APPENDIX

B

Transcription Guidelines

Part of an administrative medical assistant's role may be to transcribe physicians' chart notes and other medical documents. Using dictation equipment, physicians may dictate notes for a medical record and then give or transmit the recording to an assistant for transcription during a stated time period, such as 48 hours.

Using an outside transcription service is common practice for medical providers. This allows a skilled medical transcriptionist to be employed through an outsourced transcription service. Also, transcription may be completed through a home office. Self-discipline and productive time management skills are crucial for the success of an at-home transcriptionist.

With the use of electronic medical/health records, physicians can directly place notes in the patient's electronic record. An administrative medical assistant may be assigned the duty of proofreading a patient's chart notes for grammatical and typographical accuracy prior to the physician electronically signing and closing the chart.

Scribes are specifically trained to place physician-directed clinical information in electronic medical records. Extensive knowledge of medical terminology (terms and abbreviations), grammar, keyboarding, and computer skills are all imperative for accurate input. Experience in medical transcription provides a solid foundation for the duties of a scribe.

EQUIPMENT AND TECHNIQUES

Dictation (data input) equipment comes in various formats. Either digital media, such as a CD, or analog media, such as a cassette tape, store the recording.

Transcription equipment includes these basics:

- Floor pedal
- Headset
- Transcription-specific software
- Timing/tracking software (can be included with the transcription-specific software—used when compensation is based on word production)
- Medical and regular dictionaries (electronic and hardcopy)
- Spell-checker and grammar checker (specific to medical transcription)
- Text expander (will complete a word after just a few letters are typed)

The principles of transcription are the same regardless of the equipment. Tone, volume, and rate of speed can be regulated for the assistant's comfort and rate of transcription. Traditional equipment involves a foot pedal used for starting the machine and for reversing it. Foot pedals for digital media are called *wave pedals.* USB headphones/headsets are

used to keep the recorded information confidential and to avoid disturbing other people in the office. Another helpful item is a counter, which makes it possible to locate a specific reference speedily and to judge the length of a document and number of produced words in a document.

Since using a transcribing machine is something of a balancing act for the ear, foot, and keyboard, a good technique is to listen to three or four words at a time, key those words, and then listen to the next three or four words. Generally, headings and subheadings are easy to determine from the dictation, especially once you become familiar with a standard format.

OFFICE POLICY

Because every office or transcription service uses its own format for transcribing chart notes, assistants need to become familiar with the policy of the office where they work. In transcribing material, you should listen carefully to what the dictator says, including any instructions or corrections he or she has included. Above all, you should not add anything that is not there, such as headings or changes to the sentence structure. If there is anything in the dictation that is not clear, it is important to flag the problem. Then, at a time that is convenient for the physician, you should ask for clarification.

BASIC MEDICAL TRANSCRIPTION GUIDELINES

Skill in spelling, knowledge of punctuation and capitalization, and familiarity with medical terminology help make the administrative medical assistant efficient in transcribing a physician's dictation. Also important is knowing the basic guidelines for capitalization and the use of standard medical abbreviations, numbers, and symbols. Study and refer to the following list of guidelines for transcribing medical documents. Further information on transcription and transcription guidelines can be accessed at the website for the Association for Healthcare Documentation Integrity (www.ahdionline.org). AHDI publishes *The Book of Style for Medical Transcription,* which contains up-to-date medical transcription guidelines.

1. Use commas in the following situations:
   - **a.** Set off nonessential words and phrases.
     Dr. Jones, a first-year resident, is on call.
     Janice, who was hired last month, will attend next week's conference.
   - **b.** Set off introductory clauses or phrases.
     After the cast was applied, the x-ray showed the fracture to be in good alignment.
     If so, the physician will have to leave an hour before closing.
   - **c.** Separate the year in a complete date. Do *not* use commas when only the month and year are presented. (*Note:* Do *not* use numerals for dates in text material—for example, "The surgery is scheduled for 11/01/22.")
     The surgery is scheduled for Wednesday, May 6, 2022.
     The patient was last seen in May 2015 for an ultrasound.
   - **d.** Separate degrees, titles, and so on after names.
     The patient was referred to Phil Stevens, PhD, for psychological testing.
   - **e.** Separate items in a series.
     The sponge, needle, and instrument counts were correct.
   - **f.** Separate independent sentences connected with a conjunction.
     Mrs. Tina Roe called in the last hour, and she still insists on seeing the physician today.

