



INDIAN HEALTH SERVICE

**RESOURCE AND PATIENT MANAGEMENT SYSTEM
RPMS ADP SYSTEMS MANUAL**

Patient Care Component (PCC) Data Entry (APCD)

Mnemonics

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Definition of PCC Data Entry Mnemonics

PCC Data Entry mnemonics are two- to four-character abbreviations for the types of data that are entered into the PCC via the PCC Data Entry system. When a mnemonic is entered, the operator is announcing to the computer that a particular type of data is about to be entered. For example, by entering the mnemonic BP, the computer knows that the data that follows will be a blood pressure entered in the format 140/88.

Use of mnemonics permits the data entry operator to enter data from a variety of PCC forms, and to do so in whatever entry order is easiest or most efficient. Mnemonics eliminate the requirement to "space through" fields on a form that contain no data.

Mnemonics are abbreviations that are usually recognizable for the data items that they represent. For example, WT represents weight, IM represents immunization, PV represents purpose of visit, PRV represents provider, and so on.

Historical Mnemonics

When a mnemonic begins with the letter H, that usually stands for historical data that occurred on a previous visit. For example, HEX represents historical exam, HPAP represents historical PAP smear, HLAB represents historical laboratory data, and so on. When a historical mnemonic is utilized, the PCC Data Entry System temporarily shifts from the date of the visit being entered, and prompts the operator to create a separate visit for the date of the historical event. Following entry of a historical mnemonic and the associated data for that visit, the system shifts back to the visit being entered prior to use of the historical mnemonic.

On-Line Documentation

In addition to the material included in this user's guide, help screens are available on-line. To access these help screens, enter a question mark at the prompt of interest and press the RETURN or ENTER key. If more help is needed, entering two or three question marks at the prompt generates more detailed help screens, when available.

A complete list of the mnemonics can be viewed by typing two question marks and pressing the RETURN or ENTER key at the MNEMONIC prompt.

Entry of Incorrect Mnemonics

If you enter a mnemonic in error, you can often enter the "Up Arrow" by pressing the Shift and 6 Keys simultaneously and then pressing the RETURN or ENTER key. This will usually allow you to exit the erroneous mnemonic and choose the correct one.

However, some mnemonics do not permit use of the "Up Arrow" for exiting. If you determine that entry of the "Up Arrow" will not let you exit that mnemonic, you will need to enter a value to return to the mnemonic prompt and then use the MOD (Modify) mnemonic to delete the data that was entered in error.

Mnemonic Descriptions and Instructions

The PCC data entry mnemonics are presented here in alphabetical order. For each mnemonic, a detailed description and instructions are provided. Also included is a sample computer dialog illustrating the use of the mnemonic.

ADX Admitting Diagnosis

The Admitting Diagnosis mnemonic is used to modify the diagnosis for a hospitalization visit. To use the mnemonic, the visit must be a hospitalization and you must be in Modify mode. As shown in the following example, if you try to use the ADX mnemonic in Enter mode, a warning message displays.

MNEMONIC: ADX	Admitting Diagnosis	ALLOWED	VISIT RELATED ONLY
You must specify MODIFY mode in order to use the Admitting DX mnemonic!			
MNEMONIC: MOD	Switch to Modify Mode	ALLOWED	VISIT RELATED ONLY
Switching to Modify Mode for ONE Mnemonic ONLY!			
MNEMONIC: ADX	Admitting Diagnosis	ALLOWED	VISIT RELATED ONLY
1 2970529	SMITH, BOB	MAY 26, 1997@10:00	
ADMITTING DX: 251.0//	250.00	250.00	DM UNCOMPL/T-II/NIDDM, NS UNCON
...OK? Yes// <RETURN> (Yes)			
Switching back to ENTER Mode!			

AG Abdominal Girth

Abdominal girth is a measurement around the abdominal area that is recorded in centimeters. At the Value prompt, enter the measurement. The value must be in the range 0 to 150.

MNEMONIC: AG	Abdominal Girth	ALLOWED	VISIT RELATED ONLY
VALUE: 50			

AL Appointment Length

The AL mnemonic is utilized to identify the length of appointment when this was a scheduled visit. This information is entered when your site is involved in Waiting Time studies.

