Importance of Medical Record

Submitted by

 College

 Date

**Medical record and the purpose for each**

Medical history

Laboratory and diagnostic test result

 Problem list

 Clinical list

 Treatment notes

Medical documentation is a system of accounting and reporting documents designed to record and analyze data describing the state of health of individuals and groups of the population, the volume, content and quality of medical care provided, as well as the activities of health care facilities. In terms of the public nature of health care, this system is mandatory and universal, because only it carries out and provides a quantitative and qualitative account of the therapeutic, diagnostic and preventive work of all medical institutions and makes it possible to analyze this work. Each form of medical records is one for the whole country, enforced by the Ministry of Health. (Robert, Vasa,Delaney, & Mark, 2018).

Medical records are a case history, an outpatient medical record, a child’s development history, etc., and a preventive vaccination record, a polyclinic exchange card, emergency notification, etc. are reported. The most important primary registration document is the history of the disease (in outpatient treatment - medical card of the outpatient). It is intended for fixing observations of the patient during his inpatient (outpatient) treatment. This is a recording system; documenting the results of diagnostic studies, the diagnosis itself, therapeutic measures, the course and outcome of the disease or injury. The history of the disease serves as the basis for further, after discharge from the hospital, medical actions related to the rehabilitation of the patient, his work activity. At a lethal outcome in the history of the disease the results of the pathoanatomical or forensic examination of the corpse are noted.(Lavallee, Chenok, Love, Petersen, & Franklin, 2016 )

**Medical history**

Since 1968, the medical history has been officially called the “inpatient medical record”, however, the familiar term “Medical history” is used everywhere and in the following: it is stated like the outpatient record (instead of the “outpatient medical record”) we will use. Making out the history of the disease (outpatient card, which is further in mind), the doctor must proceed from the fact that the entries in it have an important therapeutic, diagnostic, scientific, practical, educational, legal and social significance.

**Laboratory and diagnostic test result**

Correct and timely diagnosis is the key to successful treatment. Diagnosis of diseases is a difficult process. The doctor makes conclusions about the patient's condition, based on his own observations, on the overall clinical picture, on data from various instrumental studies. The most important link in this diagnostic chain are laboratory methods for examining a patient.

**Problem list**

The main thing about the history of the disease is that, according to the records in it, diagnostic and therapeutic measures are carried out. The diagnosis and treatment of the patient is often carried out not by one but by several doctors. In such cases, medical history records and problem list allow you to integrate the efforts of different doctors and ensure continuity during treatment.

**Clinical list**

During the production of such examinations, the investigation determines a specific list of issues: establishing the presence or absence of complications - establishing a causal link between a certain medical procedure (intervention) and the occurrence of a complication; in the presence of a causal relationship - assessment of the severity of harm to health; the decision of the question of the accuracy, timeliness of treatment in full. (Margalit, Roter, Dunevant, Larson, & Reis, 2016).

**Treatment notes**

The part of the medical record in which the SOAP format is used is the “Notes on Implementation” section. SOAP stands for subjective, objective, evaluative, plan.

References

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