


Name of Policy:	Documentation on the Ambulatory Service Telephone Note	 Effective Date: May, 2008 Initial Effective Date: April, 1993
Policy Number:	3364-101-02-07	
Department:	Ambulatory Services	
Approving Officer:	Administrator, Ambulatory Services & Behavioral Health	
Responsible Agent:	Administrator, Ambulatory Services & Behavioral Health	
Scope:	Ambulatory Services	
<input type="checkbox"/> New policy proposal <input type="checkbox"/> Major revision of existing policy		<input type="checkbox"/> Minor/technical revision of existing policy <input checked="" type="checkbox"/> Reaffirmation of existing policy

(A) Policy Statement

Ambulatory Services personnel will document pertinent patient data at the time of patient telephone contact.

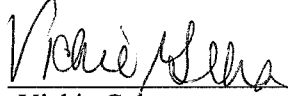
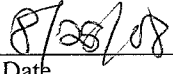
(B) Purpose of Policy

To establish a uniform procedure for documenting telephone calls from patients to Ambulatory Services personnel.

(C) Procedure

1. Ambulatory Services staff are to document on a telephone note all patient advice, assistance or information via the telephone.
2. Telephone notes may become part of the patient's medical record. Documentation shall relate only accurate, pertinent, descriptive and factual information. It shall reflect the following:
 - A. Patient's name, medical record number, date of birth, and/or social security number.
 - B. Date and time of telephone call.
 - C. Name of physician or clinic to whom the call is directed.
 - D. Caller's name and phone number.
 - E. Date of last clinic visit and next clinic visit, if available.
 - F. Message or reason for call, using the patient's words whenever possible.
 - G. Requests for medication refill should include:
 1. Name and phone number of Pharmacy
 2. Name of medication to be refilled
 3. Dose of medication
 4. Route of administration
 5. Directions for use
 - H. Patient instruction, or appointment, if given.
 - I. When physician orders are documented on the telephone note, the telephone note must be signed by the attending staff by the next ambulatory visit, prior to filing in the medical record.
 - J. Signature, date and time by the person taking the call and initiating the telephone note.
3. Entries must be legible and completed in ink. Pencil or felt tipped markers are not acceptable. The telephone note shall be recognized as confidential information.

- 4. Only hospital approved abbreviations are to be used.
- 5. The telephone note will be filed in the permanent medical record after attending physician signature.

Approved by:  _____ Vickie Geha Administrator, Ambulatory Services & Behavioral Health <i>Review/Revision Completed By:</i> <i>Ambulatory Services</i>	 _____ Date	Review/Revision Date: 4/96 10/96 4/99 7/99 1/01 12/04 5/2008
Policies Superseded by This Policy: 2-07		Next Review Date: 5/1/2011

It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.