USING MEDICAL RECORDS TO PROVE YOUR CASE IN GEORGIA

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I. GETTING THE MEDICAL RECORDS YOU NEED

A. Which Records are Considered Medical Records

1. Types of Medical Records. There are sources of recorded medical data beyond hospital charts and doctors office notes. Appreciating what is available will avoid accepting poor cases and unpleasant surprises in the course of case preparation and trial.

Incident/Accident Reports
Fire/ Police/ EMT Rescue
Ambulance Trip Report
Life Flight Records
Emergency Room Records
Hospital Charts and Records
- *Policies and Procedures: General and Departmental*
- *Organizational Records: Incorporation, Bylaws, Medical Staff*
- *Billing, Accounting and Invoicing Records*
- *Peer Review*
- *Statistical and Informational Records*
- *Safety Records*
- *Risk Management and Liability Insurance Records*
- *Personnel Hiring, Certification, Disciplinary and Employment Records*
- *Equipment Purchase, Inspection, Operation, Maintenance, and Repair and Records*

Outpatient Surgery, Clinic, Diagnostic and Treatment Records
Office Records: Patient Information Sheet, Office Notes. [the entire patient file may include phone messages, hand written notes etc. which are not provided as a routine practice]
Films, Video Imaging, Radiographic Studies, Computerized Imaging, Sonograms,
Autopsy Reports, Photographs and samples
Bodily fluid and Tissue samples

2. Content of Medical Records in Out-Patient and In-Patient Settings. *There is a degree of consistency anticipated in the medical records that can be expected to be produced. Medical professionals will generally record information based on the common accronym "SOAP": Subjective, Objective, Assessment, Plan. In hospital and outpatient clinics the records will be dictated both by internal organizational practices and procedures and the requirements of licencing and regulatory bodies (i.e. Joint Commission on Accreditation of Healthcare Organizations [JCAHO]).*

ER (Registration, Admission, Triage, Nursing Assessment, Physician Notes and Orders, Reports (i.e. Radiology), Patient Instruction Discharge)
ICU
Admission

History and Physical
Nursing Notes
Flow Sheets
Physician Progress Notes
Consultation
Laboratory Records and Reports
Radiology Records
Operative Reports
Anesthesia Chart
Medication Records
Discharge Summary

B. **Key Sources of Medical Records**

1. Physician Notes and Progress Reports
2. Nurses' Notes
3. Hospitals, Clinics, and Surgery Centers
4. Nursing Homes and Home Health Care Agencies
5. Physical Therapists
6. Mental Health Professionals

C. **Determining which Medical Records You Need:** Retrieving necessary medical records begins with the initial client interview and a knowledge of what to ask for. Clients will often overlook past medical conditions and treatment and the attorney should be prepared to assist in refreshing their recollections. Medical history questionnaires can assist in obtaining a complete history. Inquiring concerning past hospitalizations, ER visits, surgeries, accidents, injuries and other memorable medical events will often lead to disclosure of additional information. Areas to explore or obtain medical histories include: Client Interviews; Past Medical History and Records; Health Insurance and Third Party Payor Records; Disability and Life Insurance Examinations; School; Employment;, and Military Records; Claims and Lawsuits; Worker's Compensation; Accident and Injury reports.

D. **Obtaining a Complete Set of Medical Records:** There is a degree of consistency anticipated in the medical records that can be expected to be produced. Medical professionals will generally record information based on the common acronym "SOAP": Subjective, Objective, Assessment, Plan. In hospital and outpatient clinics the records will be dictated both by internal organizational practices and procedures and the requirements of licencing and regulatory bodies (i.e. Joint Commission on Accreditation of Healthcare Organizations [JCAHO]).

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1. How to Assure a Record is Complete. Common problems are failure to copy information on file folders themselves, telephone messages, stickies and other informal notations and double sided copies. Intentional destruction or deletion of records is more difficult to discover and may require detailed review of the records provided, comparison with the original record, sworn testimony of medical providers and staff, and forensic examination. There are a number of ways to confirm and assure yourself that the medical record is complete:

    a) Does it contain everything it should;
    b)Compare against original. ***O.C.G.A. 24-10-71 (c)*** *"A court upon good cause shown may order that available medical records be produced to determine the accuracy of reproductions made pursuant to this Code section."*
    c) Cross check against Itemized billing and other internal departmental records;
    d) depose records custodian and authors;
    e) Forensic analysis: page numeration, ream numbers, ink and marking consistency, handwriting, staple and punch hole marks, electronic entry analysis.

