месяц, год)
К труду «_____» _____ 20____ г.; продолжает болеть

18. Исход заболевания:

а) выписан с выздоровлением, с улучшением, без перемен, с ухудшением (нужное подчеркнуть);

б) переведен в другую организацию здравоохранения _____

_____
наименование организации здравоохранения, в которое переведен пациент

в) умер (в приемном отделении, умерла беременная до 22 недель беременности, умерла после 22 недель беременности, роженица, родильница (нужное подчеркнуть).

19. Для поступивших на экспертизу – заключение _____
_____
_____
_____
_____

20.Особые отметки_____
_____
_____
_____
_____
_____
_____
_____
_____

Лечащий врач _____ _____
подпись инициалы, фамилия

Зав. отделением _____ _____
подпись инициалы, фамилия

Лист назначений к медицинской карте № _____

Побочное действие лекарств (непереносимость) _____

Фамилия, имя, отчество пациента _____ палата № _____

Режим	Iа	Iб	IIа	IIб	IIIа	IIIб	IV	Стол			
Дата								Дата			

Лекарственные назначения

Назначения инъекционных препаратов	Дата назначения	Подпись врача	Дата отмены	Подпись врача	Назначения прочих препаратов	Дата назначения	Подпись врача	Дата отмены	Подпись врача

(оборотная сторона)

Назначения на обследования

Назначения на клинико-лабораторные исследования	Дата назначения	Врач, назначивший исследование	Дата выполнения	Назначения на инструментальные исследования	Дата назначения	Врач, назначивший исследование	Дата выполнения

Осмотрен на чесотку, микроспорию, педикулез. Опрошен на трихофитию.

«___» _____ 20___г. _____ _____
подпись инициалы, фамилия, проводившего осмотр

САНИТАРНАЯ ОБРАБОТКА

Выполнена (подчеркнуть): полная, частичная Не выполнялась

Дата ___ _____ 200__ г. _____ _____
подпись инициалы, фамилия, проводившего санитарную обработку

Онкоосмотр произведен	Дата
Кожа, губа, язык и слизистая рта Пищевод, желудок Прямая кишка Легкие Молочная железа, матка Врач _____ _____ Подпись инициалы, фамилия	

Приложение 2
к приказу
Министерства здравоохранения
Республики Беларусь
2008 №

Форма № 007/у-07

_____
(наименование организации здравоохранения)

Листок
учета движения пациентов и коечного фонда стационара

_____ Дата «____»_____ 200 г.
наименование отделения

	Фактически развернуто коек, включая койки, свернутые на ремонт	в том числе коек, свернутых на ремонт	Движение пациентов за истекшие сутки										На начало текущего дня			
			состояло пациентов на начало истекших суток	поступило пациентов (без переведенных внутри стационара)				переведено пациентов внутри больничной организации		выписано пациентов		умерло	состоит пациентов		состоит матерей при больных детях	свободных мест
				всего	из них			из других отделений	в другие отделения	всего	в том числе переведенных в другие больничные организации		всего	в том числе сельских жителей		
					сельских жителей	детей в возрасте 0- 17 лет включительно	в том числе детей до 1 года									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Всего коек																
в том числе по профилям коек (указать)																

Список пациентов на начало текущего дня

Оборотная сторона

Профиль коек	Фамилия, инициалы поступивших	Фамилия, инициалы переведенных из других отделений	Фамилия, инициалы выписанных	Фамилия, инициалы переведенных		Фамилия, инициалы умерших
				в другие отделения данной больничной организации	в другие больничные организации	

Старшая медсестра отделения _ _____ _____
подпись инициалы, фамилия

PATIENT ADMISSION AND REFUSAL OF HOSPITALIZATION LOG

_____
(наименование организации здравоохранения)

Приложение 6
к приказу
Министерства здравоохранения
Республики Беларусь
2008 №

Форма № 001/у-07

Журнал
учета приема пациентов и отказов в госпитализации

Начат «_____»_____200 г

Окончен «____»_____200 г.

№ п.п.	Поступление		Фамилия, имя, отчество пациента	Дата рождения	Постоянное место жительства или адрес родственников, близких, номер телефона	Какой организацией здравоохранения был направлен или кем доставлен	Наименование (номер) обслуживающей амбулаторно-поликлинической организации здравоохранения	Диагноз направившей организации здравоохранения	Наименование отделения, куда госпитализирован пациент, № мед. карты (истории родов)
	дата	время							
1	2	3	4	5	6	7	8	9	10

Продолжение таблицы

Несостоявшаяся госпитализации				Фамилия, инициалы врача приемного отделения
Причина отказа, принятые меры (время осмотра, жалобы, данные объективного осмотра, данные обследований), сопровождение, рекомендации по лечению и другое	Отказано		Место перенаправления	
	первично	повторно		
11	12	13	14	15

CONTENTS

Motivational characteristics of the topic....3
Documenting the medical information....3
Checking the information....4
Rules of documenting medical information....4
Medical documentation....5
Inpatient medical record (case history) form No. 003/U-80....6
Rules for maintaining medical documentation....7
Prescription sheets....10
Temperature sheets....10
Electronic medical record....11
Self-control of topic assimilation....11
Literature....13
Appendix 1....14
Appendix 2....22