Ochsner Clinic Sites
ACCOUNT SPECIFICS

Platform:	eScription
Institution/Site Code:	ochsner
Software Versions:	ESMT: Version 9.8 eMon: Version 9.10.3
Info/Resources:	ES SAMPLE SITE: https://ochsner.escriptionasp.com/Downloads/Labor/ Log in with your EditScript login ID/PW
Customer Links:	http://www.ochsner.org/

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Version/Change Record

Version	Date	Responsible Person	Description of Version/Change
1.0	7/21/11	Tammy Stuecher	Ochsner sign off 7/21/11
1.1	9/28/2011	Cathy Chiudina	Added dictator specifics
1.2	04/12/2012	Bethanne Tuel	Upload protocols
1.3	04/20/2012	Bethanne Tuel	Upload status for Split dictations
1.4	06/08/2012	Bethanne Tuel	Discrepancy in numerics
1.5	06/28/2012	Bethanne Tuel	Time Stamps

TABLE OF CONTENTS

All subjects are listed in alphabetical order and are hyperlinked. Simply click on a subject to find the information.

NOTE: Utilize the AHDI Book of Style for any format information not contained in this document.

ABBREVIATIONS/ACRONYMS

Transcribe all abbreviations and/or acronyms as dictated.
Any DIAGNOSIS, ASSESSMENT or IMPRESSION – Needs to be expanded under these headings. The only time these would not be expanded is if the meaning of the abbreviations is ambiguous (e.g. AML or CML) and it is not clearly defined in the dictation. Common lab and radiologic abbreviations do not need to be expanded.

Clinicians often use abbreviations as complete words, such as “sat” for saturation, “vfib” for ventricular fibrillation, or “tox” for toxicity. Do not expand these short-hand indicators. Assume that, if the clinician wants you to expand any acronym or abbreviation, they will speak them in their expanded form.

OP NOTES: On operative notes, dictators will often want to have the PREOPERATIVE DIAGNOSIS text copied to the heading POSTOPERATIVE DIAGNOSIS by dictating: “Postoperative diagnosis, same.” **Do NOT transcribe the word "same"** Copy verbiage from PREOPERATIVE DIAGNOSIS and paste the entire contents after the POSTOPERATIVE section, adding anything additional after the word "same."

CC vs. mL: See JCAHO abbrev list. If dictated as cc, transcribe as mL.

LATIN-BASED ABBREVIATIONS

Standard Measurements: use the associated abbreviations for common units and name suffixes and saluations when there is no ambiguity and the shorter form is easier to type and read than the spelled-out form.

Measurement (whether spoken in full or abbreviated)	Default Form
Milligrams	mg
Micrograms	mcg
Millimeters of mercury	mmHg
Centimeters	cm
Kilograms	kg
Milliliters	mL
Milliequivalents	mEq

ALWAYS place periods between each letter in Latin-based abbreviations and phrases for the frequencies of medications.

Correct	Incorrect
n.p.o.	npo
p.o.	po
p.r.n.	prn
q.a.m.	qam
q.p.m.	qpm
q.i.d.	qid
t.i.d.	tid
b.i.d.	bid

For all other acronyms not listed above: When the speaker dictates “q.” followed by a complete word, separate "q." from the rest of the phrase with a single space.

Correct	Incorrect
q. noon	q.noon
q. day	q.day

Otherwise, write exactly what you hear the speaker say, even if there is an equivalent abbreviation.

Example: If speaker says q. 4 hours, this does not get shortened to q.4h. **If dictated as q.4h., no spaces are required.**

Clinician Dictates	Correct	Incorrect
as needed	as needed	p.r.n.
twice a day by mouth	twice a day by mouth	b.i.d p.o

Always expand the following abbreviations (following JCAHO recommendations)

Correct	Incorrect
Daily	q.d. –or- QD –or- Q.D. –or- qd
every other day	q.o.d. –or- QOD –or- Q.O.D. –or- qod
unit	U
International unit	IU
morphine sulfate	MSO4
magnesium sulfate	MgSO4

Standard Acronyms

Write acronyms, which are combinations of letters and numbers, in the usual manner:

- S1
- L4 to L5 **OR** L4 thru L5
- CA-125 (Write “cancer antigen 125” if clinician speaks it as such)
- FESO4
- 2D (Write “two dimensional” if clinician speaks it as such)

Transcribe vertebral spaces literally, using the word 'to’ or ‘thru’, whichever is dictated: “L5 to S1”, “S1 thru S2”

Do NOT use the ampersand (&) as part of an acronym.