E. Digging Deep: Finding Additional Patient Information:

Incident/Accident Reports
Fire/ Police/ EMT Rescue
Ambulance Trip Report
Life Flight Records
Emergency Room Records
Hospital Charts and Records
    Policies and Procedures: General and Departmental
    Organizational Records: Incorporation, Bylaws, Medical Staff
    Billing, Accounting and Invoicing Records
    Peer Review
    Statistical and Informational Records
    Safety Records
    Risk Management and Liability Insurance Records

Personnel Hiring, Certification, Disciplinary and Employment Records
Equipment Purchase, Inspection, Operation, Maintenance, and Repair and Records
Outpatient Surgery, Clinic, Diagnostic and Treatment Records
Office Records: Patient Information Sheet, Office Notes. [the entire patient file may include phone messages, hand written notes etc. which are not provided as a routine practice]
Films, Video Imaging, Radiographic Studies, Computerized Imaging, Sonograms,
Autopsy Reports, Photographs and samples
Bodily fluid and Tissue samples

F. HIPAA Implications on Obtaining Medical Records

The implementation of HIPAA federal regulations in 2003 have changed all the rules on medical information disclosure.

1. Federal Law. Medical Request and Release forms are now substantially covered by federal law. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. Although passed in 1996, its regulations did not become effective until April 2003. The HIPAA Privacy Rule creates national standards to protect individuals' medical records and other personal health information and to give patients more control over their health information. It sets limits on the use and release of health records. It establishes safeguards that providers and health plans must implement to protect the privacy of health information. The Privacy Rule provides that, in general, a covered entity may not use or disclose an individual's healthcare information without permission except for treatment, payment, or healthcare operations. HIPAA compliant release authorizations should include:

    (a) A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;

    (b) The name or other specific identification of the person(s), or a class of persons, authorized to make the requested use or disclosure;

    (c) The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure;

    (d) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure;

(e) A statement of the individual's right to revoke the authorization in writing and the exceptions to the right to revoke, together with a description of how the individual may revoke the authorization;

(f) A statement that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by this rule;

(g) Signature of the individual and date; and

(h) If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual.

2. Georgia State Law.

§ 31-33-2. Furnishing copy of records to patient, provider, or other authorized person.

(a)(1)(A) A provider having custody and control of any evaluation, diagnosis, prognosis, laboratory report, or biopsy slide in a patient's record shall retain such item for a period of not less than ten years from the date such item was created.

(B) The requirements of subparagraph (A) of this paragraph shall not apply to:

(i) An individual provider who has retired from or sold his or her professional practice if such provider has notified the patient of such retirement or sale and offered to provide such items in the patient's record or copies thereof to another provider of the patient's choice and, if the patient so requests, to the patient; or

(ii) A hospital which is an institution as defined in subparagraph (B) of paragraph (1) of Code Section 31-7-1, which shall retain patient records in accordance with rules and regulations for hospitals as issued by the department pursuant to Code Section 31-7-2.
(2) Upon written request from the patient or a person authorized to have access to the patient's record under a health care power of attorney for such patient, the provider having custody and control of the patient's record shall furnish a complete and current copy of that record, in accordance with the provisions of this Code section. If the patient is deceased, such request may be made by a person authorized immediately prior to the decedent's death to have access to the patient's record under a health care power of attorney for such patient; the executor, temporary executor, administrator, or temporary administrator for the decedent's

estate; or any survivor, as defined by Code Sections 51-4-2, 51-4-4, and 51-4-5.

(b) Any record requested under subsection (a) of this Code section shall be furnished within a reasonable period of time to the patient, any other provider designated by the patient, any person authorized by paragraph (2) of subsection (a) of this Code section to request a patient's or deceased patient's medical records, or any other person designated by the patient.

(c) If the provider reasonably determines that disclosure of the record to the patient will be detrimental to the physical or mental health of the patient, the provider may refuse to furnish the record; however, upon such refusal, the patient's record shall, upon written request by the patient, be furnished to any other provider designated by the patient.

(d) A provider shall not be required to release records in accordance with this Code section unless and until the requesting person has furnished the provider with a signed written authorization indicating that he or she is authorized to have access to the patient's records by paragraph (2) of subsection (a) of this Code section. Any provider shall be justified in relying upon such written authorization.

(e) Any provider or person who in good faith releases copies of medical records in accordance with this Code section shall not be found to have violated any criminal law or to be civilly liable to the patient, the deceased patient's estate, or to any other person.

