# Operative Report Template

| ***Number*** | **Misspelled Medical Term** | **Common Term** | **Corrected Misspelled Word** |
|---|---|---|---|
| *Example 1* | *Uretr* | *Tube connecting the kidneys and the bladder.* | *Ureter* |
| 1. | histerectomy | removal of uterus | hysterectomy |
| 2. | ophorectomy | removal of an ovary | oophorectomy |
| 3. | urinarie | discharge of urine | urinary |
| 4. | incontinental | lack of control over urinary discharge | incontinence |
| 5. | hemorhage | bleeding | hemorrhage |
| 6. | pielonephritis | inflammation of kidney | pyelonephritis |
| 7. | folley | indwelling catheter | foley |
| 8. | muosa | mucus membrane | mucosa |
| 9. | blader | sac containing fluid | bladder |
| 10. | vaginl | relating to the vagina | vaginal |
| 11. | cystcele | urinary bladder hernia | cystocele |
| 12. | interocele | small intestine hernia | enterocele |
| 13. | suprapublically | above the pubis | suprapubically |
| 14. | insicions | surgical cut | incision |
| 15. | mid-urethre | middle of urethra | mid-urethra |

## Health Information Management Terminology

Health Information Management (HIM) involves acquiring, analyzing, and safeguarding digital and traditional medical information, which is crucial for providing high-quality patient care (Health Information, 2022). HIM encompasses data about a patient's medical history, diagnoses, test results, symptoms, procedures, and outcomes. Various HIM documents are utilized by physicians and healthcare workers to review and communicate a patient's current and past medical history. This paper will explore the following health information documents: progress notes, history and physical (H&P), operative report, and discharge summary.

## Progress Notes

Progress notes are continuous records that detail a patient's illnesses and treatments. An attending physician updates these notes daily during a patient's stay, although more frequent updates may be necessary depending on the patient's condition. Progress notes are used in various healthcare settings, including primary care clinics, outpatient clinics, long-term and short-term living facilities, and cancer centers. They aim to keep all healthcare workers involved in the patient's care informed. The notes include information on the patient's progress, responses to tests, treatments, medications, documentation of diagnoses, and any new diagnoses. The attending physician should also note any conditions defined as "possible," "probable," or "rule out". Progress notes form a part of the patient's permanent medical record and are continually updated throughout the patient's life.

## History and Physical (H&P)

A patient's history and physical (H&P) are critical medical record components. This document provides a comprehensive medical history and details the patient's condition and the reason for their visit. The H&P must be completed and documented by a qualified and privileged

physician or another qualified licensed practitioner by state law and organizational policy (Joint Commission, 2023). The H&P includes the patient's name and date of birth, chief complaint, history of present illness, current medical issues, medications, family medical history, previous surgeries and procedures, and physical examination. An H&P is required for all surgical procedures, whether inpatient or outpatient. According to The Joint Commission (2023), the H&P document must be completed and included in the medical record for all high-risk, surgical, and anesthesia procedures. The surgeon or physician performing the procedure must sign, date and time stamp the document on the day of the procedure but before the procedure begins. The H&P is used in surgical (operating room) and outpatient facilities where procedures requiring local anesthesia are performed and in ambulatory surgical facilities.

## Operative Report

The operative report is a document produced by a surgeon or other participating physicians detailing the findings, procedures used, specimens removed, preoperative and postoperative diagnoses, and names of the primary surgeon and any assistants. This report includes comprehensive details of what occurs in the operating room. It must describe all steps of the procedure, the names of all medical staff present, the start and end times of the procedure, the reason for the procedure, the outcome, and details of any biopsy taken. The operative report is included in the patient's medical chart and is referred to during follow-up care. It is used in operating rooms and ambulatory surgical facilities.

## Discharge Summary

The discharge summary is a final summary of a patient's hospital or clinic visit. The discharge summary must concisely summarize events documented in the patient's record. This summary includes the reason for the visit, follow-up visits, prescribed medications, if applicable,

and discharge instructions. The patient receives a copy of the discharge summary. This document is used in hospital settings such as the emergency room, inpatient stays, or ambulatory surgical units.

## References

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Health Information. (2022). *Health Information 101*. AHIMA. https://www.ahima.org/certification-careers/certifications-overview/career-tools/career-pages/health-information-101/

Joint Commission. (2023). *History and Physicals—Understanding the Requirements | Hospital and Hospital Clinics | Provision of Care Treatment and Services PC | The Joint Commission*. https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/provision-of-care-treatment-and-services-pc/000002272/