Correct	**Incorrect**
CTA and P	CTA&P
H and H	H&H
H and P	H&P

Pluralize acronyms and spoken abbreviations by adding a lowercase 's' to the end of the abbreviation or acronym.

Singular	Plural
ADL	ADLs
DTR	DTRs
PVC	PVCs

If forming plurals for lowercase acronyms, add's as follows:

wbc's = white blood cells (as in UA showed 3 wbc's)

JCAHO PROHIBITED ABBREVIATIONS

All of the JCAHO required AND optional do-not-use entries will be expanded. See list below.

U (unit)	Write "unit"
IU (International Unit)	Write "International Unit"
Q.D., QD q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Write "daily" Write "every other day"
Trailing zero (X.0 mg)***** **(see note below)** Lack of leading zero (.X mg)	Write X mg Write 0.X mg
***Exception to above: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.**	
MS MSO_4 and $MgSO_4$	Write "morphine sulfate" Write "magnesium sulfate"
ug (for microgram)	Write "mcg"
h.s., H.S., Q.H.S., q.h.s.	Write out "half-strength" or "at bedtime"
T.I.W. (for three times a week)	Write "3 times weekly" or "three times weekly"
S.C. or S.Q. (for subcutaneous)	Write "Sub-Q", "subQ", or "subcutaneously"
D/C (for discharge or discontinue)	Write "discharge" or "discontinue"
cc (for cubic centimeter)	Write "mL" for milliliters
A.S., A.D., A.U. (Latin abbreviation for left, right, or both ears) O.S., O.D., O.U. (Latin abbreviation for left, right, or both eyes)	Write: "left ear", "right ear" or "both ears" Write: "left eyes", right eyes" or "both eyes"

ENGLISH UNITS OF MEASURE

Spell out English units of measure.

Example:
5 feet 3 inches (not 5'3" or 5 ft. 3 in.)
150 pounds (not 150 lbs.)

METRIC UNITS OF MEASURE
Abbreviate metric units of measure when accompanied by a numeric value.
Example:
1 cm
1 m
Do not form plural by adding 's.

EPONYMS
Delete apostrophe when combined with its noun; apostrophe may be used if used alone.
Example:
Alzheimer dementia
Homans sign (not Homans' sign or Homan's sign)
BUT
"The patient has Alzheimer's."

FOLLOW UP/FOLLOWUP
Followup noun, such as, "The patient was seen in followup."
Follow up verb, such as, "The patient will follow up."
Followup modifier. "The patient has a followup appointment."

ADDENDUMS
Transcribe addendum as dictated and pend to client.

ALLERGY STATEMENTS
Standard mixed case, as dictated.

Example:
ALLERGIES: No known drug allergies.

ALLERGIES: Penicillin causes a rash.

BLANKS
Denote blanks with 5 underscores UNLESS it is a STAT.

For STATs, reduce to 4 underscores and send directly, DO NOT PEND, and email the appropriate loop to email client.

CARBON COPIES
*Only add carbon copies when specifically requested by dictator. If there are multiple listings for same physician, carbon copy the one with the same site (business entity).
*For NOC only, enter carbon copy through Alt +C AND TYPE IT AT THE END OF THE REPORT: "Copy of this consultation to be sent to Dr. XYZ."
*If CC is dictated to patient, create CC and pend to client to verify CC to patient.

- While adding NEW CONTACTS, fill in the address of the doctor as below, with the address in STREET 1 field and any additional information in STREET 2 field;

Diane (First Name) Massimini (Last Name)
NOC-424 South Tyler Street (Street 1)
Urology Clinic of New Orleans (Street 2)
Covington (City)
LA (State)

70433 (Zip Code)

CC vs. mL: See JCAHO abbrev list. If dictated as cc, transcribe as mL.