g. Set off direct address in a sentence.
Set the chart on the desk, Janis, and take the new dictation tape with you.

h. Separate equal adjectives (modifiers).
The patient is a well-nourished, well-developed female.
The 15-year-old Caucasian male has brain cancer. (The adjective "15-year-old" modifies both *Caucasian* and *male;* therefore, no comma separates them.)

i. Place commas and periods inside quotation marks.
The patient states he feels "fuzzy in the head," and he needs medication for this symptom.

j. Use a comma to indicate missing words.
Chest x-ray, normal. (*Note:* Chest x-ray was normal.)

k. Use a comma to separate parts of an inverted diagnosis.
Ankle sprain, left.

2. Use semicolons in the following situations:

a. Separate related independent clauses (sentences) without a conjunction.
The surgery was scheduled for 4 P.M.; it lasted 4 hours.

b. Set off independent clauses that already contain one or more commas and have a conjunction if a misreading could result.
If, following the call, the appointment has been made, Janet can leave at 9:30 P.M.; but, if the appointment has not been made, she needs to leave right away.

c. Separate a transitional word or phrase that begins an independent sentence, such as *therefore, however, in fact, namely,* and *thus,* from another independent sentence.
The physician will be 2 hours late; however, there are no patients scheduled until this afternoon.

d. Separate items in a series when the items have commas.
The physician has lectures scheduled in St. Paul, Minnesota; Fargo, North Dakota; and Des Moines, Iowa.

e. Place semicolons outside quotation marks.
The patient said, "I will obtain my medical records"; she did not bring them to the office.

3. Use a colon in the following situations:

a. Introduce a list, a series, or an enumeration.
The patient complains of the following symptoms: dizziness, lightheadedness, and palpitations.
The patient was instructed to do the following:
1. *Follow a low-fat, low-cholesterol diet.*
2. *Exercise 3 times a week.*
3. *Retest cholesterol in 3 months.*

b. Separate hours and minutes.
The surgery is scheduled to begin at 12:30 P.M.

c. Introduce an example, a rule, or a principle.
We have only one choice: immediate surgery.

4. Use capital letters in the following situations:

a. Emphasize allergies in full capital letters. (*Note:* An alternative method is to use boldface.)
The patient was ALLERGIC TO PENICILLIN. ALLERGIES: Penicillin.

b. Do *not* capitalize common nouns designating rooms, such as *operating room* or *emergency room.* Capitalize the official names of designated rooms.
The patient was seen in the intensive care unit. (*Note:* The patient was seen in the ICU.)
The patient is scheduled for the operating room in an hour.
The patient was sent to Recovery Room C at 9 A.M.
The meeting will take place in the Viking Room.

c. Do *not* capitalize medical specialties or variations of specialties.
The patient was referred to cardiology.
The cardiologist sent the patient back to the family practice physician.

d. Capitalize trade and brand names but do not capitalize generic names—for example, Tylenol #3, pHisoHex, and Cardizem, but alcohol, catgut, and aspirin.

e. Capitalize races, peoples, religions, and languages but generally not color designations, such as *black* or *white,* when they refer to race (*Caucasian, African American, Jewish, Hispanic, Mexican American, English,* and so on).
The patient is a well-developed, well-nourished Puerto Rican male.
The patient is a well-developed, well-nourished white female.
The 31-year-old black patient was discharged yesterday.

f. Use all-capital letters for headings and subheadings in the medical document.
GENITOURINARY: Exam will be completed next month.

5. Use a hyphen in the following situations:

a. Connect the elements of compound adjectives that appear before nouns.
She had a low-grade temperature. (*Note:* Her temperature was low grade.)
This was a well-developed Asian American male.
There was a 5-cm lesion on the left side.

b. Form *self*-compounds.
The patient was self-employed.

c. Look up compound nouns in a current dictionary to determine if they are hyphenated or closed-up. Use two separate, nonhyphenated words for two-word verbs.
The patient is scheduled for a follow-up visit.
The patient's checkup was delayed.
The patient will follow up with hematology.

d. Join a single letter to a word to form a coined compound word.
The patient had a T-cell abnormality. (*Note:* We will measure the patient's T cells.)
The x-ray results will be sent to the office.

e. Insert a hyphen between a prefix and a capitalized word, as in *non-Hodgkin* or *mid-March.*