3. O.C.G.A. § 31-33-3. **Costs of Reproduction**

(a) The party requesting the patient's records shall be responsible to the provider for the costs of copying and mailing the patient's record. A charge of up to $20.00 may be collected for search, retrieval, and other direct administrative costs related to compliance with the request under this chapter. A fee for certifying the medical records may also be charged not to exceed $7.50 for each record certified. The actual cost of postage incurred in mailing the requested records may also be charged. In addition, copying costs for a record which is in paper form shall not exceed $.75 per page for the first 20 pages of the patient's records which are copied; $.65 per page for pages 21 through 100; and $.50 for each page copied in excess of 100 pages. All of the fees allowed by this Code section may be adjusted annually in accordance with the medical component of the consumer price index. The Office of Planning and Budget shall be responsible for calculating this annual adjustment, which will become effective on July 1 of each year. To the extent the request for medical records includes portions of records which are not in paper form, including but not limited to radiology films, models, or fetal monitoring strips, the

provider shall be entitled to recover the full reasonable cost of such reproduction. Payment of such costs may be required by the provider prior to the records being furnished. This subsection shall not apply to records requested in order to make or complete an application for a disability benefits program.

(b) The rights granted to a patient or other person under this chapter are in addition to any other rights such patient or person may have relating to access to a patient's records; however, nothing in this chapter shall be construed as granting to a patient or person any right of ownership in the records, as such records are owned by and are the property of the provider.

G. Requests to Produce Medical Records

Third Party Requests for medical records pursuant to the Georgia Civil Practice Act.

H. Subpoenaing Medical Records

Subpoena Duces Tecum under Georgia Evidence Code to produce at deposition or Trial

II MANEUVERING TROUGH THE MEDICAL RECORD MAZE

F. **Understanding what You Have and What You Don't Have:** *The medical profession has its own vocabulary, terms of art, abbreviations and procedures like any other profession or industry. The key to understanding is to learn their language, abbreviations, and symbols; appreciate how the information is organized; and, relate the information to the activities and procedures they record. A medical chart must be approached with diligence and caution. Each entry must be checked and rechecked, interpreted, understood and correlated. Invest in a quality medical dictionary and consider purchasing a basic practice manual for any area of medicine that may be unfamiliar. (i.e.* *Manual of Obstetrical Anesthesia, Gerard W. Ostheimer, Churchill/Livingstone, New York 1996)*

G. Guide to Medical Symbols, Abbreviations, and Key Terminology

1. Symbols Used

	urine
μ	urine
	urine and defecation
⁒	defecation

Symbol	Meaning
	ounces
	drams
□, ♂	male
○, ♀	female
↑	goes up (toe signs)
↓	goes down (toe signs)
>	increased, enlarged, more than
<	decreased, diminished, smaller than, less than
#	number, or pounds
▪	death
S	birth

2. <u>Abbreviations</u>. The abbreviations which follow are illustrative of the types of entries found in a medical record. Medical record abbreviations will vary from one section of the country to another, from one doctor to another, and from hospital to hospital. Local usages or customs and variances from doctor to doctor and hospital to hospital may drastically alter the meaning of a particular entry. The context in which a particular abbreviation is used will control its meaning. Capitalization and punctuation may completely alter the meaning of an abbreviation in a medical record. [Appendix 1]

3. <u>Basic Medical Terminology</u>. Prefixes and Suffixes. The language of medicine is a composite of many languages, both ancient and modern, the most frequent contributions being Greek, Latin, French, and Anglo-Saxon. Many words are derived from the name of the discoverer of some scientific fact or the name of a physician who perfected the technique in general use. Prefixes, suffixes, and roots are the keys to medical terminology. If you will take time to memorize a few prefixes and suffixes, the language of medicine immediately becomes easier. [Appendix 2]

4. <u>Medical Equivalents of Lay Terminology</u> [Appendix 3]

H. Diagnostic Tests and Procedures

1. X-Ray Terminology [Appendix 4]

2. Laboratory Procedures [Appendix 5]

3. Operative Terminology [Appendix 6]

4. Operating Instruments [Appendix 7]

5. Pathology Terminology [Appendix 8]

I. Specific Types of Charts and How to Use Them

Anesthesia Chart as an illustrative example.

J. Coding and Filing Procedures

The Medical Management Institute is proud to offer the 2006 Physician ICD-9-CM, Professional Coder's edition

The Healthcare Common Procedural Coding System (HCPCS) details approximately 2,500 supplementary codes required for supplies and services not listed in the CPT. These codes are referred to as level II codes, with CPT and local codes being levels I & III respectively

The Resource Based Relative Value System (RBRVS) grew out of a need to somehow standardize fees for medical practices. After much debate and refinement, the RBRVS was created through an addition to the Social Security Act.

CPT Current Procedural Terminology AMA

The Healthcare Common Procedural Coding System (HCPCS) details approximately 2,500 supplementary codes required for supplies and services not listed in the CPT. These codes are referred to as level II codes, with CPT and local codes being levels I & III respectively. Although this book is vital, some doctors still only code CPT and do not pursue HCPCS codes. The proper usage of the HCPCS will allow for increased payment to the practice. Why settle for less reimbursement than your practice is worth when this book is readily available?