CONTINUATIONS

Transcribe CONTINUATION at top of report and complete report as dictated and pend to client.

CONTRACTIONS

Transcriptionists should expand contractions when they are spoken unless in a direct quote.

Examples:
Dictated: He's a vegetarian.
Transcribed: He is a vegetarian.
OR
Dictated: The patient was murmuring, "I'm a diabetic."
Transcribed: The patient was murmuring, "I'm a diabetic."

DATES

Concise numeric, 01/02 or 01/02/2006 (as dictated) for all clinic entities. EXCEPTION: Spell out dates for LETTERS and MEMOS.

Provider dictates:	Transcriptionist types:
I saw the patient on one twelve.	I saw the patient on 01/12
… January twelfth.	01/12
… Oh one oh two oh nine	01/02/2009
… January second … the twelfth of January	01/02 01/12
… one twelve two thousand nine	01/12/2009
… last January	Last January

For Letters, dates will be spelled out.
Example: The patient was seen on September 9 for chronic cold symptoms.

DEMOGRAPHICS

MRN, dictator name and signing clinician will have the site code "NOC/BRC/NSC" attached to differentiate them. Along with MRN, there will be a column called "Location." Ensure that the MRN matches the site location. For any missing patient information, pend to client to verify patient demographics."

For all files with "Person, Unknown," ensure the dictated patient name is selected, the MRN has the correct site attached with it and the patient does not belong to any other Ochsner entity like JHH, BRC, NSH, etc. If the patient is from a different entity other than NOC, do not select that patient name. Instead, just pend the report to the client stating – ***<site mnemonic>: Please verify patient demographics, not found for <site mnemonic> entity for the dictated patient name, _____.***

ACCOUNT NUMBER

While selecting the account number, ensure after scrolling down the account number has the appropriate site code along with matching DOS and Speaker name in attending field.
* If there are 2 account feeds with same date, one with speaker name and one with signing clinician name, select the feed which has the speaker name attached to it.
* If there are 2 feeds with the same date as DOS and speaker's name in attending physician tab, select either one and send through. Do not pend.

* If there is not an account number that matches the visit date and speaker, do not select an account number and pend to the client.
* There will not be a physician name attached to the account number on all EEG reports. It will state EEG or EEG-Pediatric. Select the account number matching with DOS and send through. No need to pend.

DEPARTMENT NAMES

Department names are capitalized. For eg: Emergency Room, Transplant Department, Infectious Disease, etc.

FORMATTING INSTRUCTIONS

AUTO-NUMBERING

No. Turn off auto-formatting feature.

FONT

Arial 10

FORBIDDEN CHARACTERS

Do NOT use the following characters. They are not accepted in the electronic interface: Pipe **|,** Caret **^,** Backslash **\,** Ampersand **&** or Tilde **~**

Note: The ampersand (&) should not be used anywhere in the report, including headings.

SPECIAL FORMATTING

Do NOT use bold, underline, superscript, subscript or italicize as requested by speaker. Do NOT change any of the special formatting that is part of a normal template you have pulled into your document. Do not use RTF formatting.

TABS

Do not use TABS.

TIME FORMAT

Times may be spoken in many ways. It is important that they be formatted as uniformly as possible.

- Use the hour:minute format and use military hour time if the provider dictates as such. Note, there is no colon in military time, i.e., 1900, not 19:00.
- If dictated, add “a.m.” and “p.m.”
- Never include the word o'clock when talking about time. Use o'clock only if dictator is referring to anatomy, i.e., "...a lesion at the 8 o'clock position.)

Provider dictates:	Transcriptionist types:
I saw the patient at one fifteen.	I saw the patient at 1:15.
… quarter past one.	… 1:15.
… one fifteen p.m.	… 1:15 p.m.
… thirteen fifteen.	… 1315.
… thirteen hundred fifteen.	… 1315.
… around one o’clock.	… around 1:00.
… around thirteen hundred hours.	… around 1300.