6. Use abbreviations as follows:

a. Use published abbreviations.
The mole is 1.25 cm in circumference with irregular borders.

b. Use proper abbreviations for transcribing medication administration times.
The patient was placed on Augmentin 125 mg t.i.d. x 5 days.
A prescription for tetracycline 500 mg q.i.d. was given to the patient.
(*Note:* Always keep units of measurement on the same line.)

c. Do not abbreviate the diagnosis, conclusion, or procedural/operative title in medical documents. Nondisease-related words in the diagnostic or procedural titles may be abbreviated.
DIAGNOSIS: End stage renal disease. (*Note: Not* ESRD)
OPERATION: Excise 0.5-cm polyp from right naris.

d. Spell out a word if the abbreviation could be misunderstood.
The patient has no history of a cancer problem. (*Note:* The abbreviation *CA* could mean *calcium, cancer,* or *coronary artery.*)

e. Do *not* abbreviate beats per minute.
Pulse was 72 beats per minute.

f. Use lowercase letters with periods for a.m. and p.m. (preferred style). Spell out even times when *a.m., p.m.,* or *o'clock* is not used. For hours without minutes, *o'clock* may be used to express emphasis and words to express formality. Do not use a colon and two zeros.
The next available appointment is for 10 a.m.
The patient will be seen at three.
The patient arrived at 3 o'clock OR
The patient arrived at three o'clock.

7. Use numbers as follows:

a. Spell out numbers at the beginning of a sentence, or recast the sentence.
Ten milligrams was given to the patient.
Then 10 mg was given to the patient.

b. Use Arabic numbers with technical measurements.
A #14 Foley catheter was inserted.
A No. 4 Foley catheter was inserted.
The surgeon suggested 5- to 6-inch elastic stays.
The patient was given 10 tablets.
The patient was prescribed Paxil 20 mg q.d., #60.

c. Express ages in figures.
This 5-year-old boy has had cold symptoms for the past 2 weeks.
The 5½-month-old child was not left unattended.

d. Spell out ordinal numbers and simple fractions (preferred style).
The patient was discharged on the fifth postoperative day.
Next, one-third of the abdomen was prepped.

e. Use roman numerals for cranial nerves, ECG leads, EEG leads, clotting factors, and noncounting listings (preferred style).
The exam found the cranial nerves II–XII were intact.
The patient had stage II carcinoma.
The patient had type II diabetes mellitus.

f. Use Arabic numbers with grades.
The patient had a grade 2 systolic ejection murmur.

g. Insert a zero in front of the decimal point when a decimal is less than a whole number.
The patient's prescription was changed to 0.125 mg.

h. Enumerate listings as much as possible.
DIAGNOSES: 1. Right otitis media.
2. Laryngitis.
3. Pharyngitis.
The diagnoses were (1) right otitis media, (2) laryngitis, and (3) pharyngitis.

i. Do *not* repeat units of measure in a series.
The patient was given 5, 10, and 20 cc.

8. Use symbols when transcribing numbers or abbreviations. The following are some common examples:

Dictated	Transcribed
used two oh chromic catgut	*used 2-0 chromic catgut*
two by point five millimeter	*2.0 × 0.5 mm*
number two oh silk	*#2-0 silk* or *2-0 silk*
one point two percent	*1.2%*
pulses are two plus	*pulses are 2+*
blood pressure one hundred twenty over eighty	*Blood pressure: 120/80*
fifty-five milligrams percent	*55 mg%*
diluted one to one hundred	*diluted 1:100*
ninety-nine degrees Fahrenheit	*99°F*
the plane was raised ten degrees	*The plane was raised 10 degrees.* (*Note:* Spell out *degrees* in expressing angles.)
at a minus two station	*at a −2 station*
medication times three days	*medication × 3 days*
one hundred milligrams per hour	*100 mg/h*
normal es one and es two	*normal* S_1 *and* S_2 or *normal S1 and S2* or *normal S-1 and S-2*
one hundred milligrams per teaspoon	*100 mg/teaspoon*
ten to fifteen wbcs	*10–15 wbc's* or *10–15 WBCs*
two to four plus	*2 to 4+*

9. Follow proper guidelines for letters and memorandums. Use a reference manual.
10. Consult a reference manual about questionable punctuation, capitalization, or grammar.
11. Use an acceptable or approved format for each medical document.