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| **Glossary** |  |
| **Chapter 16** |  |
| **Association for Healthcare Documentation Integrity (AHDI)** | professional organization in the field of medical transcription/editing |
| **auditor** | a person responsible for determining the final content of a document and the document’s correctness in every aspect |
| **authentication** | dictating provider signs or authenticates the document indicating that the information was accurate and complete at the time of signing |
| **autopsy report** | also called an autopsy protocol, a necropsy report, or a medical examiner report. Autopsies are performed to determine the cause of death or to ascertain and confirm disease presence. |
| **Certified Medical Transcriptionist (CMT)** | completion of a two-part certification examination administered by the Association for Healthcare Documentation Integrity (AHDI) |
| **chart notes** | (also called progress notes) provider’s formal or informal notes about presenting problem, physical findings, and plan for treatment for a patient examined in the office, clinic, acute care center, or emergency department |
| **chief complaint (CC)** | specific symptom or problem for which the patient is seeing the provider today |
| **confidentiality** | ethical and legal rules in regard to patient privacy |
| **confidentiality agreement** | when signed, the agreement signifies that the medical transcriptionist is committed to keep all patient information confidential |
| **consultation report** | document that reports the findings and advice of another provider requested to see a patient by the attending provider |
| **current reports** | reports such as history and physical examinations that should be complete within 24 hours |
| **discharge summary (DS)** | medical reports that document the hospitalization history of a patient |
| **editor** | a person responsible for determining the final content of a document and the document’s correctness in every aspect |
| **flag** | method of identifying a blank space or a question regarding dictator’s meaning by attaching a note or marker to indicate the question |
| **gross examination** | viewing specimens with the naked eye |
| **history and physical examination report (H&P)** | report of patient’s history and physical examination to document reason for visit |
| **history of present illness (HPI)** | the chronologic description of the development of the patient’s illness |
| **Joint Commission** | formerly the Joint Commision on Accreditation of Healthcare Organizations, a commission established to improve the quality of care and services provided in organized health care setting, through a voluntary accreditation process |
| **microscopic examination** | viewing a specimen with the aid of a microscope |
| **old reports** | reports such as a discharge summary that should be completed within 71 hours |
| **operative report (OR)** | medical report that chronicles the details of a surgical procedure |
| **outsourcing** | the practice of contracting with a service outside of the clinic or hospital to a company where the task can be accomplished at a lower cost and with a faster turnaround time |
| **pathology report** | medical reports generated to describe the gross and microscopic examinations performed during a surgical procedure |
| **present problem (PP)** | specific symptom or problem for which the patient is seeing the provider today |
| **privileged** | confidential information that may only be communicated with the patient’s permission or by court order |
| **progress notes** | also called chart notes. Provider’s formal or informal notes about presenting problem, physical findings, and plan for treatment for a patient examined in the office, clinic, acute care center, or emergency department. |
| **quality assurance (QA)** | process to provide accurate, complete, consistent health care documentation in a timely manner while making every reasonable effort to resolve inconsistencies, inaccuracies, risk management issues, and other problems |
| **radiology and imaging reports** | medical reports that describe the findings and interpretations of the radiologist |
| **registered medical transcriptionist (RMT)** | completion of a two-part certification examination administered by the Association for Healthcare Documentation Integrity (AHDI) |
| **review of systems (ROS)** | inquires about the system directly related to the problems identified in the history of the present illness |
| **transcriber** | device that makes it possible to transform voice recordings into a transcript or printed documents |
| **turnaround time** | specific time limits established for completion of medical reports |
| **voice recognition software (VRS)** | software that translates voice commands and is used in place of a mouse and keyboard |

 | http://www.cengage.com/images/spacer_tr.gif |

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