VERBATIM VS. NON-VERBATIM

Verbatim. Small changes to grammar are expected, but keep to verbatim as much as

possible. Any obvious discrepancies in dictation should be flagged and pended to client for verification.

HEADER AND FOOTER INFORMATION

Do not repeat information in text that already appears in the header such as DATE OF BIRTH.

HEADINGS

Do NOT use **"/" or "&**" as any part of headings, i.e.,

CORRECT:
LABORATORY TESTS PROCEDURES AND RESULTS:

PAST FAMILY AND SOCIAL HISTORY:

INCORRECT:
LABORATORY TEST/PROCEDURES & RESULTS:

PAST FAMILY/SOCIAL HISTORY:

Heading followed by colon and 2 spaces with text immediately following on the same line as heading.

SOCIAL HISTORY: The patient denies history of alcohol use.

Single blank line space between headings

MEDICATIONS: None.

ALLERGIES: No known drug allergies.

If FOLLOWUP VISIT, NEW PATIENT VISIT, etc., are dictated, transcribe as the first line of the document.

Subheadings: Drop-down format

Note: This example is for Exam AND Review of Systems.

PHYSICAL EXAMINATION:
HEENT: Unremarkable.
SKIN: Warm and dry.
HEART: Normal

Do **NOT** abbreviate headings, i.e.,

INCORRECT: GI:
CORRECT: GASTROINTESTINAL

Do not type any text that the clinician dictates which repeats the meaning of the heading.

Example:
DICTATED: Past medical history. The patient's past medical history is significant for asthma.
TRANSCRIBED: PAST MEDICAL HISTORY: Significant for asthma.

EMPTY (UNUSED) SECTIONS/HEADINGS

Delete any section or heading for which the dictator does not dictate information.

VAGUE SECTION HEADINGS

If speaker dictates “HISTORY,” please do NOT expand to “HISTORY OF PRESENT ILLNESS” or PAST MEDICAL HISTORY”, PAST SURGICAL HISTORY.

Transcribe headings exactly as dictated.

HYPHENATION

Limit the amount of hyphenation inserted.
Always hyphenate a patient’s age in the following manner

Correct	This is a 42-year-old male…
Incorrect	This is a 42 year old male

Correct	The patient is a 2-1/2-month-old infant..
Incorrect	The patient is a 2 and 1/2 month old infant

Correct	The wound was reapproximated
Incorrect	The wound was re-approximated

Correct	A 5 cm lesion was debrided…
Incorrect	A 5 cm lesion was de-brided

Correct	He is taking non-steroidal anti-inflammatories…
Incorrect	He is taking nonsteroidal antiinflammatories

LETTERS

Difference between Letter (2) and General Consult Letter (4). The Letter (2) should be used only for correspondence which DOES NOT PERTAIN TO PATIENT CARE -- Thank You Letters, Letters of Referral, etc. The General Consult Letter (4) should be used when a provider is dictating his Progress Note (1) in the form of a letter rather than a Progress Note. This should also be used for Letters for Jury Duty, Return to Work, ANY TYPE OF LETTER RELATED TO THE PATIENT (if there is no other specialty letter template to use).

Also, for the Consultation reports dictated in letter format, THE ADDRESSEE PHYSICIAN WILL GO IN HEADER AS REFERRING PHYSICIAN.

For letters, you can use date of dictation as the date on top if no date is dictated, but account number should be matching with the date.

LETTER FORMATTING;

a. Date in extended format - December 3, 2010 (1 hard return after the date)
b. Addressee physician - Copy address of the addressee physician if not dictated and found in the list; if unsure, pend (1 hard return after addressee physician)
c. Patient information as:
RE: SMITH, JOHN (LAST NAME, FIRST NAME)
Ochsner Clinic No.: 1234
(1 hard return)
d. Dear Dr. _____, (1 hard return)
e. Body of the report (1 hard return)
f. Salutation (Type out Sincerely if salutation is not dictated).