F. Identifying Consistencies and Inconsistencies

F - H. <u>ANALYSIS</u>: Identifying Consistencies and Inconsistencies; Deciphering Normal versus Abnormal Findings; Looking for Red Flags in Medical Records. The analysis of medical records for consistency, errors and abnormal findings is a function of <u>both</u> medical knowledge and persistence. If you do not have the knowledge they hire it by consultant or other sources. Even the most knowledgeable specialist will not always have the persistence and tenacity necessary to decipher all the information available in a medical record.

APPENDIX 1

ABBREVIATIONS IN MEDICAL RECORDS

ABBREVIATION	MEANING	USE OR EXAMPLE
a.	artery	femoral a. inj.
A	area, anterior	scar a. lt. knee
Ab., ab.	abortion, antibody	ii prev. Ab.
Abd., abd.	abdomen, abdominal	distention of abd.
ABP	arterial blood pressure	ABP 135/80
abs	absent	rt. K/J abs
a/c or a.c.	on Rx means before meals	caps. I a/c
acc.	accident	no acc. hist.
accom.	accommodation	pupil reflex accom. & abs
A.D.	Right ear (in ear exam)	A.D. neg.
add.	adductor, or adduction	biceps add. weak
ad lib	as desired	fluids ad lib
adm.	admission	SSE on adm.
ADT	a placebo (anything you desire)	ADT h.s.
A/G, A.G.	albumen / globulin ratio (in blood)	A/G reversed
A/J	ankle jerk	A/J hypoactive
alb.	albumen	alb. pos.
alc., alcho.	alcohol	no alc.
AlcR.	alcohol rub	AlcR to bk.
alt.	alternate	alt H & C to ch.
A.M.	morning	A.M. care
amb.	ambulatory (up and about)	Pt. amb.
amt.	amount	small amt. of blood in emesis (vomitus)
ann. fib.	annulus fibrosus (in intervertebral. disc)	hern. ann. fib.
ant.	anterior	scar ant. Tongue
ante	before	ante h.s.
A.P.	anterior and posterior	AlcR. A.P. lt. lg.
AP	antero-posterior	AP ch. x-ray
Approx.	approximately	approx. 300 cc V.C.
aq.	water	aq. only
art.	artery, arterial	femoral art. inj.
A.S.	left ear (in ear exam)	A.S. 20/20

ABBREVIATION	MEANING	USE OR EXAMPLE
Ax.	axilla, axillary	used to designate axillary temperature
A.Z.	Ascheim-Zondek test (for pregnancy)	A.Z. neg.
B.	bath	Tub B.
Bab.	Babinski sign	lt. Bab. Pos.
BaEnema, BaE., BE	Barium enema	BE in A.M.
Bas.	basal, basilar	Bas. skull frac.
Baso.	basophile	in blood count
Bic.	biceps	lac. over lt. Bic.
b.i.d.	twice a day (bis in diem)	TPR b.i.d.
bk.	back	mss to bk,
blad.	bladder	blad. palp.
bld.	blood	bld. sugar neg.
B.M.	bowel movement	small B.M.
BMR	basal metabolism test (rate)	BMR + 20
B/P, B.P.	blood pressure	B.P. 120/80
Brach	brachial	Brach, plexus inj.
BRP	bathroom privileges	BRP for stool only
BSP	bromsulphalein test	BSP pos. 25%
BUN	blood urea nitrogen	BUN 40%
č	con, cum-meaning with	Fo. to sp. č AlcR. to bk.
C.	centigrade	Tub. B. 40° C
C-I-XII	1st to 12th cranial nerve	C-VII involv.
Ca	cancer, or carcinoma	Ca rectum
ca.	about	pain ca. umbilicus
Cal.	calorie, calories	1000 Cal. diet
Calc.	calcium	bld. Calc. elev.
caps.	capsule	caps I h.s.

ABBREVIATION MEANING USE OR EXAMPLE

car.	carotid	rt. car inj.
card.	cardiac	card. status OK
Cauc.	Caucasian	WDWN Cauc. M.
CBC	complete blood count	CBC on adm.
cc, c.c.	cubic centimeters (also, often erroneously used for liquid measurement	4000 cc vital capacity
C.C.	chief complaint	C.C.: headache
C.D.	contagious disease (ward)	C.D. technique
C.E.	cardiac enlargement	C.E. ii F lt.
Cerv.	cervix, or cervical	Cerv. boggy
cf.	compare	cf. pupils
ch.	chest	Fo. to ch.
chlor.	chlorides	bld. chlor. decreased
C.I.	color index (of blood)	C.I. 0.95
CI.	chloride	test bld. CI.
clav.	clavicle	frac. lt. clav.
cm.	centimeter	Hd. circumference 38 cm.
comm.	communicable	comm. disease
CNS	central nervous system	CNS neg.
CO_2	Carbon dioxide	CO_2 combining power
OK		
Coc.	coccygeal	Coc. pain
comb.	combine, combination	CO_2 comb. power elev.
comf.	comfortable	made comf.
comp.	compound, compress	comp. to Hd.
cons.	consultation	C-V cons. neg.
cont.	continue, containing, continuous	cont. steam inhalation
contrib.	contributory	hist, non-contrib.

