UMass
ACCOUNT SPECIFICS

Platform:	eScription
Institution/Site Code:	umass
Software Versions:	ESMT: Version 11 eMon: Version 11
Customer Links:	http://www.umassmemorial.org/

Version/Change Record

Version Date	Responsible Person	Description of Version/Change
1.0	Implementation Team	Customer Approved Final Version w/GoLive. Enter Name of Customer approving, date and time.

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. Exception: always type out subcutaneous or subcutaneously.

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.

STANDARD ACRONYMS:

Write acronyms, which are combinations of letters and numbers, in the usual manner.
Eg: S1, L4-L5, CA-125 etc

Transcribe vertebral spaces literally, using hyphens: “L5-S1,” “S1-S2”

Use the following associated abbreviations for common units and name suffixes and salutation when there is no ambiguity and the shorter form is easier to type and read than the spelled-out form. Eg: mg, mL, mcg, mmHg, cm, kg etc.

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."

PLEURAL ACRONYMS:

Form plurals of acronyms by adding an (s). Do not use apostrophe.

Example:
WBCs = white blood counts
DTRs = deep tendon reflexes
PVCs = premature ventricular contractions
If forming plurals for lowercase acronyms, add ‘s as follows:
wbc’s = white blood cells (as in UA showed 3 wbc’s).

Latin-Based abbreviations: ALWAYS place periods between each letter in Latin-based abbreviations phrases for the frequencies of medications. **Eg**: n.p.o., p.o., p.r.n., q.p.m., etc.

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)

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 “subcutaneous” or "subcutaneously"
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"

ADDENDUMS

Upload directly. Do NOT pend for addendums.

ALLERGY STATEMENTS

Nothing specific. Type as dictated. Not to be capped or bolded.

BLANKS

5 _____ (Underscores)

MT: 2 blanks allowed to be uploaded to client unless required to pend all blanks. NTS_IN: or NTS_US: xxxxx BLANKS. (xxxxx=login ID)

QC: NonSTAT. If 3 or more blanks after review**,** PEND TO UMASS: BLANKS
QC: STAT 4 underscores and upload with any number of blanks. If more than 4 blanks, upload and email TSM/Manager.

CAPITALIZATION OF DEPARTMENT NAMES

Department names are in general not capitalized, unless they are proper nouns and followed by the name of the speciality or hospital, except for "Emergency Department." However, it is now acceptable to leave them either way, capitalized or not, as presented on the draft.

Eg: St Josephs Regional Medical Center
St Vincents Nursing Home

CARBON COPIES

NTS:
NEVER CREATE A CC ON UMASS!
Use Alt+C to locate the cc physician or addressee of letter.

If not found in list, select "Copy, Physician" from Alt+C list AND ALSO type it out manually at the bottom of the report as, CC: "The name of the physician" as best as you can decipher it.

Letters: ALWAYS cc the addressee of the letter. If the addressee is not found in the Alt+C, please select Physician Copy and type the information at the bottom of the letter. If letter is to patient, cc Patient Copy and type the patient name at the bottom of the letter after cc:. If the letter is to a Facility, To Whom It May Concern or no addressee is specified but it is clearly a letter, select Physician Copy from Alt+C.
Use Alt+C to locate the cc physician or addressee of letter. If found, select and you are done. If not found in list, select "Copy, Physician" from Alt+C list AND ALSO type it out manually at the bottom of the report as, CC: "The name of the physician" as best as you can decipher it.

Do not select a cc unless you are certain it is the correct cc. If there are two with the same name and you are not certain which is correct, select Copy, Physician and type the cc info at the bottom of the report.

If the speaker asks to send a cc to the patient, "Copy, Patient" and type the cc info at the bottom. If speaker requests a cc to himself, add it.

Referring physicians mentioned by name need to be sent a copy **always**, even if not requested by the speaker. Do not cc PCP unless requested by the speaker. Do not cc Requesting Physician unless requested by the speaker. Type Requesting Physician name in the body of the report, as dictated.

LDMTS:
COURTESY COPY - Do not use Alt-C to add a copy to the header. Add CC request at the bottom of the document.
Do not CC the addressee.

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

CONTRACTIONS

Do NOT use contractions 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
Format for all dates in **body of report** can be in either format: month spelled out with forced 4-digit year (January 02, 2006 or January 2, 2006), or with mm/dd/yyyy (09/23/2013 or 9/23/2013).