1. All LETTERS to have date in expanded format, e.g. October 15, 2010, in the body of the report.
2. All HEADINGS in Letters are ALL CAPS.

Insert this as;
RE:____
Ochsner Clinic No: _____
(if patient data not found).

ALWAYS INSERT THE MRN FOR THE LETTER FORMAT – OCHSNER CLINIC#

Eg: 1. Ochsner Clinic No. 1234567 -- **If the letter is addressed to the patient**.

If letter is addressed to patient, the format remains the same except do not write "RE: LAST NAME, FIRST NAME" but just put "Ochsner Clinic No." as the addressee will be the patient himself.

2. RE: DOE, JOHN
Ochsner Clinic No. 1234567 -- **If the letter is addressed to a doctor, insurance co., to whom it may concern, etc.**

BRC/NSC ONLY: For Baton Rouge Clinic (BRC) and North Shore Clinic (NSC) only, when a sympathy letter is dictated, formatting should be as below:

Normal letter format:

RE: John Doe
Clinic #12345

Dear _____

Sympathy letter:

Dear _____ (Patient's relative) Leave off the RE and clinic #.

LISTS
For all lists

Do not enumerate lists of items unless dictator explicitly requests so.
Instead, enter the sequence into a comma-separated list, as you would when listing a series of words in a sentence.

Example:
PAST MEDICAL HISTORY: Diabetes mellitus, hypertension and hypercholesterolemia.

Listen for the following common phrases that a clinician uses to ask you to enumerate a list such as "Number two", "Number Next", "Next" or "Next item."

Enumerated lists will have the number, a period and 2 spaces. Do NOT use tabs.

PAST MEDICAL HISTORY:
1. Hypertension.
2. Diabetes mellitus.

NUMERICS
CIN 3 (not CIN III)

Decimals: Use decimal form in metric measurements when dicated as a fraction:
Example:
2.5 cm (not 2-1/2 cm)
0.25% Marcaine (not 1/4 percent of 1/4%)

Dimensions: Indicate dimensions by using the 'x' with spaces, as follows.
Example:
CORRECT: The lipoma was 2 x 3 cm in size.

INCORRECT: The lipoma was 2x3 cm in size.

Frequencies or number of times: Indicate frequencies or number of times by placing the 'x' abutted to the number with no space.

Example:
The patient was alert and oriented x3.

Laboratory data and values

Platelets: Transcribe platelets as dictated, i.e., 236 or 236,000. No need to expand if not dictated.

Trailing zeros: Please see JCAHO Abbreviation List. Trailing zeros in laboratory values are acceptable to transcribe if dictated.

Numeric Ranges: Identify numeric ranges by placing a hyphen between both numeric values

Example:
The patient will return for followup in 3-4 months.

Numeric Units: Separate the number from its unit with a space.

Example 5 mg

Numeric Words: Write out numeric words one through nine.

OB/GYN: When dictated as words, use commas to separate OB/GYN histories.

Example:
The patient is gravida 1, para 2.
When dictated as an abbreviation, leave a space.
Example:
The patient is G1 P2 with NO comma in between.

Quantities: Write all quantities above 9 as Arabic numerals with the following exceptions:
Never begin a sentence with a number. Add the appropriate preposition.
Example:
Dictated: 0.5% Marcaine was injected.
Transcribed: Then 0.5% Marcaine was injected.

Examples:
The patient has had two mammograms within the past 12 years.
But
Two small cysts were removed.
And
There was another one on the left side.
I observed hundreds of particles.

Roman Numerals vs. Arabic Numerals:

- Use Arabic numerals for "grades" of conditions and diseases
  Example "Grade II/VI systolic murmur"
- Use Roman numerals for "stages" of conditions and diseases
  Example "Stage II cancer"
- Use Roman numerals for cranial nerve numbering
  Example "CN II-XII"
- Use Arabic numerals for "types" of conditions or diseases
  Example "diabetes mellitus type 2"

Vertebral Spaces: Fill in the missing type and use "-". For example when the second S is not dictated: "S1-S2"

OTHER SPECIFIC INSTRUCTIONS

When "meds and allergies updated on OCW" is dictated, always transcribe as:

> **MEDICATIONS AND ALLERGIES: Updated on OCW.** (do not separate these headings unless dictated as separate).