ABBREVIATION	MEANING	USE OR EXAMPLE
cpd.	compound	epd. frac.

CR	cardiorespiratory system	CR sys. neg.
cran.	cranial	cran n. intact
CR. Ns.	cranial nerves	Cr. Ns. VII & IX involv.
C.S.	central service	C.S. requisition
CSF	cerebrospinal fluid	CSF neg.
C-V	cardiovascular	C-V sys. OK
CVA	costo-vertebral angle	fluid, lt. CVA
CVA	cerebrovascular accident (stroke)	CVA on adm.
Cysto	cystoscopy	to cysto for kidney study
D&C	dilatation and curettage	D&C mos. prev.
dehyd.	dehydrated	Pt. dehyd.
depr.	depressed	Pt. depr.
dept.	department	Housekeeping dept.
decr.	decrease, decreased	decr. reflexes
diff.	differential (blood count)	diff. nor.
dil.	dilute, diluted	10 qtts. HC1 č water
dim.	diminish, diminished	breathing dim.
dis.	disease	comm. dis.
dist.	distilled (water)	dist. aq. only
dist.	distal	dist. phalanx
DOA	dead on arrival	pt. DOA 9:27 P.M.
Dors.	dorsal	Dors. ft. pain
D.P.	dorsalis pedis (pulse)	D.P. felt on lt. only
Dr.	Doctor	Dr. Smith in
DTR's	deep tendon reflexes	DTR's present and equal
ECG	electrocardiogram	ECG č in normal limits

ABBREVIATION	MEANING	USE OR EXAMPLE
EEG	electroencephalogram	EEG shows focal lesion
EENT	eye, ear, nose and throat	EENT neg.

ABBREVIATION	MEANING	USE OR EXAMPLE
EKG (German)	electrocardiogram	EKG neg.
elev.	elevated	keep ft. elev.
En.	enema	En. P.R.N.
ENT	ear, nose and throat	ENT neg.
EOM	extraocular muscles, equal ocular movements	EOM neg.
EOM	external otitis media	EOM at 8 yrs.
Eos.	eosinophiles	Eos. Excessive
ESR	erythrocyte sedimentation rate	ESR norm.
ees.	essentially	hist. ess. neg.
excess.	excessive	excess. urine
ext.	external	ext. use only
extr.	extremities, extremity	keep extr. elev.
extens.	extension, extensor	extens. mm. weak
F.	finger (s)	I F. From knee
F.	in history, can mean either male or father	F. 1 & w
F.	fahrenheit (temperature)	104° F.
fem.	femoral, femur	fem. pulses OK
F.H.	family history	F.H. non-contrib.
flac.	flaccid	flac. paralysis
flex.	flexor, flexion	flex. mm. weak
fl. oz.	fluid ounces	limit to 16 fl. oz. q.d.
fl.	fluids	fl. ad. lib.
Fo.	fomentation	Fo. to rt. ft.
Ft.	foot, or feet	Fo. to rt. ft.
Fr. or Frx Fx. or frac.	fracture	frac. rt. clav.
G. or gm.	gram or grams	limit fats to 60 gm qd.

G.B.	gall bladder	G.B. removed
gen. or genl.	general	gen. diet
genit.	genitalia	ext. genit. norm.
G.I.	gastro-intestinal	x-ray G.I. neg.
gluc.	glucose	test for urine gluc.
gr.	grains (dosage)	pentobarbitol gr.išs h.s.
grav.	gravid	Para ii-grav. I
gt, gtt.	drop, drops	10 gtt. t.i.d.
G.U.	genito-urinary	G.U. sys. neg.
Gyn.	gynecology, gynecological, gynecologist	Gyn. consult. neg.
h.	hour (as q.h.)	TPR q.h.
H.	hypodermic	m.s. gr. ¼ per H.
HCI	hydrochloric acid	test for free HCI
H & C	hot and cold	H & C to ch.
Hd.	head	Fo. to Hd.
hern.	herniated	hern ann. fib. L-IV
hg. or hbg.	hemoglobin	Pt. has low hg.
hist.	history	past hist neg.
Hr.	hour	¯q 4 Hr.
H.S. or h.s.	hour of sleep	Fo to sp. at H.S.
Ht.	height or heart	Ht. norm.
hyst.	hysterectomy, or hysteria	hyst. 10 yrs. ago

ABBREVIATION	MEANING	USE OR EXAMPLE
I^{131}	radioactive iodine	I^{131} shows 25% uptake
I ii, iii	1, 2, 3, etc.	Para iii
i.d.	in diem (during the day)	visitors i.d.
in.	inch	55 in.