MNEMONIC: AL	Appointment Length	ALLOWED	VISIT RELATED ONLY
APPOINTMENT LENGTH: 30			

APO Activate an Inactive Problem

In order to use the APO mnemonic, an active problem must already exist in the patient's problem list. The instructions on the PCC encounter form must specify the exact problem number and indicate that the status of that problem is to be changed from inactive to active.

After entering the APO mnemonic, the patient's active and inactive problems appear on the screen. You will enter the problem number exactly as it appears on the list and the PCC encounter form. The number will consist of a location code and a problem number. A confirmation message displays to indicate that the selected problem has been activated.

MNEMONIC: APO ACTIVATE AN INACTIVE PROBLEM	
***** ACTIVE PROBLEMS AND NOTES *****	
SX1 01/01/89	Hypertension, Well Controlled with Medication
SX1SX1	HCTZ AM DAILY
SX3 01/15/89	Morbid Obesity
***** INACTIVE PROBLEMS AND NOTES *****	
SX2 01/30/89	Pneumonia RSV 3/89
Enter Problem Number: SX2 SAN XAVIER HEALTH CENTER	
TUCSON SELLS TUCSON 11 TUCSON SELLS TUCSON 11	
Activating Problem SX 2. . .	

APPT Appointment Date and Time

This mnemonic is used for entering the patient's appointment date and time. You will be asked for both pieces of information at a single prompt. Enter the date and time using standard RPMS conventions. You can enter the date followed by the "at" sign (@) and the time, as shown in the example. If you enter a time only, the current date is automatically entered. The time is a required response for this mnemonic.

MNEMONIC: APPT	Appointment Date&Time	ALLOWED	VISIT RELATED ONLY
APPT DATE&TIME: MAY 31, 1997@2:30			

AT Activity and Travel Time

The AT mnemonic is primarily used for Public Health Nurses (PHNs) and Community Health Nurses (CHNs) who record their activity and travel times when visiting patients at their homes or outside the health-care facility. Staff from other disciplines may record their activity and travel times as well. The times are entered in minutes and must be in the range of 0 to 9999 with no decimal digits.

MNEMONIC: AT	Activity & Travel Time	ALLOWED	VISIT RELATED ONLY
Enter ACTIVITY TIME (in Minutes): 30			
TRAVEL TIME (in minutes): 15			

AUD Audiometry

This mnemonic is used to record the results of hearing exams, which are typically performed by an audiologist. At the value prompt, you must enter 8 readings for the right ear followed by 8 readings for the left ear. The values should be separated by slash marks (/). Each value must be in the range of 0 to 110.

MNEMONIC: AUD	AUDIOMETRY
VALUE: 100/100/100/95/90/90/85/80/105/105/105/105/100/100/95/90/	

BP Blood Pressure

The blood pressure measurement consists of a systolic (contraction of the heart) and a diastolic (dilatation of the heart) reading. Each of the readings will be recorded on the PCC encounter form and should be entered as indicated on the PCC encounter form and separated by a slash mark (/). The systolic measurement must be between 20 and 275. The diastolic measurement must be between 20 and 200.

MNEMONIC: BP	BLOOD PRESSURE
VALUE: 120/80	

BS Blood Sugar

The BS mnemonic is used to record the ordering of a glucose laboratory test. This mnemonic should be used only if the Laboratory System is not operational at your facility. The BS mnemonic indicates only that the test was ordered. Results are not entered.

MNEMONIC: BS 11 BLOOD SUGAR ORDERED
--

BT Blood Type Entry

This mnemonic allows for the entry of a patient's blood type. The blood type displays on the health summary in the upper right-hand corner of the demographic section. [CHECK THIS ONE] After selecting this mnemonic, enter one of the following blood types:

- A+ • A-
- B+ • B-
- AB+ • AB-
- O+ • O-

MNEMONIC: BT BLOOD TYPE ENTRY
BLOOD TYPE: O+

CBC CBC Ordered

The CBC mnemonic is used for recording that a CBC lab test was ordered for a patient. It is to be used only if the Laboratory package is not operation at your facility. The mnemonic records only that the test was ordered. Results are not entered.