Possible words utilized in dictation - **a Mardi Gras parade, with the Krewe du Vieux.** It is always **E and M (Evaluation and Management)** and not ENM.

This site might be helpful for some common words -
http://www.experienceneworleans.com/glossary.html

PATIENT NAME

It is acceptable to transcribe the patient's name in the body of the report if dictated as such. Do NOT change to "the patient."

If a sentence begins with "patient" always insert the article "the". Do NOT begin sentence with "Patient…"

NOTE: Any other identifying information, such as family names, phone#s or room# is completely fine to transcribe as dictated.

RADIOLOGIC WORK TYPE

Insert the heading in the body of the report. For eg: Ultrasound or X-ray or MRI, as applicable. If no heading is dictated, pend to client.

REFERRING PHYSICIAN

Applicable to Consultation work types only. Will feed in with the ADT. If missing, add the referring physician in the header and the body of the report as dictated. If not found in the database, add the referring physician in the header as a new contact and pend to client.

RESIDENT/FELLOW/PA DICTATING – New Orleans Clinic (NOC) Only

Physician	Change in Header	Body of Report	Pended to NOC
Resident	When the dictating physician is a RES, then you need to change the Speaker Name in the header to the SIGNING CLINICIAN name (in case autopopulated speaker name is RES). Verify correct BE is attached by verifying letters following physician ID (2533NOC or 4967BRH)	Need to put "Dictated By: ___(RES)" in the body of the report.	Pend to NOC as "NOC: Resident."
Fellow	No changes to be done in header	Need to put "Dictated By:____ (FEL)" in the body of the report.	No need to pend.
PA/PA-C	No changes to be done in header	Need to put "Dictated By:____(PA)" in the body of the report.	No need to pend.

REVIEW OF SYSTEMS/PHYSICAL EXAMINATION MACRO

Whenever inserting **ROS/PE macro**, make sure that while inserting the positives, the rest of the macro is not deleted. Insert the positives first and then retain the later part of the macro as applicable.

For eg: The macro to be inserted is:

CONSTITUTIONAL: Denies fever, headache, weakness, fatigue, weight loss or gain (> 5 pounds) and night sweats. HEENT: Denies hearing loss, sore throat, sneezing or post nasal drip. CV: Denies shortness of breath, chest pains or palpitations. RESPIRATORY: Denies cough, sputum production, wheezing or hemoptysis. GI: Denies nausea, vomiting, abdominal pain, indigestion/reflux, bowel habit changes, melena or hematochezia. GU: Denies dysuria, flank pain, hesitancy, frequency or nocturia. MUSCULOSKELETAL: Denies myalgias, back pain, joint pain, joint swelling or bone pain. SKIN: Denies itching or lesions. NEUROLOGIC: Denies tingling, numbness, confusion or memory problems. PSYCHIATRIC: Denies anxiety or nervousness. ENDOCRINE: Denies heat or cold intolerance. HEMATOLOGIC/IMMUNOLOGIC: Denies anemia or lymphadenopathy.

Doctor dictates, please insert negative ROS ID template with the exception of poor appetite, blurred vision, nasal congestion, diarrhea heartburn, rash, depression, thirst.

To be transcribed as:

REVIEW OF SYSTEMS:
CONSTITUTIONAL: **Poor appetite**. Denies fever, headache, weakness, fatigue, weight loss or gain (> 5 pounds), and night sweats. HEENT: **Blurred vision, nasal congestion.** Denies hearing loss, sore throat, sneezing or post nasal drip. CV: Denies shortness of breath, chest pains, or palpitations. RESPIRATORY: Denies cough, sputum production, wheezing, or hemoptysis. GI: **Diarrhea, heart burn**. Denies nausea, vomiting, abdominal pain, bowel habit changes, melena, or hematochezia. GU: Denies dysuria, flank pain, hesitancy, frequency, or nocturia. MUSCULOSKELETAL: Denies myalgias, back pain, joint pain, joint swelling, or bone pain. SKIN: **Rash**. Denies itching or lesions. NEUROLOGIC: Denies tingling, numbness, confusion, or memory problems. PSYCHIATRIC: **Depression**. Denies anxiety or nervousness. ENDOCRINE: **Thirst**. Denies heat or cold intolerance. HEMATOLOGIC/IMMUNOLOGIC: Denies anemia or lymphadenopathy.