ABBREVIATION	MEANING	USE OR EXAMPLE
inj.	injured	rt. arm inj. in fall
int.	internal	int. organs OK
involv.	involved	Pt. involv. in auto acc.
I.M.	intramuscular (injection)	I ml. B_{12} I.M. q.d..
irreg.	irregular	pulse irreg.
irrig.	irrigate, irrigation	irrig. blad b.i.d.
I.V.	intravenous	start I.V. at 3 P.M.
IVD	intervertebral disc	hist. of IVD
IVP	intravenous pyelogram	IVP in A.M.
IVU	intravenous urogram	IVU tomorrow
Jt.	joint	Jt. pain occas.
K.	potassium	check bld. K.
K.	kidney	lt. K. removed
KJ	knee jerk	rt. KJ absent
KUB	kidney, ureter, bladder (x-ray)	KUB neg.
L	can variously mean liver, liter, left, lower, light, lumbar (depending on context)	L.L.Q. (left, lower quadrant)
L & A	light and accommodation (reflexes of pupil)	pupils react to L & A
lab.	laboratory	urine spec to lab.
lac.	laceration	lac. lt. thumb
lacr.	lacrimal	lacr. probe in A.M.
lact.	lactic acid, lactate, lactating	Pt. lact. norm.
lam.	laminectomy	old hist. of lam. L-IV
lap.	laparotomy	lap performed last yr.
lat.	lateral	pain lt. lat. ch.
lav.	lavatory	lav privileges

lb.	pound	15 lb. traction to neck
L.E.	can mean lupus erythematosus, or lower extremities	L.F. bruised
leuc.	leucocytes (in blood)	leuc. elev.
lg.	leg or large	Fo to lg.
lig.	ligament	strained lig. lt. knee
liq.	liquid	liq. only
L.L.E.	left lower extremity	L.L.E. cold
L. lat.	left lateral	L. lat. abd. area
LOA	left occip, anterior (obstetrics)	LOA present
LOP	left occipital posterior	LOP present
L.P.	lumbar puncture	L.P. neg.
L.S.	lumbosacral	L.S. pain
LSK	liver, spleen and kidneys	LSK not palp.
Lt., lt.	light, or left	Fo to lt. lg.
L.U.E.	left upper extremity	L.U.E. absent
lumb.	lumbar	lumb, pains q.n.
l & w	living and well	4 sibs. l & w
lymphs.	lymphocytes (in blood)	lymphs, increased
m.	minims (1/16th of fluid dram)	10 m. Hel a/c
M.	in history, means male or mother.	M. 1 & w
M.	meter	use 2 M. stomach tube

ABBREVIATION	MEANING	USE OR EXAMPLE
macro.	macrocytic, macroscopic	RBC's macro.
max.	maximum, or maxillary	rt. max. pain
mcg. or mcgm.	microgram	10 mcg. B_{12} q.d.
MCH	mean corpuscular hemoglobin	MCH 30
MCHC	mean corpuscular hemoglobin concentration	MCHC 35%
MCV	mean corpuscular volume	MCV 90 cu. micro.

med. .... medial .... med. aspect thigh

mEq./L .... milliequivalents (mEq./L-per liter)Na-100 mEq./L

mg. or mgm. .... milligrams .... aspirin 300 mg. q.d.

micro .... microcytic, microscopic .... RBC’s micro.

min. .... minimal, or minims .... min. pain over Ht.

ml. .... milliliter (approximately 1 c.c.) ... urine 400 ml.

mm. .... muscles .... leg mm. weak

MN .... mononuclears (leucocytes) .... MN excessive

mod. .... moderate, moderately .... reflexes mod. active

monos. .... monocytes (in blood) .... monos, absent

M.S. .... multiple sclerosis .... M.S. last yr.

m.s. .... morphine sulfate .... no m.s. this Pt.

Ms .... Murmurs .... no Ms

mss .... massage .... mss to abd.