MNEMONIC: CBC CBC Ordered ALLOWED VISIT RELATED ONLY

CHA CHS – Outpatient Form

This mnemonic is used for entering Contract Health Care ambulatory data from the HRSA 64-PO for CHS visits other than hospital or dental. In order to use this mnemonic, you must have selected Contract as the visit type. If you have not, a warning message will appear indicating that you need to change the visit type.

You will be prompted first to enter the authorizing facility. Enter the facility name. Next, enter the authorization number, which is a 10-character number beginning with the two-digit fiscal year followed by the three-digit location code and a five-digit number for the authorization. No hyphens are required. At the Vendor prompt, type the name of the contract service provider. Then enter the number of visits at the next prompt. You will then be prompted for total charges and pay status. Enter the dollar amount, if known, then indicate whether the pay status is full pay or partial pay.

```

MNEMONIC: CHA    CHS - Ambulatory (HRSA 64)    ALLOWED    VISIT RELATED ONLY
Select V CHS AUTHORIZING FACILITY: SELLS HOSPITAL/CLINIC    001 TUCSON SELLS 01
AUTHORIZATION NO.: 9712345678
VENDOR: AFFILIATED CARDIOLOGISTS PA    EIN.....: 1860267899
                                MAIL TO-CITY...: PHOENIX

    NO OF VISITS: 1
TOTAL CHARGES: 150
PAY STATUS: F    FULL PAY

```

Note: After you have finished making entries for the CHA mnemonic, you will still need to enter the provider (PRV) and purpose of visit (PV) to complete this visit record.

CHC Centimeter Head Circumference

The CHC mnemonic allows for the entry of the head circumference measurement in centimeters. Before using this mnemonic, be sure that the provider has indicated centimeters as the unit of measure for head circumference. The entry must be in the range of 26 to 76. Decimals and fractions may be used. The fractional/decimal portion of the entry must be a multiple of 1/8 (0.125).

```

MNEMONIC: CHC    Centimeter Head Circumference    ALLOWED    VISIT RELATED ONLY
VALUE: 35

```

CHH CHS – Hospitalization Form

This mnemonic is used for entering contract health care hospitalization data from the HRSA 43-CHS PO for Hospital Services Rendered. In order to use the CHH mnemonic, you must have selected Contract as the visit type and Hospital as the service category. If you have not, when you enter the CHH mnemonic a warning message will appear indicating that you need to change these values.

You will be prompted first to enter the authorizing facility. Enter the facility name. Next, enter the authorization number, which is a 10-character number beginning with the two-digit fiscal year followed by the three-digit location code and a five-digit number for the authorization. No hyphens are required. At the Vendor prompt, type the name of the contract service provider. Next, enter the date of discharge and the discharge type. For discharge type, you have the following choices:

- | | | | |
|---|----------------------|---|---------------------|
| 1 | Discharged | 4 | Died after 48 Hours |
| 2 | Irregular Discharge | 5 | Transferred |
| 3 | Died within 48 Hours | | |

You will then see the prompts Newborn Diagnosis and Stillborn. Enter data in these fields, if applicable; otherwise, press RETURN to bypass them. Finally, you will then be prompted for total charges and pay status. Enter the dollar amount, if known, then indicate whether the pay status is full pay or partial pay.

MNEMONIC: CHH CHS - Hospitalization HRSA 43 ALLOWED VISIT RELATED ONLY AUTHORIZING FACILITY: SAN XAVIER HEALTH CENTER TUCSON SELLS 11 AUTHORIZATION NO.: 9789463725 VENDOR: UNIVERSITY MEDICAL CENTER DATE OF DISCHARGE: 6/14/97 DISCHARGE TYPE: 1 DISCHARGED NEWBORN DX: <RETURN> STILLBORN: <RETURN> TOTAL CHARGES: 4580 PAY STATUS: F FULL PAY
--

Note: After you have finished making entries for the CHA mnemonic, you will still need to enter the provider (PRV) and purpose of visit (PV) to complete this visit record.

CHI CHS – In-Hospital Form

This mnemonic is used only for entering Contract Health Care in-hospital data from the HRSA 64-PO for CHS Other than Hospital or Dental. To use the CHI mnemonic, you must have selected a visit type of Contract and a service category of In-Hospital. If you have not done so and try to use this mnemonic, a warning message will appear indicating the changes required.

