MOT 110—Medical Office Administration

Chapter 9
Maintaining Patient Records

Objectives:

- Explain the purpose of compiling patient medical records
- Describe the contents of patient record forms
- Describe how to create and maintain a patient record
- Identify and describe common approaches to documenting information in medical records
- Discuss the need for neatness, timeliness, accuracy, and professional tone in patient records
- Discuss tips for performing accurate transcription
- Explain how to correct a medical record
- Explain how to update a medical record
- Identify when and how a medical record may be released

Vocabulary:

- documentation
- electronic health records (EHR)
- electronic medical records (EMR)
- informed consent form
- noncompliant
- objective
- patient record/chart
- POMR
- sign
- SOAP
- subjective
- symptom
- transcription
- transfer

Assignments:

_____**Read Chapter 9**—pages 176-197 or pages 156-174 (2nd Edition)

_____Preview Chapter 9 **PowerPoint Presentation**

_____Complete **End of Chapter Review**—pages 198-199

_____Complete **Worksheet Pages**—pages 82-89

- Content Review 1-17
- Short Answer 38-44

Assessments:

_____Complete **Student Tutorial CD**

- Six Cs of Charting
- Electronic Health Records

- **E-Mail or Print Progress Report**

_____**Application Activities #3**—Medical History and Physical Exam Form—page 198
Use copied form

_____**Chapter 9 Exam**