All dates at **top of letters** should be spelled out (July 7, 2013), and all dates after headings should be numerical, 07/07/2013, i.e. such as DATE OF BIRTH:, DISCHARGE DATE:, etc.

Do not type the date of service in the body of the report except on Discharge Summaries, where date of admission and date of discharge are typed, as dictated.

EMPTY (UNUSED) SECTIONS/HEADINGS
Delete any section or heading for which the dictator does not dictate information.

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."

FONT Times New Roman 11

FORMATTING

INSTRUCTIONS

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

FORBIDDEN CHARACTERS:

|	**pipe**
^	**caret**
&	**ampersand**
****	**backslash**
~	**tilde**

SPECIAL FORMATTING
Do NOT use RTF formatting. No bold, underline or italics.

TABS: Do not use TABS.

Wrong formatting:

DIAGNOSIS:
1. 314.01, attention Deficit Hyperactivity Disorder.
2. 312.34, intermittent explosive disorder.
3. 300.00, anxiety disorder, NOS.
4. 317, mild mental retardation.

Correct formatting:

DIAGNOSES:
1. 314.01, Attention Deficit Hyperactivity Disorder.
2. 312.34, Intermittent Explosive Disorder.
3. 300.00, Anxiety Disorder, NOS.
4. 317, Mild Mental Retardation.

Please note that the **first letter of all words are capped**.

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.)

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. Do not change free text into separate sections.

Example:
Correct
PROCEDURE: The patient was placed in supine position. With the patient under satisfactory general anesthesia, an incision was made...

Incorrect
ANESTHESIA: General
PROCEDURE: The patient was placed in a supine position. An incision was made.

HEADINGS

If Headings in a draft are appropriate for that section, no need to edit for verbatim, i.e. "Past Medical History" or "History of Present Illness," can be left "Past History" or "History" as per draft, or vice versa.

Avoid using in-paragraph sub-headings. Use paragraphed narrative style, or list capped subheadings at left margin.

Example:
PHYSICAL EXAMINATION:
HEENT: PERRLA. EOMI...
NECK: Supple. Full range of motion...
(No in-paragraph capped subheadings).

Do NOT use **ANY** symbol in any headings**, i.e. "/" or "&**"

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, with double space between headings
SOCIAL HISTORY: The patient denies history of alcohol use.
MEDICATIONS: None.
ALLERGIES: No known drug allergies.

Subheadings: Drop-down format
PHYSICAL EXAMINATION:
HEENT: Unremarkable.
SKIN: Warm and dry.
HEART: Normal

Subheading style:
No in-paragraph capitalized subheadings. Use paragraphed narrative style, or list capped subheadings at left margin.

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.

GENUS AND SPECIES NAMES

Genus: Capitalize genus names and their abbreviated forms, but do not capitalize their plural or adjectival forms.
Example:
Staphylococcus
staphylococci
staphylococcal

Species: Usually preceded by genus name. Use lower case for species names. **Example:** Escherichia coli Staphylococcus aureus

Abbreviations with genus-species: The genus name may be abbreviated as a single letter followed by a period. A longer abbreviation with a period may be used to avoid confusion. Do not abbreviate the species name even if the genus name is abbreviated.
Example: S. aureus or Staph aureus H. influenzae (not H. flu)
If dictated “staph” or “strep” followed by species, it is correct to spell out genus and species.

D: staph aureus
T: Staphylococcus aureus

D: strep pneumonia
T: Streptococcus pneumoniae

HEADER INFORMATION

1. Enter MRN as dictated. Do not add any dictated leading zeros. If MRN is not dictated, leave blank. Wing speakers may dictate letters after the MRN, type those in the MRN field along with numbers, as dictated. If the MRN is already populated in MRN field and not dictated, no need to pend, leave it alone and send on through.

2. Enter a signing clinician only if the speaker is not a valid signer. Please check if the speaker is a valid signer by verifying if his/her name is available in the "Signing Clinician" drop down. If the speaker's name is available in the dropdown, please do not add another physician as signer. If a different physician is being mentioned as attending/signing, please add the same in the body of the text and pend to UMass for verification.