You will be prompted first to enter the authorizing facility. Type the facility name. Next, enter the authorization number, which is a 10-character number beginning with the two-digit fiscal year followed by the three-digit location code and a five-digit number for the authorization. No hyphens are required. At the Vendor prompt, type the name of the contract service provider. Next, enter the hospital voucher number, if any. This response must be 10 to 15 characters in length. At the Number of Visits prompt, enter the appropriate value. Finally, you will be prompted for total charges and pay status. Enter the dollar amount, if known, then indicate whether the pay status is full pay or partial pay.

MNEMONIC: CHI CHS - In-Hospital (HRSA 64) ALLOWED VISIT RELATED ONLY Select V CHS AUTHORIZING FACILITY: SAN XAVIER HEALTH CENTER TUCSON SELLS 11 AUTHORIZATION NO.: 9784637452 VENDOR: UNIVERSITY PHYSICIANS HOSPITAL VOUCHER NO.: <RETURN> NO OF VISITS: 2 TOTAL CHARGES: 300
PAY STATUS: F FULL PAY

Note: After you have finished making entries for the CHI mnemonic, you will still need to enter the provider (PRV) and purpose of visit (PV) to complete this visit record.

CHT Centimeter Height

The CHT mnemonic allows for the entry of the height measurement to be entered in centimeters. Be sure that the provider has indicated on the PCC Encounter form that the measurement has been recorded in centimeters. The entry must be in the range of 10 to 80 centimeters. Decimals or fractions may be used.

MNEMONIC: CHT	Centimeter Height	ALLOWED	VISIT RELATED ONLY
VALUE: 28			

CKO Check Out Date and Time

The CKO mnemonic is used to identify the time that the patient's visit was concluded. This information is entered when your site is involved in Waiting Time studies.

MNEMONIC: CKO	Check Out Date & Time	ALLOWED	VISIT RELATED ONLY
Enter the CHECK OUT DATE: Sep 21, 1998// (SEP 21, 1998)			
Enter CHECK OUT TIME: 233			
Sep 21, 1998@233 (SEP 21, 1998@14:33)			
APPOINTMENT LENGTH: 30//			

CL Clinic Type

To enter the clinic type, use the CL mnemonic. Clinic Type is a required data item for an ambulatory care visit record when the visit type is IHS, 638, or Tribal and the facility (location) code is between 0 and 49. Clinic Type may be entered by code or name. Choose from:

- | | | |
|-------------------------------------|--------------------------|-----------------------|
| • Alcoholism and Substance Abuse 43 | • Follow-Up Letter 53 | • Orthopedic 19 |
| • Audiology 35 | • General 01 | • OTC Medications 78 |
| • Cancer Chemotherapy 62 | • General Preventive 27 | • Other 25 |
| • Cancer Screening 58 | • Genetics 73 | • Pediatric 20 |
| • Cardiac 02 | • Group Services 09 | • Pharmacy 39 |
| • Cast Room 55 | • Gynecology 10 | • PHN Clinic Visit 45 |
| • Chart Review/Record Mod 52 | • High Risk 26 | • Physical Therapy 34 |
| • Chest/Tb 03 | • Home Care 11 | • Plastic Surgery 29 |
| • Chronic Disease 50 | • Hypertension 31 | • Podiatry 65 |
| • Computed Tomography 71 | • Immunization 12 | • Postpartum 32 |
| • Crippled Children 04 | • Indirect 41 | • Radio Call 54 |
| • Day Surgery 44 | • Infant Stimulation 40 | • Radiology 63 |
| • Dental 56 | • Inhalation Therapy 33 | • Rehabilitation 21 |
| • Dental (Third Party) 99 | • Internal Medicine 13 | • Retinopathy 64 |
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- Neurology 37
- NIH Clinic 46
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- Obstetrics 16
- Ophthalmology 17
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- Speech Pathology 74
- Surgical 23
- Telephone Call 51
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- Urology 75
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MNEMONIC: **CL** Clinic Type ALLOWED VISIT RELATED ONLY
 CLINIC: GENERAL// **WELL CHILD** 24
 WAS THIS AN APPOINTMENT OR WALK IN? : WALK IN// W WALK IN

CODE Coding Guidelines Display

The CODE mnemonic displays general coding guidelines for data entry operators. A copy of these guidelines is included in Appendix A of this manual.

