Case Medical Records PDF Generation Instructions

Read through the following instructions carefully. Each section provides guidance on what documents to include for the audit. Work closely with your Medical Records or IT department to assemble this PDF. It is critical to the success of your audit that you provide the information requested in this document.

PDFs that do not include the requested information or are not bookmarked in a usable manner will be returned to you and you will be asked to re-create the PDF.

PDF Bookmarking Instructions

To view the example bookmarks click this icon. 

To add bookmarks 

1) Make sure you are on the page you would like to bookmark.
2) Click on the bookmark symbol.
3) Then name the bookmark and click enter.

Pre-op H &P:

Preoperative H&P and preoperative office notes. These documents are required to code Risk Factors, Clinical Staging, and Patient Zubrod score.

Admission H&P:

H&P used for the patient's admission. This document is needed to determine the patient's status just prior to surgery. (Zubrod score)

Diagnostic Tests:

Pre and post diagnostic test results, include studies used for clinical staging. Test documentation should include: CT scans, PET/CT scans, EBUS, Bronchoscopy, Path reports of any biopsies. This information is needed to code Clinical Staging.

PFT:

Pulmonary Function Tests done prior to surgery. Include the actual PFT report if available. If PFT report is not available, provide test results in Office Visit note.

Operative Notes:

All operative notes for the entire episode of care including the index surgery and returns to OR. If multiple physicians participated in the surgery, include the notes from both surgeons.

Anesthesia:

Anesthesia report that includes the patient's disposition from the OR. In addition, please provide a Key to **your facilities** rooms/floors.
For example,
Unit A701 = Intermediate Care
Floor 5W = Regular Floor Bed
CVIC = ICU unit

Procedure Times:

Include documentation that provides the procedure start and end times. Please provide a Key to your source document for these data elements. For example, Surgical Record Case Start = Procedure Start or Use procedure times from Anesthesia Record

Hospital Progress Notes:

Progress notes from the patient's surgical admission including any notations of complications, intubation, extubations, and reintubations.

Consult Notes:

Consult notes from the patient's surgical admission including any notations of complications.

Pathology Reports:

Pathology reports for final pathology after surgery

Discharge Status:

Discharge Summary for the episode of care

Smoking Cessation:

Include documents that indicate whether the patient received smoking cessation counseling, if appropriate. Also, indicate if you provide smoking cessation to all patients regardless of their smoking status.

30 Day Follow Up:

Medical or surgical dictation, office notes, or screen shot of encounters. Documentation of any follow up encounter the patient had after discharged **greater than or equal to 30 days.** Do not just include the first follow up after surgery as this is often less than 30 days.

Readmission Data:

Medical or surgical dictation, office notes, or screen shot of encounters.
Documentation of any admissions occurring after the patient has been discharged within 30 days

Misc Data:

Any additional information that you deem important for your audit. This may include a key to your facilities ICU, Intermediate Care, and regular floor units.