3. Enter dictated Date of Service in Service Date field in header (on Discharge Summaries, DOS=dictated date of discharge). If no date of service is dictated, enter date of dictation. **Inpatient Consults, Operative Reports** and **Special Procedures,** if speaker does not dictate the date of service, PEND TO UMASS: No DOS.

4. If PCP name is dictated, verify PCP field in header and correct, if necessary. If no PCP name is dictated, leave alone.

5. If patient name is unknown, when report is complete, PEND TO UMASS: Verify patient.

6. If account number *is unknown*, pend PEND TO UMASS: Verify account number.

7. If account number *is populated*, we do not touch it and do not pend even if it is wrong. Facility reports Account numbers may have a T prefixed to them. Please do not make any changes to the account number. DO NOT touch patient visit. We never change a patient visitor search for a patient.

8. Verify worktype. If incorrect or in question, PEND TO UMASS: Verify worktype.

NTS INCOMPLETE/ABRUPT END/NO DICTATIONS

Pend as
PEND TO UMASS: INCOMPLETE
PEND TO UMASS: ABRUPT END
PEND TO UMASS: NO DICTATION

Whenever in UMASS reports a speaker dictates an incomplete dictation and ends the dictation by saying, "Report to follow," "leave this dictation blank," or "I will dictate this later," please treat these dictations as complete dictations and upload these jobs directly. Please type at the end of the report the line dictated, i.e. "Report to Follow," "Leave dictation blank," and then please upload these dictations and **do NOT pend** as incomplete dictation.

Exception - Clinton Business entity is pend as
PEND TO CLINTON: INCOMPLETE
PEND TO CLINTON: ABRUPT END
PEND TO CLINTON: NO
DICTATION

LABORATORY DATA AND VALUES

When multiple lab results are given, separate related tests by commas. Use semicolons if entries in the series have internal commas.

Example:
Hemoglobin 13.1, hematocrit 42.3, platelet count 236,000; white count 6.1. Urinalysis reveals specific gravity of 1.011, 10 wbc's, 10 rbc's, moderate glucose, negative ketones, and no crystals.

Note: wbc's and rbc's are lower case when they stand for white blood cells/red blood

cells. WBC and RBC stand for white blood count and red blood count, and are capped – Per AAMT

***Note: platelet count will always be expressed in thousands even if not dictated as such.* D: The platelet count was 236.**
T: The platelet count was 236,000.
pH – Do not express other than with a lowercase ‘p’ and a capital ‘H.’ If the term begins a sentence, precede it by “The.”

LISTS

Medications are listed and numbered

Do not enumerate ANY OTHER 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.

Do NOT list only 1 item.
Separate lists of items in a sentence by placing a comma between each items, but not before the conjunction prior to the last item in the list.

Example: He is taking Prilosec, Tylenol and Zyrtec.

MEASUREMENTS

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.

MULTIPLE DICTATIONS IN ONE VOICE FILE

Transcribe all the reports in the single file. Type the patient details at the beginning of each report. NTS_IN: MULTIPLE REPORTS or NTS_US: xxxxx MULTIPLE REPORTS (xxxxxis MLS user ID)

NUMERICS

Quantities: Write all numeric quantities as Arabic numerals (0-9). Apply this rule equally to both large and small numbers; however, there are two exceptions:

- Numbers that commence a sentence:

“Two small cysts were removed from the patient’s sigmoid colon ....” - Numeric words in non-numeric contexts:
“There was another one on the left side.”

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 and do not space around the hyphen.
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.
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.

Roman Numerals vs. Arabic Numerals:
Use Arabic numerals for “grades” of conditions and diseases
Example "grade 2/6 systolic murmur” "grade 2 kidney disease"
Exception - orthopedics (“grade II condylar fracture")

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”

PATIENT NAME

If the clinician dictates the patient’s actual name, type it as dictated. If patient's information comes in as "unknown patient" and the MLS cannot verify spelling and/or speaker does not spell it, **"the patient"** can be used instead of blanking, misspelling or pending for the patient's name.

We do not encourage using the patient name in the text if the same is not verifiable with ADT. This is to avoid any kind of spelling mistakes.

PEND NOTES TO CLIENT

If pending to UMass, start pend note with PEND TO UMASS: The exception is if the business entity is Clinton, then use PEND TO CLINTON:

SIGNING CLINICIAN

Do not select the attending physician from the ADT and insert in signing clinician field if not dictated. Insert attending physician only if dictated by the speaker.