CPE CPT Codes with Entry of Encounter Provider

The CPE mnemonic is used to enter CPT codes for a visit including entry of the provider for the encounter. The CPT code can be entered by numerical code, as shown below, or by description. To enter CPT codes without entering the encounter provider, utilize the CPT mnemonic.

MNEMONIC: **CPE** Cpt Entry with Enc Prov ALLOWED VISIT RELATED ONLY
 Enter CPT Code: **10140** DRAINAGE OF HEMATOMA/FLUID
 INCISION AND DRAINAGE OF HEMATOMA, SEROMA OR FLUID COLLECTION
 ...OK? Yes// (Yes)
 QUANTITY: **1**
 EVENT DATE AND TIME: **T@345** (NOV 28, 1998@15:45:00)
 ENCOUNTER PROVIDER: **ACC** CURTIS,CLAYTON ACC
 Enter CPT Code: **<RETURN>**

CPT CPT Codes

CPT codes can be recorded for a visit with the CPT mnemonic. The CPT code can be entered by numerical code, if known, or by description, as shown below.

```
MNEMONIC: CPT
Enter CPT Code: TRANSPLANTATION OF KIDNEY
( KIDNEY/KIDNEYS/KIDNEYSKIN/KIDNEYURETER TRANSPLANTATION/TRANSPLANTATIONS )

The following word was not used in this search:
  OF
...

The following 2 matches were found:

  1: 50360 (50360)
    TRANSPLANTATION OF KIDNEY
      RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; EXCLUDING DONOR AND
      RECIPIENT NEPHRECTOMY
  2: 50365 (50365)
    TRANSPLANTATION OF KIDNEY
      RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; WITH RECIPIENT
      NEPHRECTOMY

Press <RET> or Select 1-2: 1

QUANTITY: 1
Enter CPT Code: <RETURN>
```

CXD Cervix Dilation

To enter the cervix dilatation measurement for a patient, use the CXD mnemonic. The value entered must be in the range 0 to 10.

MNEMONIC: CXD	Cervix Dilatation	ALLOWED	VISIT RELATED ONLY
VALUE: 3			

DDS Dental – Direct Services

This mnemonic should be used to capture dental data only if the IHS Dental Module is not currently operating at your facility. A Purpose of Visit is automatically created as well as the designation of Primary for the provider entered. You will be prompted for the dental service code, quantity, operative site, and tooth surface. If needed, you may view a list of appropriate entries for each of these prompts by typing a question mark and pressing RETURN. **Note:** The help screens are lengthy and may require a great deal of processing time.

```

MNEMONIC:   DDS      Dental Direct Service      ALLOWED      VISIT RELATED ONLY
Select V PROVIDER: BLACK,HAROLD C      DENTIST      IHS      207      152207
Select V DENTAL SERVICE CODE: 2330      COMPOSITE RESIN, ONE SURFACE, ANTERIOR
QUANTITY: 1
OPERATIVE SITE: <RETURN>
TOOTH SURFACE: <RETURN>
Select V DENTAL SERVICE CODE: <RETURN>
Now generating V POV entry!
DENTAL/ORAL HEALTH VISIT
  
```

DHS Display Health Summary

A health summary can be displayed from within the Data Entry system with the DHS mnemonic. The type of health summary that displays is defined in the Site Parameter file. After the health summary displays, the commands at the bottom of the screen are used to browse through the patient information. For more information on health summaries, refer to the Health Summary system user's manual.

```

MNEMONIC: DHS      Data Entry Health Summary      ALLOWED      NON-VISIT/VISIT MNEMONIC
...SORRY, LET ME PUT YOU ON 'HOLD' FOR A SECOND...

OUTPUT BROWSER      Jun 18, 1997 08:07:09      Page:      1 of      9
PCC Health Summary for SMITH,GRANT

***** CONFIDENTIAL PATIENT INFORMATION -- JUN 18,1997 8:07 AM [CC] *****
***** SMITH,GRANT #100243 (ADULT REGULAR SUMMARY) pg 1 *****

----- DEMOGRAPHIC DATA -----
SMITH,GRANT      DOB: JUL 2,1957 39 YRS MALE no blood type
TOHONO O'ODHAM NATION, OF, ARIZON SSN: 007-30-0073
MOTHER'S MAIDEN NAME: MARTIN,MARY ELLEN
(H) 602-555-0073      FATHER'S NAME: SMITH,DOUGLAS
BIG FIELDS (55 5TH ST., SAFFORD,AZ, 88776)

LAST UPDATED: MAR 28,1997      ELIGIBILITY: CHS & DIRECT
HEALTH RECORD NUMBERS: 100241 PHOENIX HOSP
                      100242 HIS IID
                      100243 SELLS HOSPITAL/CLINIC
                      100244 SAN XAVIER HEALTH CENTER
+      Enter ?? for more actions      >>>
+      NEXT SCREEN      -      PREVIOUS SCREEN      Q      QUIT
Select Action: +// <RETURN>
  
