

Name: _____ Date: _____

Intro to HIT Puzzle 4

1. A form signed by the patient in an inpatient facility granting permission to the hospital to provide general diagnostic and therapeutic are as well as to release patient information to a third party payer. Also known as a general consent form.
 2. An anesthesiologist's documentation of [patient evaluations before, during, and after surgery, including the specifics of the administration of anesthesia.
 3. In the SOAP format for medical decision making, the diagnostic, therapeutic, or palliative measures that are taken to investigate or treat the patient's condition.
 4. The examination of internal body structures using radiographs and other imaging technologies.
 5. The physician's directions regarding the patient's care. Also refers to the data collection device on which these elements are captured.
 6. Surgery; an operation consists of one or more surgical procedures.
 7. Clinical data including the name of the medication , dosage, date and time of administration, method of administration, and the nurse who administer it.
 8. Health record documentation comprising the patient's history and physical examination; a formal, dictated copy must be included in the patient's health care record within 24 hours of admission for inpatient facilities.
 9. The first page in a paper record. Usually contains at least the demographic data and contains space for the physician to record and authenticate the discharge diagnoses and procedures. In many facilities, the admission record is also used as the face sheet.
 10. An expedited inpatient admission arranged in advance by a physician's office or other entity due to a patient's urgent medical condition.
- A. Medication administration
 - B. Direct admission
 - C. Anesthesia report
 - D. Radiology examination
 - E. Face sheet
 - F. History and physical
 - G. Admission consent form
 - H. Operation
 - I. Physician's order
 - J. Plan of treatment