If the dictator states **"supervising physician is Dr. xxx," "I saw this patient with Dr. xxx**", "**Patient was seen/discussed with Dr. xxx"**, "**Dr. xxx was present for the entire visit,**
procedure", "Preceptor is Dr. xxx," **"Dr. xxx was not present for exam, but case was reviewed with**," then that phrase should be typed in the document as dictated, **AND** identifies the attending physician, so that attending physician's name should be added as the signing clinician.

In **Operative Reports,** if the speaker does not have signing privileges, the person dictated as the surgeon will be the signing clinician, and that name will be added to the signing clinician field as well as typed in the document, as dictated. If the speaker names an attending other than the surgeon, that attending's name is to be entered as the signing clinician in the header.

If the speaker is dictating **Primary Care Physician or Referring Physician, this name is to be entered as the first line of the report in the text,** and NOT in the signing clinician field in the header.

Only enter signer if dictated. Client will handle if job autopends for no signer.

PA and NP with signing rights can sign their own outpatient reports, but need a signer on inpatient reports. If there is a double entry in the database for any speaker, pend to UMass for their selection, as appropriate.

SPECIAL SPEAKER INSTRUCTIONS

We have several speakers that require a pend for review (NTS_IN: or NTS_US: REQUIRED REVIEW). Always refer to the MTI. The list currently includes **Charles Cavagnaro**, **Stephen Erban, Gary Fudem, Richard Irwin, Richard Pieters and David Wexler.**

Dr Richard Pieters in UMASS has requested us to format Spine under Physical Examination in a special way. He wants it as:

SPINE: Spine, costovertebral angles and sacroiliac joints are nontender to percussion.

Please remember he does not dictate Spine twice. He just says Spine, Costovertebral angles...etc.

Dr. Michael Hirsh of Pediatrics Surgery, there is a template, which needs to Inserted, "Dr. Hirsh H&P template."

Dr. Jonathan Kay of Rheumatology has a template which always needs to be inserted first, and followed to the letter and punctuation, "Dr. Kay Consultation template."

NOTE: Two "Dr. Alan/Allen Brown(e)." Dr Alan Brown, who is a psych provider, has been mixed up with Dr. Allen F. Browne who is a pediatric surgeon.
Dr Alan Brown always dictates Psych reports and hence please do not get confused with **Dr Allen F Browne** who is a pediatric surgeon. If in doubt, please pend such reports.

WORK TYPES

Do NOT make any changes to work types. Even if dictated different, do not make any changes. Please pend all reports where there is worktype discrepancy, i.e. dictated is different from what has come downloaded.

PEND TO UMASS: Verify worktype.

Please enter the Date of Admission and Date of Discharge in the body of the report for Discharge Summary reports**,** if dictated.

Letters: ALWAYS cc the addressee of the letter in Alt+C. If addressee is not found in the Alt+C, select "Physician Copy" in Alt+C and type the cc info at the bottom of the letter.

If the speaker starts a report stating Dear doctor so and so but the worktype is not a letter, transcribe in letter format and PEND TO UMASS: Verify worktype.

Exception: Do not pend speakers Lisa or John Shufflebarger, MDs. Leave worktype as it comes in and upload.

Exception: Dr. Syed Kamil’s clinic note or OP reports should not be transcribed as letters, ignore the "Dear Dr. x."

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:

NTS_IN: FOR REVIEW or NTS_US: xxxxx FOR REVIEW (xxxxx is MLS user ID)

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
Upload directly. Do NOT pend for addendums.

BLANKS
(5 underscores).
MT: 2 blanks allowed to be uploaded to client unless required to pend all blanks. NTS_IN: or NTS_US: xxxx BLANKS. (xxxx=login ID)
QC: NonSTAT. If 3 or more blanks after review**,** PEND TO UMASS: BLANKS
QC: STAT 4 underscores and upload with any number of blanks. If more than 4 blanks,

upload and email TSM/Manager.

NTS ONLY CARBON COPIES:
Copies to physicians can be entered in the CC column in the footer by pressing Alt+C, and selecting the proper physician name. If the CC is **not documented in the list**, select "**copy, physician**" from the drop down list of the name of the physicians using Alt+C, **AND ALSO** type it out manually at the **bottom of the report as, CC: "The name of the physician"** as best as you can decipher it.
We need to be very careful here, especially in case of multiple entries for same last name. Unless the first name is dictated clearly, please do not guess and select any name. Use the Copy physician option in such cases.

