Veterinary Health Center
MANHATTAN, KANSAS

OFFICIAL PROTOCOL

MEDICAL RECORDS

KSU-VHC Protocol for Problem-Oriented Veterinary Medical Records (POVMR) system.

1. On each patient the DATA BASE (history, physical examination, laboratory data) should be obtained and recorded on the history and physical exam page of the medical record.

2. Record ALL problems identified in the data base in the PHYSICAL EXAMINATION/ ASSESSMENT FORM (PEIA). Date and number each problem.

3. For EACH active PROBLEM on the PEIA develop an INITIAL PLAN. The initial plan includes the ASSESSMENT (Rule-outs in order of probability), and INITIAL DIAGNOSTIC AND THERAPEUTIC PLAN. The initial plan should include tests you feel should be done for the initial evaluation of the problem.

4. PROGRESS NOTES must be recorded for every active problem as often as the progression of the problem requires (minimum of once daily). Progress notes are written in narrative form using the SOAP format.

PROBLEM TITLE

S: SUBJECTIVE, record subjective clinical information (i.e., history, attitude, appetite).

O: OBJECTIVE, record objective clinical information such as body weight, temperature, significant lab data and radiographic findings. Flow sheets should be used to record lab data on patients with multiple lab sheets.

A: ASSESSMENT, most important part of medical record for evaluating students

This is the portion of the record where the interpretation of the subjective and objective information should be made. Use this section to discuss the rule-outs (R/O's) and the information supporting your R/O's and/or what needs to be done to further define the problem. This section should identify and explain changes in the level of understanding of the problem(s) and how this problem relates to the animal's other problem(s). This section is an analysis of information, not a repetition of data.

P: PLAN: This section is for recording the revised diagnostic (Dx) and therapeutic (Rx) plan. Explain the purpose of the diagnostic and therapeutic plans. For all medications, record the form, dose, route of administration and time to be

administered. For each Dx and Rx plan there should be a box ([ ]) behind it which should be checked when test is in ([/]) and when the Dx or Rx has been done([X]).

5. Upgrade the PEIA list as problems are refined.

6. Record in the appropriate column on the Progress Note page of the record: appetite, urine and feces data on a daily basis. Record the temperature, pulse/heart rate, respiratory rate, and body weight daily.

7. **SIGN AND DATE ALL ENTRIES IN THE MEDICAL RECORD**. If this is not done the record will not be complete!

An accurate record of ALL drugs, surgery, dressing, etc., must be maintained in each case (special forms are available in all record areas). It is the responsibility of the student assigned to the case to see that this is done. The student assigned the case should estimate the current charges on a daily basis.

All records are confidential. Release of information contained on case records shall be by the medical records personnel. If there is a possibility that the record could be used in court, then the clinician and Hospital Director will be notified. Please do not discuss cases with any outside person other than the owner or his/her designated representative.

Re-assignment of cases will occur at the time of group rotation. A student receiving such a case will proceed with a thorough physical and complete a review of the active problem and diagnostic and therapeutic plans.

NO CHANGE IN THE COURSE OF THERAPY WILL BE MADE WITHOUT PRIOR AUTHORIZATION OF THE CLINICIAN IN CHARGE. STUDENTS SHOULD NOT USE CONSULTATION WITH CLINICIANS WHO HAPPEN TO BE AVAILABLE IN THE AREA AS A REASON TO FOREGO CONTACT WITH THE CLINICIAN IN CHARGE OF THE CASE.