SCOTT & WHITE
ACCOUNT SPECIFICS

Platform: eScription
Institution/Site Code: sw

Software Versions: ESMT: Version 9.60.1
eMon: Version 9.10.0

Info/Resources: ES SAMPLE SITE:
https://scottandwhite.escriptionasp.com/Downloads/Labor-1.0.0/
Log in with your EditScript login ID/PW

Customer Links:

Version/Change Record

Version	Date	Responsible Person	Description of Version/Change
1.0		Implementation Team	waiting customer signoff
1.1	09/24/2012	Bethanne Tuel	Sites/Numerics/PCP
1.2	11/15/2012	Bethanne Tuel	Split Dict/Abbrev/EMRx Codes

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.

- Do not expand unless they are dictated in their expanded state.
- Do not abbreviate unless dictated as an abbreviation.

EXCEPTION: Expand all acronyms/abbreviations *related to the diagnosis* under **ANY** diagnosis, assessment, or impression heading, to include but not limited to, PREOPERATIVE DIAGNOSIS, POSTOPERATIVE DIAGNOSIS, DISCHARGE DIAGNOSIS, ADMISSION DIAGNOSIS, etc. Common lab and radiologic abbreviations do not need to be expanded.

> Example under DIAGNOSIS heading:
> Dictated: COPD. Awaiting results from CT lung, CBC.
> Transcribed: Chronic obstructive pulmonary disease. Awaiting results from CT lung, CBC.
> Example under IMPRESSION heading:
> Dictated: EKG evidence of MI
> Transcribed: EKG evidence of myocardial infarction.
>
> Example under PLAN heading:
> Dictated: Continue IV fluids
> Transcribed: Continue IV fluids.

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."

Carbon Copies: A CC is sent automatically only to the speaker.
If a copy is requested to a title but no specific name is identified, ignore the cc request. Ex: copy referring physician. Ignore this request. If Primary Care Physician or referring physician is dictated at the beginning of the report as a heading, create the heading and send them a carbon copy.

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

For all other Latin acronyms not listed above: When the speaker dictates “q.” separate "q." from the rest of the phrase with a single space unless it is a number.

Correct	Incorrect
q. noon	q.noon
q. day	q.day or q.d.
q.4 hours or q.4 h.	q. 4 hours or q. 4 h.

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 need to be shortened to q.4h.

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

Standard Acronyms

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

- S1
- L4-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': “L5 to S1”, “S1 to S2”

- Use the ampersand (&) as part of an acronym.

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

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"

ALLERGY STATEMENTS

Uppercase for positive allergy statements; lowercase otherwise.

Example:
ALLERGIES:
No known drug allergies.

ALLERGIES:
PENICILLIN CAUSES A RASH.

CAPITALIZATION OF DEPARTMENT NAMES

The below list of department names should always be capitalized. If not listed below, do not capitalize.

Department of Anesthesiology
Department of Emergency Medicine
Department of Family Medicine
Department of Medicine
Department of OB/GYN
Department of Pathology
Department of Pediatrics
Department of Radiology
Department of Surgery
Dermatology
General Surgery
Internal Medicine
Neurosurgery
Ophthalmology
Oral and Maxillofacial Surgery
Orthopedics
Otolaryngology
Pediatric Dentistry
Urology

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

CONFIDENTIAL STATEMENT

If the speaker states the report is confidential, please
As first line of text transcribe, CONFIDENTIAL
Do not add a colon after Confidential, make sure it is all caps.
Also, type a Y in the Confidential Field in the header (This field does not apply to Hillcrest jobs).

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."
Transcribe: The patient was murmuring, "I'm a diabetic."

DATES

Transcribe dates with month spelled out, concise day, concise year, as dictated.
If year is dictated as 2 digits, expand to 4 digits (dictated as '02, transcribe as 2002).

EMRx CODES

Transcriptions are to ensure that the EMRx field matches the specialty the dictator is dictating for. This could be different if it is any dictator that has an ID that starts with 71 through 77 as those dictators float.

FACILITY CODES

The following are the facility codes found in the visit line in Editscript. The code for the visit selected on each job must match the Business Entity in the header.

