Loma Linda University Medical Center

DICTATION INSTRUCTIONS

1. To dictate for Loma Linda University Medical Center: **In-house access dial 44080**
Outside access dial 877-583-6143
2. Enter your 5-digit Loma Linda Physician I.D. code **followed by the # key.**
3. Enter the **8-digit CSN Code. followed by the # key.**
4. Enter **4-digit** report type **followed by the #key.**

1305 History & Physical
1335 Operative Report
1355 Discharge Summary
1315 Consultation
1356 Transfer Summary
1357 Death Summary
1306 Pre-Operative History & Physical

(continued)

DICTATION INSTRUCTIONS

5. Dictate after tone.
6. Identify yourself clearly, spell the patient's name, and give the medical record number.
FOR RESIDENTS: Please state the attending physician's first and last name.
7. After each report press 4. The system will give you a job confirmation number. Keep this confirmation number for your records.
8. To dictate multiple reports press 6. The system will re-enter your physician ID code, the follow the voice prompts.

DICTATION CONTROL CODES

1 STOP
2 RESUME DICTATION
3 LISTEN to last phrase dictated. Press 2 to resume dictation.
7 FAST FORWARD to end of dictation. Press 2 to resume dictation.
9 REWIND TO BEGINNING of dictation. Press 0 to listen.
6 SEPARATE REPORTS System re-enters physician ID code.
4 JOB CONFIRMATION NUMBER

Dictation Instructions Online:
From the VIP Intranet Webpage:
Departments . LLUMC Departments . Health Information Management Dictation

DISCHARGE SUMMARY FORMAT

All Discharge Summaries should be dictated within 48 hours of the patient's discharge.
IDENTIFY yourself clearly (first and last name), spell the patient's first and last name, and give the 8-digit CSN code.

• Discharge date
• ATTENDING PHYSICIAN
FOR RESIDENTS: Please state "I am dictating for. . ." including physician's first and last name.
• Referring physician
• Admitting physician
• REASON FOR ADMISSION
Condition requiring inpatient status
• PATIENT PROFILE
Identify the patient regarding age, etc.
• FINAL DIAGNOSIS
Conditions found, after study, to be the reason for admission to the hospital. List all documented diagnoses.

(continued)

DISCHARGE SUMMARY FORMAT

• FINAL DIAGNOSIS, cont'd.
Identify which conditions were present on admission. Do NOT use abbreviations in diagnosis.

• PROBLEMS ARISING DURING HOSPITALIZATION
List additional diagnoses, infections, and/or complications integral to a procedure or treatment.
• PROCEDURES
Surgeries in and out of the OR, interventional and significant treatments/procedures. Do NOT use abbreviations in procedure name.
• MANAGEMENT OF PROBLEMS
Diagnostic findings, therapeutic approaches, and outcomes for significant problems addressed.
• PATIENT CONDITION AT DISCHARGE
• DISCHARGE INSTRUCTIONS
List medications. State instructions given to patient regarding follow-up, diet, level of activity, etc.

HISTORY AND PHYSICAL FORMAT

A complete history and physical must be recorded within 24 hours after admission.
IDENTIFY yourself clearly (first and last name), spell the patient's first and last name, and give the 8-digit CSN code.

The **HISTORY** should contain:

• Date History taken
• Patient's Chief Complaint
• Present Illness
• Past History
• Social History
• Family History
• Review of Systems

The **PHYSICAL EXAMINATION** should contain:

• Date of Exam
• Pertinent findings by each Body System
• Provisional Diagnosis
• Recommendations

OPERATIVE REPORT FORMAT

IDENTIFY yourself clearly (first and last name), spell the patient's first and last name, and give the 8-digit CSN code.

• Date of Surgery
• Operating Surgeon
FOR RESIDENTS: Please state "I am dictating for. . . "including physician's first and last name.
• First Assistant, Second Assistant, etc.
• Postoperative Diagnosis (Do NOT use abbreviations in Diagnosis)
• Operation Performed - include biopsies (DO NOT use abbreviations in procedures or operations)
• Anesthesia
• Incision
• Findings, in detail
• Procedure, in detail
• Closure
• Condition of patient at end of operation
• Prognosis
• Specimens removed
• Estimated blood loss
• Drains or packs
• Needle and sponge counts
• Classification of wound

NOTE: Please note in dictation: Attending surgeon was present during the critical portion of the procedure and/or entire procedure.

CONSULTATION REPORT FORMAT

IDENTIFY yourself clearly (first and last name),spell the patient's first and last name, and give the 8-digit CSN code.

• Date of Consultation
• Referring Physician
• Consulting Physician
• Reason for Consultation
• Body of the report
• Brief history and physical with impressions and plan
• Indicate review of chart and examination of the patient

DELIVERY SCHEDULE;

All dictated reports returned within a max of 24 hours, determined by report type.