Mail-in Quiz 32

Review the Transcription Tips and then follow the Report Instructions.

Transcription Tips

These tips are designed to help you through certain spots in the upcoming dictation where you may have difficulty. Each tip is referenced by the patient chart number and the pertinent section of the report. Read over the tips for a specific report before you begin transcribing it. Then, if you have a question about formatting or editing while you are transcribing a report, refer back here to see if we have given you a tip about that part of the report. You should also keep your Transcription Reference Guide on hand as you transcribe and use it frequently to check the patient and doctor names, punctuation rules, format and laboratory values.

Listen for the doctor to misspell some terms. You will need to check the spellings and be sure the terms are typed correctly.

When headings or subheadings are dictated out of order, edit them into the correct format order.

Report 1

Identifying Information
A woman’s name is given, but the doctor refers to the patient as a male. Include a note to the doctor at the end of the report asking him if this is the right patient.

PHYSICAL EXAMINATION
Compound adjectives should be hyphenated when they come before the noun they modify. Also use a hyphen when one part of a compound adjective is missing. For example, “The patient had a 1st- and 2nd-degree burn.” (Rule 46)

The doctor only dictates “98.6 Fahrenheit” for the temp in vital signs. When either “degrees” or “Fahrenheit” is dictated, the other term should be included to accompany it. You can’t have just “degrees” or “Fahrenheit”—you must type both. (If neither of them are dictated, then they both can be omitted and the temp can be typed with just the number.)

ASSESSMENT
A comma is used between the name of the condition and the location of the condition, e.g. 2nd-degree burn, left hand.

Often, the consulting physician will include a closing statement in a consultation report, thanking the referring physician. This closing statement is placed in a paragraph by itself, beginning at the left margin.
Report 2
Eyes: In this paragraph, there is a missing word because of a cutoff. Did you notice it? Can you guess what word might have been cut off? If you think you know, leave a note for your instructor. Leave a blank in the report for the missing word.

Report 3
Listen for the doctor to dictate only part of one of the headings. Edit the heading so it is complete.

Identifying Information
The doctor gives the patient name as “Bob.” This does not match the patient list you have been given. In this case, use the name identified on the patient list.

VITAL SIGNS
The doctor dictated one of the vital signs incorrectly. Did you catch which one? Refer to your list of normal laboratory values to help you decide. What did she probably mean? Leave the incorrect value blank, and include a flag for the doctor.

RECTAL
This section contains a false start. Edit out the false start.

Report Instructions
In order to ease you into transcription, you’ll fill in the blanks for the following reports as you listen to the dictation.

Audio Exercise
Follow these steps:

a. Access your audio for Lesson 44 Quiz 32—Reports 1.

b. As you listen to the audio, follow along with the reports provided and write in the missing words. Feel free to pause the audio at any time.

c. Research to confirm the correct term and spelling. Proofread your work.

d. Once you are satisfied with your researched terms, type each report in its entirety. Bold the terms you filled in. You must submit complete reports to the school to receive credit for the Quiz. Be sure your reports are formatted correctly, using the format guidelines set forth in this course. Your typed reports must look neat and professional.
Report 1
Listen to the audio to fill in the blanks. Each blank is worth 1 point, for a total of 34 points for this report.

Name: ___________________

Dr ___________________

PLASTIC SURGERY CONSULTATION REPORT

REASON FOR REFERRAL
I was asked by _________________ to see this 30-year-old _________________ for evaluation of cellulitis secondary to burn injury.

HISTORY OF PRESENT ILLNESS
Several days ago the patient _________________ in the kitchen, injuring his right upper arm. When the patient turned to look at his arm in the shower, he _________________ the _________________ upper arm with hot water. In spite of local treatment initiated after an emergency room visit, he developed increasing _________________.

PAST HISTORY
_________________: No medications.
Illnesses: _________________ history of _________________. 
_________________: NO KNOWN ALLERGIES.

REVIEW OF SYSTEMS
_________________.

PHYSICAL EXAMINATION
GENERAL: The patient is afebrile. The right upper arm is swollen, erythematous and warm. There is a 2nd- and 3rd-degree burn measuring _________________ on the _________________ upper arm. One-third of the area had ruptured _________________, and the _________________ is covered by a black _________________.

DATABASE
_______________ blood cell count _________________.

ASSESSMENT
_______________ 2nd- and 3rd-degree burn, right upper arm, with cellulitis.
RECOMMENDATIONS

______________ eschar. Continue _________________ dressings t.i.d. Once the wound is clean and granulating, he will require a split-thickness skin _________________ to expedite _________________ closure. Agree with IV antibiotics.

Thank you for allowing me to _________________ in the care of your patient.

__________________________________

_________________

Include your note to the doctor here:
Report 2

Listen to the audio to fill in the blanks. Each blank is worth 1 point for a total of 31 points for this report.

Name: ____________________

__________________________

Dr _______________________

HISTORY AND PHYSICAL EXAMINATION

HISTORY

CHIEF COMPLAINT
_______________ over eye.