For letters, ALWAYS cc the addressee of the letter. If the addressee is not found in the Alt+C, please select Physician Copy and type the information at the bottom of the letter. If letter is to patient, cc Patient Copy and type the patient name at the bottom of the letter after cc:. If the letter is to a Facility, To Whom It May Concern or no addressee is specified but it is clearly a letter, select Physician Copy from Alt+C.

NTS ONLY INCOMPLETE/ABRUPT END/NO DICTATIONS

Incomplete dictations/abrupt ending dictations/No dictations can be pended to UMASS directly by MT. Examples:
PEND TO UMASS: Incomplete.
PEND TO UMASS: Abrupt end.
PEND TO UMASS: No Dictation.

Exception, any Clinton business entity job is pend
PEND TO CLINTON: Incomplete
PEND TO CLINTON: Abrupt end
PEND TO CLINTON: No Dictation

Whenever in UMASS reports a speaker dictates an incomplete dictation and ends the dictation by saying "Report to follow" please treat these dictations as complete dictations and upload these jobs. Please type at the end of the report: Report to Follow. Please upload these dictations and do NOT pend as incomplete dictation.

MULTIPLE REPORTS

Transcribe all the reports in the single file. Type the patient details at the beginning of each report. NTS_IN: MULTIPLE REPORTS or NTS_US: xxxxx MULTIPLE REPORTS (xxxxxis MLS user ID)

APPENDIX A

Letter Formatting

December 11, 2010

Phillip O. Fournier, M.D.
UMass Memorial Primary Care
55 Lake
Avenue North
Worcester, MA
01655

RE: XXXXX, Ann
UMMMC#: 000000
DATE OF SERVICE: 12/11/2010
DATE OF BIRTH:

Or:

RE: XXXXX, Ann
MRN:
DOS:
DOB:

Dear Phil:

It was my pleasure to _____

Sincerely yours, (As dictated) *(four returns)*
(Leave three line spaces but do not insert any signature line)

An enclosure line, if dictated, is to be added below the CC line if there is one added in the text, or add the enclosure line with one blank line after the last line of the text, if a copy is not added to the text.

Explanation:
If the speaker starts a report stating Dear doctor so and so but the worktype is not a letter, transcribe in letter format and PEND TO UMASS: Verify worktype.

Exception: Do not pend speakers Lisa or John Shufflebarger, MDs. Leave worktype as it comes in and upload.

Exception: Dr. Syed Kamil's clinic note or OP reports should not be transcribed as letters, ignore Dear Dr.

The date dictated should always be at the top of the letter.

Type the date of dictation in the format specified above (Spelled out) at the top of the letter. Never add a period after the date.

Eg: January 30, 2008

There has to be one space after the comma and before the year.

2. Please leave 3 line spaces after the date. This means that right after the date, please enter 4 hard returns.

3. Write the name of the addressee after the 3 line spaces in the format as above.

4. **Please remember to insert the comma before the credentials of the doctor. Between the comma and the credentials there is one space (eg.** Phillip O. Fournier, MD)**.**

If you miss this comma, the system rejects the report and never enters the Meditech for the doctor to sign. Hence it is very important to have the comma there.

If the letter is addressed to more than one physician, please enter only the first addressee in the body of the report and for all other physicians, send a copy. Do NOT enter their name and address in the body of the report even if dictated. If there are two entries/addresses for the same physician in the database, pend to UMass for selection.

5. After the name and address of the addressee physician, there has to be ONE line space (two hard returns) before the next section.

Please follow this section formatting very closely. The last name of the patient will be ALL CAPS and then the comma, one space, and then the first name. UMMMC# is for the UMass Medical record number. If not dictated, insert the section and put a blank line after. Eg:

UMMMC#:
RE: XXXX, Ann
UMMMC#: This is the medical record number (MRN) DATE OF SERVICE:
DATE OF BIRTH:

Two spaces after the colon in UMMMC#, Date of service, and Date of birth.

6. After this section, again one line space (two hard returns) and then the salutation:

Dear Dr ....

7. After the salutation, again one line space (two hard returns) and then the text (body of the report).

8. After the body of the report, again one line space (two hard enters) and complimentary closure: Sincerely yours, OR Best Regards, as dictated.