Scott and White Facility	**Code**
B/CS Arrington Road	
B/CS Arrington Road	AR
Bryan-College Station	CS
Hillcrest-HBMC	**HPS or HBMC**
Kileen Region	
Haker Heights Clinic	HH
Killeen Clinic	KL
Killeen Hemingway	KH
Killeen West Clinic	KW
Metroplex Cancer Center	RA
Metroplex Clinic	MX
Round Rock Region	
Cedar Park	CP
Cedar Park West	CW
Georgetown Central	GE
Georgetown PT	GP
Georgetown Sun City	SC
Hutto	HU
Lake Area Medical Center	LA
Leander Clinic	LE
Pflugerville	PF
Round Rock Clinic	MB
Round Rock Dialysis	RR
Round Rock Hospital	UH
Round Rock West	RW
Southwest Sports Center	**SP**
Taylor	TY
Temple Region	
Bellmead	BM
Belton	BT
Cameron Clinic	CA
Continuing Care	LT
Gatesville	GT
Hewitt	HW

Moody	MD
Northside	NS
Salado Clinic	SL
Sante Fe Family	FP
Sante Fe Skilled Nursing	TM
Sante Fe/Westfield Clinic	WF
Temple Clinic	TM
Temple Hospital/Children	TM
Waco	
Burnet Clinic	BU
Waco Clinic	WC
Waco Hillcrest Clinic	HM
Waco OB/GYN	WG

FORMATTING INSTRUCTIONS

AUTO-NUMBERING
No. Turn off auto-formatting feature.

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

SPECIAL FORMATTING
Do NOT use bold, underline 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.

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 corrected or, if in doubt, should be flagged and pended to client for verification.

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 with text beginning immediately underneath heading.

IMPORTANT: There should be NO spaces after the colon following a heading. It should be heading, colon, then hard return, then begin text.

SOCIAL HISTORY:
The patient denies history of alcohol use.

Double space between headings

MEDICATIONS:
None.

ALLERGIES:
No known drug allergies.

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,” expand to “HISTORY OF PRESENT ILLNESS” or PAST MEDICAL HISTORY”, PAST SURGICAL HISTORY as appropriate.

HEADER AND FOOTER INFORMATION

Do not repeat information in text that already appears in the header such as Date of Birth, Speaker name.
EXCEPTION: Any time an ATTENDING is dictated, this information is to be typed in the body of the document as well as added to the signing clinician field in the header.

LETTERS/CORRESPONDENCE

Type body of letter only. Do not type the date, addressee, dear line, sincerely or signature line. Only type the body of the letter. The system adds all the other information when printing. Procedure Date in header of should be entered as the date of dictation.

LISTS

For any lists

Do not enumerate lists of items unless dictator explicitly requests so.
(see exception to any DOCTOR LIST (more than 1 name listed), PROCEDURES, MEDICATIONS and DISCHARGE DIAGNOSES below)
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.

Exception:
Any doctor name lists, Procedures and Medications will always be listed if more than one.

ATTENDINGS:
1. John Jones, MD
2. Sally Miller, MD
3. Mark Johnson, MD

OTHER PHYSICIANS:
1. Rebekkah Wilson, MD
2. Kelly Givens, MD
3. James Qualls, MD
4. _____ Schumann

PROCEDURES:
1. Lobotomy
2. Brain transplant
3. Hair plugs

MEDICATIONS:

1. Xanax
2. Amoxicillin
3. Lanoxin

DIAGNOSES LISTS: For diagnosis headings, keep the diagnosis on a line by itself, begin extra verbiage directly underneath. See example below.

DISCHARGE DIAGNOSIS:
1. Possible transient ischemic attack
The patient states that his symptoms resolved shortly after admission to the hospital and on the following morning, he was asymptomatic. The diplopia had resolved as did the paralysis of his left medial rectus muscle. On admission, he has been started on 325 mg of aspirin.
2. Alcohol abuse
The patient has been counseled by Dr. Patel on admission. I have discussed this with him again as well as our social work department who will provide the patient with outpatient alcohol counseling resources.
3. Tobacco abuse
Smoking cessation counseling has been provided.

NUMERICS

Quantities: Write all quantities as Arabic numerals with the following exceptions:
Examples:
The patient has had 2 mammograms within the past 3 years.
But
Two small cysts were removed.
And
There was another one on the left side.
I observed hundreds of particles.

Numeric Units: Separate the number from its unit with a space.
Example 5 mg

Numeric Ranges: Identify numeric ranges by placing a hyphen between both numeric values
Example:
The patient will return for followup in 3-4 months.

Frequencies or number of times: Indicate frequencies or number of times by placing the 'x' abutted to the number with no space between.
Example:
The patient was alert and oriented x3.

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.

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.

Ribs: Do not spell out ribs, utilize ordinals such as 3rd, 7th, etc.