HISTORY OF PRESENT ILLNESS
This is a _______________ white female who was involved in an _________________.
The patient sustained injury and was brought to the Weston Emergency Room for evaluation.

PAST HISTORY
Habits: The patient _______________ smokes nor drinks. No history of recreational drug use.
Medications: None.
Illnesses: UCD.
Operations: No _______________ surgeries.
ALLERGIES: NO KNOWN ALLERGIES.
Social history: The patient is a high school student who is doing well academically and active in extracurricular activities.
Family history: The patient’s mother is 35 years, living and well. The patient’s father is 40 years and has a _______________ of hypertension and diabetes. There is no family history of cancer.

REVIEW OF SYSTEMS
Skin: Multiple bruises on extremities.
HEENT: No loss of vision.
Neuropsychiatric: No history of seizure activity or loss of _________________.
Musculoskeletal: There are bruises on the extremities but no localized _______________ pain.

PHYSICAL EXAMINATION
GENERAL: This is a well-nourished, well-developed 16-year-old white female in moderate distress who appears somewhat frightened. Patient is responsive, alert and _________________.
Temperature: 98.6 °F.

CONTINUED
HEENT: Head: _________________. Eyes: There is a _________________ laceration in the right _________________ area. EOMs intact. There is a _________________ lateral to the orbit and up under the scalp, across the eyelid. The laceration was of subcutaneous _________________. The orbit does not appear to be involved or damaged in any way. The medial aspect was deep and extended down to the periorbital fat, but again no pertinent structures were involved. Patient has a notable numbness over the lateral right eyebrow, and midfrontal area had good sensation. There was no evidence of entrapment. The bony areas appear to be intact as well.

NECK: Neck is _________________ and nontender.

CHEST: The heart and lungs are clear to auscultation and percussion.

ABDOMEN: The abdomen is soft and nontender. There is no _________________.

PELVIC: Deferred at this time.

EXTREMITIES: There are bruises on the forearm and pretibial areas bilaterally. No evidence of fracture is present. No _________________ pinpoint tenderness or loss of sensation is noted. There is good strength in both hands bilaterally. The DTRs are _________________ and equal bilaterally. There is full range of motion.

NEUROLOGIC: The patient is oriented to time, place and person. No neurologic deficits are noted except as described under HEENT.

IMPRESSION
1. A 9 cm ___________ laceration over the right eyelid and _________________ area without involvement of the orbital structures and contents.
2. Cannot rule out possible nerve damage of the supraorbital nerve.

PLAN
Orbital tomography to rule out orbital fracture. Plastic surgery consultation to repair the laceration in a _________________ fashion and repair the flap avulsion.

_________________, MD

D: _________________
T: _________________
RS: _________________

Include your note to the doctor to flag the cut off in HEENT here:
Report 3

Listen to the audio to fill in the blanks. Each blank is worth 1 point for a total of 35 points for this report.

Name: ___________________

Dr Anne Jones

HISTORY AND PHYSICAL EXAMINATION

HISTORY

CHIEF COMPLAINT
Patient developed a rash of the right _________________ with swelling and tenderness.

The patient had joined a gym 1 month ago and noticed the onset of the rash 1 week prior to _________________ beginning with redness and _________________ to small blisters. He had a fever since yesterday with chills and _________________.

PAST HISTORY
Noncontributory.

ALLERGIES: NO KNOWN ALLERGIES.

REVIEW OF SYSTEMS
Skin: There is _________________ between the 1st and 2nd _________________ of the right foot for approximately 1 month. Other systems are noncontributory.

PHYSICAL EXAMINATION
GENERAL: This is a well-nourished, well-developed 22-year-old white male who is pleasant and cooperative.


HEENT: Head: Normocephalic. Eyes: EOMs intact. Ears: The tympanic membrane is normal to inspection.

NECK: Supple. No _________________.

CHEST: The heart and lungs are normal to percussion and auscultation.

ABDOMEN: There is right _________________ adenopathy. The abdomen is soft without evidence of _________________.

RECTAL: The _________________ is normal in size. _________________ blood is seen on the examining finger. Stool _________________ negative.

EXTREMITIES: There is a large, well-demarcated, shiny, red, _________________, tender rash covering most of the lateral aspect of the right leg with peripheral tenderness. Vesicles are present. In addition, there is an _________________ rash between the _________________ of the right foot.

CONTINUED
HISTORY AND PHYSICAL EXAMINATION
Page 2

NEUROLOGIC: Except for tenderness in the right leg, no deficits are demonstrated.
______________ are ________________.

IMPRESSION
1. Febrile ________________ rash, right leg, most likely ________________.
2. ________________ fungal infection, right foot, between the great toe and second.

PLAN
1. Blood cultures ________________.
2. Penicillin G 1.2 million units IV q.6 h. for 36 hours.
3. If there is a rapid response, switch to Pen.Vee K ________________ p.o. q.i.d. on an outpatient basis for 14 days.
4. ________________ p.r.n. for pain.
5. Aspirin ________________ p.o. q.3 h. p.r.n. for pain.

________________________, MD

D: ________________
T: ________________

Include your note to the doctor here: