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MEDICAL RECORDS HELP ATTORNEYS

MEDICAL RECORDS HELP ATTORNEYS UNCOVER CRUCIAL CASE DETAILS

Nurse from Pennsylvania

Within medical records lies the hidden detail that could prove negligence or that could absolve the unjustly accused practitioner. Though the records often seem incomprehensible, attorneys can find crucial information in them if they know where to look. Following is a summary of what information should be included in various types of hospital records.

Progress Notes – A daily narrative of a patient’s medical care. They describe the patient’s progress, symptoms and course of recovery. Often written by a resident or intern, and then signed or initialed by the treating physician. Each entry should be dated and signed.

Admission Notes – Done on the day of hospitalization by the treating physician. Notes should include a history and physical examination, diagnosis and recommendations for treatment.

Examination Form – The history should include the chief complaint, details of the present illness, relevant past, social and family histories and inventory of the body systems. This should be completed within 24 hours of admission. The physical examination should reflect a general evaluation and a notation of blood pressure, pulse and respiration; the skin, eyes, ears, nose and throat; neck; breasts, lungs, and heart, abdomen; genitalia or pelvis; rectum; extremities and lymph nodes. A neurological examination should be recorded and allergies noted. A final impression should be stated.

Doctor’s Orders – Requests for diagnostic testing and therapeutic treatment. All orders should be dated and signed by the physician. Verbal orders are expected to be signed by the doctor during the next patient visit, or within 24 hours. The treating physician is responsible to check that the patient is receiving what was ordered. The nursing staff should conduct a 24-hour review of the orders. Treating physicians should be notified of impending stop orders.

Surgical Records – Documents the preparation of a patient scheduled for surgery. Generally includes a surgical check list of preparatory steps taken by the nursing staff the night before surgery.

Operative Report – A complete and detailed report made within 24 hours. Contains identification of procedures used, a description of all findings, including anomalies encountered, specimens removed, postoperative diagnosis, unusual events and name of primary surgeon and assistants. A progress note, written by the physician concerning the operation should appear in the records.

Anesthesia Record – Documents the anesthesiologist’s visit, including conversation with the patient, efforts to obtain

information pertinent to the patient’s past surgeries, a physical examination, and complete review of the patient’s chart. During surgery, the anesthesia record should show:

- The length of time anesthesia was administered;
- Time needed to complete surgery;
- Quantities and types of drugs, blood, and intravenous fluids administered during surgery;
- Continuous record of pulse, blood pressure and respiration;
- Observation notes to include reaction to anesthesia surgery.

Consent Form – Informed consent is necessary for elective treatment and diagnostic procedures involving invasion or disruption of the integrity of the body. A consent form should include: The date, identity of the patient, and the name of the procedure or treatment interpreted in laymen’s terminology, as well as the name of the person administering treatment and authorization for anesthesia. The form should state possible risks or complications that have been explained to the patient; authorization for disposal of tissue or body parts; explanation of alternative treatment, and signature of the patient and a witness.

Nursing Notes – Written on a per shift basis, should be recorded at the time of or immediately after patient events, depending on hospital policy or patient condition. The notes should detail the progress of the patient and be made in chronological order. They should be signed by the person performing a procedure or witnessing an event.

Discharge Summary – Should be a recap of relevant diagnosis, operative procedures performed significant findings, treatment rendered, the condition of the patient upon discharge and the discharge instructions. It should be dictated by the treating physician.

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Since 1983, Medical Advisors has assisted in the selection of expert witnesses in several thousand cases. We have provided medical opinions and testimony which have resulted in competent preparation and in-court support for cases involving medical malpractice, hospital negligence, personal injury, workers' compensation and product liability.

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