Roman Numerals vs. Arabic Numerals:

- Use Roman 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”

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.

PATIENT NAME

It is acceptable to transcribe the patient's name in body of report if dictated as such by speaker. 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.

PRIMARY CARE PHYSICIAN/REFERRING PHYSICIAN

When primary care physician or referring physician is dictated at the beginning of the note in heading format, add the major heading to the body of the note AND send a carbon copy to the physician. If the dictator informally mentions a PCP or referring physician within the body of the note, no major heading or copy will be needed unless requested. If the PCP is the dictator, do not send a copy, but do add a heading if dictated. There may also be times when a dictator will say, “Do not send a copy.” This is when physician instructions override account specifics, and a copy should not be sent.

VISIT SELECTION

We verify speaker entered visits on Scott and White by verifying the patient name, date of service (start date on visit line) and verifying that the facility code (in visit line) matches the Business Entity in the header. (Facility codes are listed under FACILITY CODE in this document).
1. First verify the patient name. If the visit checked by the speaker has the correct facility and start date, no need to search for other matching visits. If the visit is a match, leave the visit selected.
2. If you need to search for patient due to unknown or incorrect patient, AND if there are *multiple matching visits* (patient, date and facility match):
-if one has the speaker/signer name in the attending field and one has a number in the attending field, select the one with the speaker/signer name.
3. When any job (inpatient or outpatient) does not have a Date of Service dictated:
-if the visit entered by the speaker is the correct patient and facility, verify that the start date matches the *date of dictation*. If it matches, you may assume the DOS is the date of dictation. Put that date in the Procedure Date field in the header. Do not pend these jobs for DOS not dictated.

WORK TYPES

WORKTYPE
Admit/Inpatient H&P (6)
Cancer Center Note (20)
Cardiac Procedure (22)
Catheterization Report (21)
Consultation Note (8)
Correspondence/Memo (5)
Discharge Summary (3)
Echocardiogram (61)
ED Note (4)
Electroencephalogram (80)
GI Endoscopy Procedure (79)
Holter Monitor (23)
Inpatient Progress Note (12)
Nerve Conduction Velocity Study (81)
Operative Report (2)
Outpatient Clinic Note (1)
Preoperative H&P (13)
Procedure Note (7)
Pulmonary Function Test (70)
PVR (24)
Sleep Study (90)
Treadmill Test (71)
Work Related Injury Document (9)
XX - Memo (10)

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.
Also, transcribe a Y in the Addendum field in the header (This field does not apply to Hillcrest jobs)

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

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

NO DICTATION
MT/QC: Pend **exactly** as below. **Ownership is NTS**.
NO DICTATION

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 signing clinician field is blank, this person requires a signing clinician. 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

Note: There will be times the speaker's name populates in the signing field, yet they state they are dictating for someone else. In these cases, replace the signing clinician field with the name they state.

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

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.

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.*

ADDENDUMS
Transcribe **Addendum** as first line of text
Also, transcribe a Y in the Addendum field in the header (This field does not apply to Hillcrest jobs)
Pend as SW: ADDENDUM

BLANKS
MTs: NO blanks may be uploaded directly to client. For ANY blanks, pend to QC.
QCs: You may upload up to 2 blanks. If more than 2 blanks, pend SW: Blanks remain.

Stats with blanks: After 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.

HEADER CHECK
Pend notes to QC for any discrepancy or header checks as follows. Include what is in question, ex: Visit not found or Patient not found.
Offshore: NTS_IN: Header check please.
Onshore: 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
SW*:* Incomplete dictation.

MULTIPLE REPORTS ON 1 DICTATION
Offshore: NTS_IN: Split dictation.
Onshore: NTS_US: Split dictation

NO DICTATION
MT/QC: Pend **exactly** as below. **Ownership is NTS.**
NO DICTATION

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 signing clinician field is blank, this person requires a signing clinician. 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: **SW: No signing clinician dictated.**

Note: There will be times the speaker's name populates in the signing field, yet they state they are dictating for someone else. In these cases, replace the signing clinician field with the name they state.

STAT DICTATIONS

A stat dictation will be a priority 2. Please always check the priority of your dictation in your EditScript header.
Priority 2 jobs that need to be pend to SW must have SW: STAT at the beginning of the pend note. Ex: SW: STAT HEADER CHECK
Stats with blanks: After QC review, change blanks to 4 underscores and upload directly.

WRONG WORKTYPE

If job uploads with wrong work type:

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