M.T. .... muscles and tendons .... M.T. OK

multip. .... multiparous (more that one pregnancy) .... multip. cervix

musc. .... muscle, muscles, muscular .... Pt. has musc. weakness

M.T. .... membrana tympani (ear drum) .... rt. M.T. perforated

N_2 .... nitrogen .... liq. N_2 to lesion

n. .... nerve .... facial n. paralysis

ABBREVIATION	MEANING	USE OR EXAMPLE
N_2O	nitrogen oxide anesthetic	N_2O used
Na	sodium	Na free diet
NaC1	sodium chloride	Low NaC1 in diet
NBM	nothing by mouth	NBM until x-ray completed
neg.	negative	Ht. neg.
norm.	normal	Ht. norm.
NPO	nothing per mouth	NPO today

NPN	nonprotein nitrogen	NPN in A.M.
Ns.	nerves	Ns. seem OK
N.S.	nervous system	N.S. review neg.
N.P.	neuropsychiatry	N.P. review neg.
neur. or neurol.	neurology, neurologist, neurological	neur. consult today
noc.	night (nocturia)	noc. pains
nullip.	nulliparous (no pregnancies)	nullip. introitus
O_2	oxygen	O_2 P.R.N.
OB	obstetrics	OB service
Occ., occip.	occiput, occipital	Occ. pains
occas.	occasional	occas. fluids
Occup. Rx.	occupation, occupational therapy	Occup. Rx. q.d. x 7
O.D.	right eye (oculus dexter)	O.D. - 1.50 (lens Rx.)
O.M.	otitis media	O.M. lt. ear
OPD	out patient department	to: OPD
O.R.	operating room	to: OR
orth.	orthopedic	orth. consult neg.
O.S.	left eye (oculus sinister)	O.S. - 0.75
O.T.	old tuberculin	O.T. neg.

ABBREVIATION	MEANING	USE OR EXAMPLE
oz.	ounce	oz. vi q.d.
PA	postero-anterior	PA ch. x-ray in A.M.
P & A	percussion and auscultation (exam. of chest)	clear to P & A
palp.	palpate, palpated, palpable	liver palp. ii F.
Para I	has had one pregnancy (para ii, para iii, etc.)	OB hist. Para ii

PBI	protein-bound iodine	PBI 5.5
p/c, p.c.	after meals	amb. p/c
PCV	packed cell volume (of blood)	PCV norm.
pdr.	powder	pdr. lesion b.i.d.
P.E.	physical examination	P.E. neg.
ped.	pediatrics	ped. dept.
PEG	pneumoencephalogram	PEG in A.M.
Per.	perineal	Per. pad, or Per. care
pen.	penicillin	allergic to pen.
P.F.	push fluids	P.F. to 3000 ml.
pH	acidity value of blood or urine	pH 7.0
P.H.	past history or personal history	P.H. non-contrib.
physio.	physiotherapy, physical therapy	physio. b.i.d.
phys.	physical	phys. neg.
P.I.	present illness	P.I.: headache began 2 mos. ago
p^{131}	radioactive phosphorus	p^{131} test

ABBREVIATION	MEANING	USE OR EXAMPLE
P.M.	afternoon	P.M. care
PMN	polymorphonuclear (leucocytes)	PMN's increased
pneu.	pneumo, pneumonia	pneu. last yr.
po	per oral (by mouth)	nothing po
P.O.	post-operative	usual P.O. care
polys.	polymorphonuclear (leucocytes)	polys. decreased
pos.	positive	pos. lt. Bab.
post.	posterior	post. head pains
pot. or potass.	potassium	add pot. to diet
pre-op	preoperative	routine pre-op care
prev.	previous	no prev. hist.
primip.	primiparous (first pregnancy, no prior pregnancies)	Pt. is primip.

P.R.N.	in dosage, means as required, when necessary, as needed	Fo. to abd. P.R.N. for pain
pron.	pronator, pronation	pain in forearm when pron
pros.	prostate, prostatic	pros. enlarged
prox.	proximal	prox. phalanx painful
PSP	phenolsulfonphthalein test	PSP in A.M.
Pt., pt.	patient	Pt. resting comfortably
P.T.	physiotherapy, physical therapy	to P.T. dept. for whirlpool
P.T.	posterior tibial artery pulse	P.T. pulses felt
Pwd.	powder	Pwd. R.
Px.	physical examination	Px. ess. neg.
q̄, q	every	q̄ day
q.d.	every day	16 fl. oz. q.d.

ABBREVIATION	MEANING	USE OR EXAMPLE
q.n.	every night	alcR. q.n.
q.2.h.	every two hours	amb. q.2.h.
q.i.d.	four times a day	B/P q.i.d.
q.n.s.	quantity not sufficient	urine q.n.s.(for testing)
q.s., qs.	quantity sufficient	urine q.s. (when not measured)
qtts. (hand-writing corruption)	drops	10 qtts. t.i.d.
q.v.	as much as you wish	liq. q.v.
R.	right, rub	alc. R. to sp.
R., ®)	rectal (temperature)	T. per R.
rad.	radial	rad. pulse OK
RBC	red blood cells	RBC's normal
rect.	rectum, rectal, rectis (muscle)	rect. pain