SIGNING CLINICIAN

PAs dictate and are to dictate the name of his/her attending. Verify with what populates. If blank, and no attending/signing clinician is dictated, pend to client.

TELEPHONE NOTES

All telephone notes will not be without a visit grid. Enter the DOS and upload. Do not pend.

WORK TYPES

NOC Only: If Progress Note (1) and Consultation Note (3) are dictated in Letter format, USE THE LETTER FORMAT (BUT DO NOT CHANGE THE WORKTYPE. Upload as Progress Note or Consultation Note only. If the dictation starts as “Dear Dr. Smith,” use the letter format and place Dr. Smith as the addressee physician.

For Consultation reports dictated in letter format, THE ADDRESSEE PHYSICIAN WILL GO IN HEADER AS REFERRING PHYSICIAN. **This is only for the dictations dictated in Letter format.**

Dictated: "The patient comes in for consultation by Dr. Roger Smith." and the autopopulated Worktype is Progress Note, change Work type to Consultation and place "Dr. Roger Smith" as the Referring Physician in header. DO NOT CHANGE WORKTYPE, IF YOU ARE UNSURE and pend to NOC for verification of worktype.

If a procedure note/EEG note is dictated but the worktype autopopulated is Progress Note, DO NOT CHANGE THE WORKTYPE, just pend to NOC for worktype verification.

PENDING RULES and UPLOAD PROTOCOL
Non-DSP MT

NOTE: *Please do not include personal notes or opinions in pend notes. Keep all comments direct, professional, and to the point.*

Pend all notes to QC with note as follows:
Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

ADDENDUMS
Transcribe **Addendum** as first line of text. Pend to:
Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

BLANKS
Pend all notes to QC with note as follows:
Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

CARBON COPIES:
Add CC dictated by creating a new contact with all provided information. Pend to:
Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

CONTINUATIONS
Transcribe CONTINUATION at top of report and complete report as dictated. Pend to:
Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

INCOMPLETE DICTATIONS
If dictation is incomplete, transcribe "DICTATION ENDS HERE" as last line of text and pend to
Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

LETTERS
Pend all notes to QC with note as follows:
Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

MULTIPLE REPORTS ON 1 DICTATION
Transcribe/Speech Edit and Pend To:
Offshore -- NTS_IN: FOR REVIEW. Split dictation.
Onshore -- NTS_US: FOR REVIEW. Split dictation.

NO DICTATION
Transcribe NO DICTATION in top of report.
MT/QC: Pend **exactly** as below
NO DICTATION

RADIOLOGIC WORK TYPE MISSING NAME OF TEST

If no heading is dictated pend to QC with note as follows:

Offshore -- NTS_IN: FOR REVIEW Missing heading
Onshore -- NTS_US: FOR REVIEW Missing heading

RISK MANAGEMENT (Discrepancy in dictation)

1. MT to pend to NTS for discrepancies that cannot be resolved with complete confidence/competence.
2. Type comments that are pertinent to the dictation.
   Example:
   "This is a re-dictation."
3. Omit comments that are NOT pertinent to the dictation.
   Example:
   "This is the third time I have dictated this chart! I won't dictate it a fourth time!"
   If in doubt, pend to QA.

SIGNING CLINICIAN

If the speaker is someone who requires a signing clinician for their dictations then the signing clinician field in the header will be blank. The MT should fill this in based on who the speaker states they are dictating for. If the speaker does not dictate a signer or if the signer cannot be found then the MT/QC should pend the document as below:

Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

Please always follow MT instructions regarding surrogate speakers if one exists for the dictation you have open!