9. In case of letters to the patient or to insurance company's, lawyers, etc the date of dictation, RE: Patient name and UMMMC#: should always be entered. We put a space between the date and patient name so the MD knows that the addressee information needs to be added if nothing was dictated. If the address of the patient or other type of addressee is dictated, this information should be entered above the patients name as would be done in a letter to a provider.

SAMPLE LETTER TO PROVIDER:

January 11, 2005 ***(The comma is very important here, NO period after date)***

Kim Houde, M.D. ***(Comma before credentials is very important)Add addressee into Alt c also.***
Shrewsbury Family Medicine ***(Check Alt Ifor address if address not dictated)***
604 Main Street

RE: WOO, Robert
UMMMC#: 783114 ***(Pls enter MRN here)***
DATE OF SERVICE: 10/11/2005
DATE OF BIRTH: mm/dd/yyyy ***(if dictated, otherwise delete this field)***

Or:

RE: WOO, Robert
MRN#: 783114 ***(Pls enter MRN here)***
DOS: 10/11/2005
DOB: mm/dd/yyyy ***(if dictated, otherwise delete this field)***

Shrewsbury, MA 01545

Dear Dr. Houde:

I had the pleasure of seeing your patient, Mr. Robert Woo, in the Neurology Clinic on January 12, 2005 for concerns about upper extremity tremors.

COORDINATION: He has a negative Romberg. He has intact finger-to-nose, heel-to-shin and rapid alternating movements bilaterally.

SENSATION: He has intact temperature, vibration, joint position sense, pinprick, and light touch x4.

CARDIOVASCULAR: He has a regular rate and rhythm. Normal S1, S2. No murmurs, rubs or gallops.

ASSESSMENT AND PLAN: Mr. Woo is a 54-year-old gentleman, generally healthy. He comes in with complaints of upper extremity tremors. These have been present for at least 30 years and relatively nonprogressive. The patient comes in with concerns regarding possible Parkinson's disease as it runs in his family. However, the patient doesn't have any other symptoms of Parkinson's including gait abnormalities, voice changes, bradyphrenia or cognitive difficulties. On the other hand, the patient does have a family history of tremors in his brother and his niece and their relatively long, stable course would suggest that the patient instead has benign essential tremor. I discussed the diagnosis with the patient and made him aware that in the future his tremors may become more pronounced. Currently, he does not wish to have any medications for this. However, we discussed possible treatment in the future with primidone or propranolol if his tremors worsened. We are also going to check his TSH today to make sure his that his tremors are not due to hyperthyroidism.

The patient is to followup on an as needed basis.

Thank you very much for this interesting and pleasant consult. This patient was precepted by Dr. William Schwartz. Please feel free to contact me with any questions or concerns. The number is 508-856-2527.

Sincerely, *(four returns)*

(Leave three line spaces but do not insert any signature line)

SAMPLE TOP OF LETTER TO PATIENT:

June 6, 2013 ***(four returns)***

John Jones

RE: JONES, John
UMMMC#: 1537589 ***(four returns)***

In reviewing the records of John Jones.....

SAMPLE TOP OF LETTER FOR TO WHOM IT MAY CONCERN:

June 14, 2013 ***(four returns)***

RE: LAST, First
UMMMC#: 1568596
DATE OF SERVICE: 06/12/2013
DATE OF BIRTH: (remove heading if not dictated)