rehab.	rehabilitation	rehab. gradual
resp.	respiratory, respirations	resp. increased
Rh	Rh factor of blood	Rh positive
R/O	rule out	R/O hepatitis
ROA	right occiput anterior	ROA presentation
ROP	right, occiput posterior (obstetrics)	ROP presentation
RRE	round regular and equal (pupils)	pupils RRE
Rt.. rt.	right	rt. leg pain
Rx.	prescription, prescribe	Rx. aspirin P.R.N.
s	sine (without)	Fo. s cold compress
Sa	saline	replace bld. č Sa.
Sed. rate	sedimentation rate of blood	Sed. rate 10 mm./hr.
sem. ves.	seminal vesicles	sem. ves. intact

ABBREVIATION	MEANING	USE OR EXAMPLE
sens.	sensory, sensation	sens, OK
sero, or serol.	serology, serological test	sero. positive
SGO-T	serum glutamic oxalacetic transaminase (test)	SGO-T 120
SGP-T	serum glutamic pyruvic transaminase	SGP-T 85
skel.	skeletal	skel. mm. seem fine
sibs.	siblings	5 sibs. l&w
sig.	take (on prescription)	sig. : I caps. P.R.N.
sl.	slight, slightly	pt. sl. nauseated
SLR	straight-leg raising (test)	SLR pos. on lt.
sod.	sodium	low sod. diet
S.O.S.	when necessary	cold pack S.O.S.
sp.	spine, spinal	Fo. to sp.
sp. cd.	spinal cord	heat to sp.cd.
spec.	specimen	stool spec. to lab
sp. fl.	spinal fluid	sp. fl. clear

spg.	sponge	soap spg.
sp. gr.	specific gravity	sp. gr. 1,006
spin.	spine, spinal, spinous	pain over T-12 spin. process
S.R.	sedimentation rate	S.R. norm.
ss	one-half	grs. ss h.s.
s.s.	soap suds	s.s. En.
SSE	soap suds enema	SSE in A.M. if no B.M. in P.M.
stat.	immediately, at once	Fo. to sp. stat.
stom., st.	stomach	Fo. to st.
S.T.S.	serological test for syphilis	S.T.S. pos.

ABBREVIATION	MEANING	USE OR EXAMPLE
subcut.	subcutaneous	atropine subcut. only
sulf.	sulfate	m. sulf. forbidden
sup.	superior	sup. vena cava
supin.	supination	pain č supin. lt. arm
surg.	surgery	to surg.
sys.	system	sys. review neg.
T.	temperature	T. q̄ 2 hrs.
T & A	tonsillectomy and adenoidectomy.	T & A at 12 yrs. of age
tab.	tablet	tabs. ii q. 4 h.
talc.	talcum	talc. rub h.s.
T.A.T.	tetanus antitoxin	allergic to T.A.T.
T.F.	tuning fork	responds to T.F.
thor.	thorax, thoracic	thor. pains
thromb	thrombosis	thromb. lt. fem. a.
t.i.d.	three times a day	amb. t.i.d.
T.M.	tympanum membrani (ear drum)	T.M. clear
TPR	temperature, pulse, respiration	TPR q̄ 4 hrs.
uln.	ulnar	uln. n. intact

ABBREVIATION	MEANING	USE OR EXAMPLE
upper G.I.	upper gastrointestinal (as in series of x-rays)	upper G.I. neg.
u/o	under observation for	u/o comm. dis.
Vag.	vaginal	no Vag. exam.
V.C.	vital capacity	V.C. 2500 cc.
V.D.	venereal disease	V.D. work up
VDRL	serologic test for venereal disease. (venereal disease research laboratory	VDRL, doubtful
ABBREVIATION	**MEANING**	**USE OR EXAMPLE**
vent.	ventral	burn vent. surface ch.
VI	volume index	VI = 1.0
V.I.	vaginal irrigation	V.I. daily at 9 A.M.
vol.	volume	urine vol. 400 ml.
WBC	white blood count	WBC test in A.M.
w.d., WD	well developed	w.d.w.n.w.m.
wh. ch.	white child, wheel chair	to P.T. in wh. ch.
w.n., WN	well nourished	w.d.w.n.w.m.
w.m., WM	white male	w.d.w.n.w.m.
w.f., WF	white female	w.d.w.n.w.f.
wt.	weight, weigh	wt. q.d.
x	times	q.d. x 5
yrs.	years	6 yrs. ago

APPROXIMATE EQUIVALENTS

4 cc		1 tsp.
30 cc	1 oz.	2 tbsp.
240 cc	8 oz.	1 glass
500 cc	16 oz.	1 pint
1000 cc	32 oz.	1 quart

(To be technically exact, all “cc” should
be written “ml.” for liquid measurement)