WRONG WORKTYPE

If job uploads with wrong work type, change to correct the worktype. Pend to:

Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

The information listed below in this document pertains to MTs/QCs who have been granted Direct Send Privilege status. If you are not yet DSP'd, please follow pending rules and upload protocol instructions that are outlined above.

PENDING RULES and UPLOAD PROTOCOL
ALL DSP MTs & QCs

NOTE: *Please do not include personal notes or opinions in pend notes. Keep all comments direct, professional, and to the point.* ***All jobs pended to client must have time stamps IN THE PEND NOTE (not in the report) for all blanks.***

Please add appropriate mnemonic to beginning of pend note when pending to facility. Select Ochsner (Ochsner (Non-transcription)) from the drop-down menu. Available in Business Entity field in header.

Mnemonic	Account Name
BRC	Baton Rouge Clinic
NOC	New Orleans Clinic
NSC	North Shore Clinic

ADDENDUMS
Transcribe **Addendum** as first line of text and pend to client as
<site mnemonic>: Addendum.

BLANKS
1 or less blanks may be uploaded directly to client without pending.

MTs: For more than 1 blank pend to QC
NTS_IN: Blanks
NTS_US: Blanks

DSP MTs/QCs: You may upload to client with 1 or less blanks. If more than 1 blank, pend to client as:
<site mnemonic>: Blanks remain with time stamps in the pend note.

Stats with blanks: After MT or QC review, change blanks to 4 underscores and upload directly. A stat dictation will be a priority 2. Please always check the priority of your dictation in your EditScript header.

CARBON COPIES
Add CC dictated by creating a new contact with all provided information. Then upload directly. Do NOT pend to client only for the reason of CC not found.

CONTINUATIONS
Transcribe CONTINUATION at top of report and complete report as dictated. Pend to:
<site mnemonic>: Continuation

DATE OF SERVICE
If no DOS is dictated, enter in date of dictation and pend to client. DOS will be in the header and mapped to Admit date.
<site mnemonic>: Verify DOS

HEADER CHECK
Pend notes to QC for any discrepancy or header checks as follows:
NTS_IN: Header check please.
NTS_US: Header check please

INCOMPLETE DICTATIONS
If dictation is incomplete, transcribe "DICTATION ENDS HERE" as last line of text and pend to client as

<site mnemonic>: Incomplete dictation.

LETTERS
Pend all letters to the client as follows:

<site mnemonic>: Letter

MULTIPLE REPORTS ON 1 DICTATION
Transcribe/Speech Edit and Pend To:

NTS_US: Split dictation.
. NTS_IN: Split dictation.

NO DICTATION or CANCELLATION REQUESTED BY SPEAKER

Transcribe NO DICTATION in top of report.
MT: Pend **exactly** as below
NTS_IN: NO DICTATION
NTS_US: NO DICTATION

QC: Change the work type to “Canceled” and upload. If longer than 3 seconds–Pend to client as:

<site mnemonic>: No dictation (Longer than 3 seconds)

RADIOLOGIC WORK TYPE MISSING NAME OF TEST
If no heading is dictated pend to QC with note as follows:

<site mnemonic>: Missing heading

RISK MANAGEMENT (Discrepancy in dictation)

1. MT to pend to NTS for discrepancies that cannot be resolved with complete confidence/competence.
2. Type comments that are pertinent to the dictation.
   Example:
   “This is a re-dictation.”
3. Omit comments that are NOT pertinent to the dictation.
   Example:
   “This is the third time I have dictated this chart! I won’t dictate it a fourth time!”
   If in doubt, pend to QA.

SIGNING CLINICIAN
If the speaker is someone who requires a signing clinician for their dictations then the signing clinician field in the header will be blank. The MT should fill this in based on who the speaker states they are dictating for. If the speaker does not dictate a signer or if the signer cannot be found then the MT/QC should pend the document as below.
Pend to client as such: **<site mnemonic>**: **No signing clinician dictated.**

WRONG WORKTYPE
If job uploads with wrong work type:

MT/QC: Change worktype and upload directly. Do not pend.