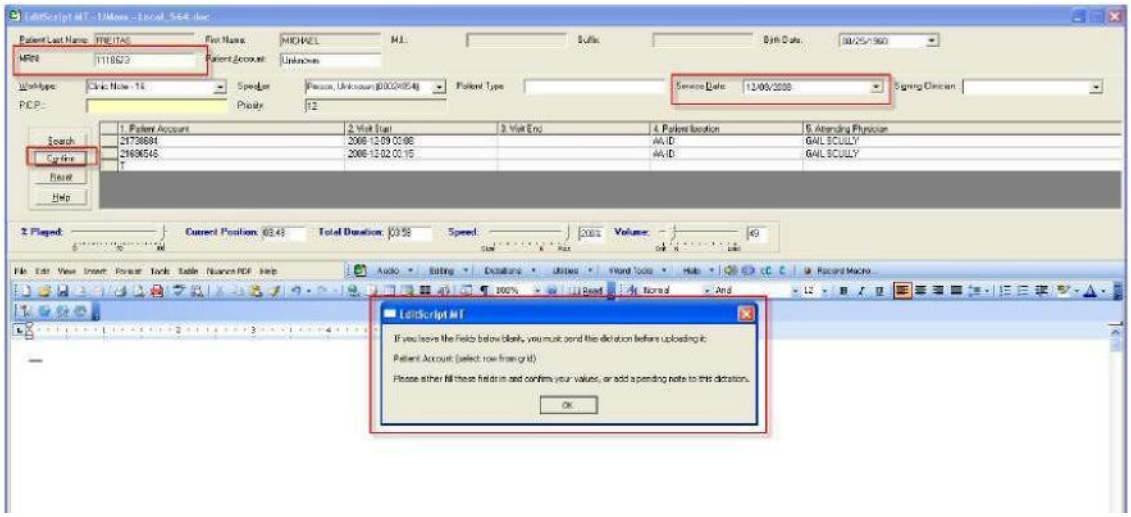
To Whom It May Concern ***(two returns)***

I had the opportunity to see .....

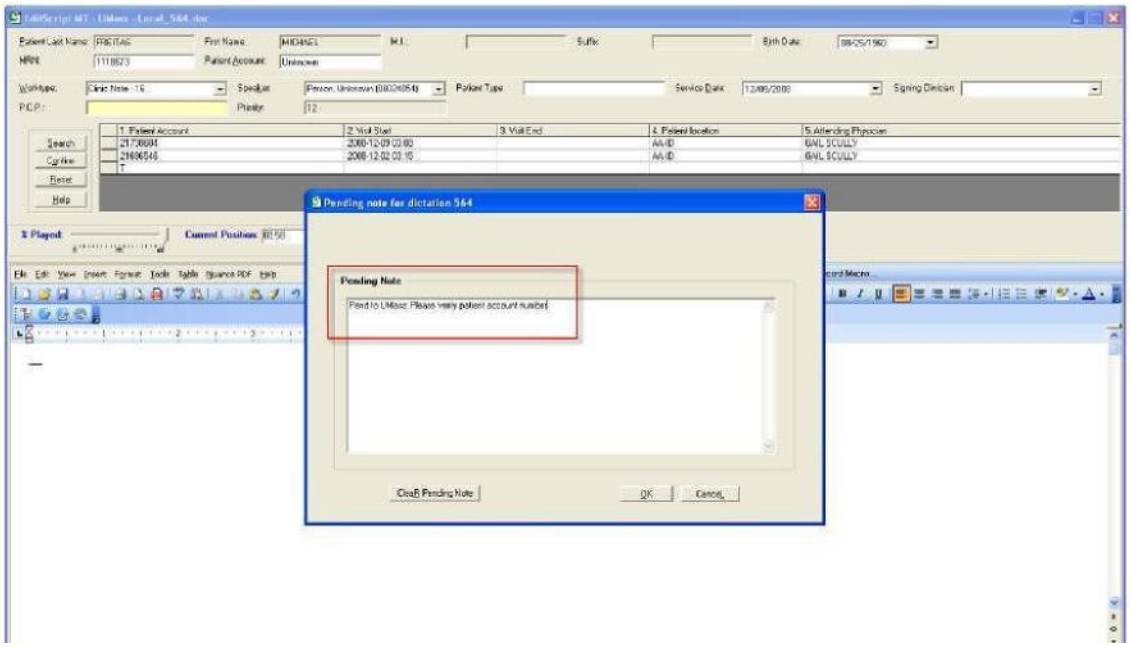
APPENDIX B – Uploading a job without an account number/visit selected

MT downloads the job into ESMT and notes that the account number is Unknown. Hypothetically speaking, let's assume the provider does dictate the MRN and service date, but does not dictate the proper account number. The MT knows that she can enter the first 2 pieces of data into the header, but will have to pend the report. She will follow these steps for the header:

Enter the MRN and service date into the header, and click on Confirm. When she does this, she will get a message box indicating that the MT will have to manually pend the document if she intends to leave the account number field blank.



The MT should click OK to this message box, and she should use the Alt+Y shortcut to enter a pending note to UMass:



She should click OK to finish entering the pending note. She should then click Confirm in the header again. When she does so, she will get a new message box asking her if she wants to