```

DISP Visit Display

The DISP mnemonic displays all data that has been entered for a patient for the visit with which you are working. Brief patient demographics display along with the Visit file. Note that historical and non-visit related entries do not display in the active visit file with which you are working. To browse through the information, use the commands listed at the bottom of the screen.

MNEMONIC: DISP	Visit Display	ALLOWED	NON-VISIT/VISIT MNEMONIC
PCC VISIT DISPLAY	Jun 18, 1997 08:22:21	Page:	1 of 3
Patient Name:	REAGAN, BRANDY		
Chart #:	100105		
Date of Birth:	SEP 05, 1949		
Sex:	F		
===== VISIT FILE =====			
VISIT/ADMIT DATE&TIME:	JUN 14, 1997@15:21		
DATE VISIT CREATED:	JUN 18, 1997		
TYPE:	IHS		
PATIENT NAME:	REAGAN, BRANDY		
LOC. OF ENCOUNTER:	SELLS HOSPITAL/CLINIC		
SERVICE CATEGORY:	AMBULATORY		
CLINIC:	GENERAL		
DEPENDENT ENTRY COUNT:	5		
DATE LAST MODIFIED:	JUN 18, 1997		
WALK IN/APPT:	UNSPECIFIED		
CREATED BY USER:	CHVATAL, CHRISTINE		
USER LAST UPDATE:	STEIN, JILLIAN		
+ Enter ?? for more actions			
+ Next Screen	- Previous Screen	Q	Quit
Select Action: +// <RETURN>			

DP Designated Provider

If a patient is assigned a specific designated provider for all visits, this provider's name can be captured with the DP mnemonic. The provider's name will display on the Adult Regular health summary in the Demographics section. DP will rarely be used and should not be confused with the provider entry that is required for all visits. (Note that this mnemonic is the same as the PCP—Primary Care Provider. Only the terminology is different.)

MNEMONIC: DP	Designated Provider	ALLOWED	NON-VISIT/VISIT MNEMONIC
PERSONAL PHYSICIAN: RBW	WIRTH, ROBERT	INTERNAL MEDICINE	IHS RBW 171RBW

DTC Diagnostic Procedure Tran Code (Chargemaster)

The DTC mnemonic is utilized specifically for entry of Chargemaster Transaction Codes for diagnostic procedures. Other Chargemaster Tran Codes that are not for diagnostic procedures are entered utilizing the TC mnemonic. The codes are usually recorded on a special-purpose billing form such as a Superbill. A Chargemaster Transaction File must be loaded at your site in order to make use of this mnemonic.

MNEMONIC: DTC	Diagnostic Procedure Tran Code	ALLOWED	VISIT RELATED ONLY
Enter (DTC) TRANSACTION CODE: 10100330		X-RAY, FOREARM, AP/LAT	
ORDERING DATE: T-1	(NOV 28, 1998)		
ORDERING PROVIDER: ACC	CURTIS, CLAYTON	ACC	

ECOD Append an E-Code to a Purpose of Visit

An E-code can be appended to a purpose of visit using the ECOD mnemonic. The E-code allows a cause of injury to be recorded along with the visit diagnosis. For a visit with more than one purpose of visit, you will need to specify to which one the E-code should be appended. At the Enter E-code prompt, you can type the name or numerical code for entry.

MNEMONIC: ECOD	Append an E-Code to a POV	ALLOWED	VISIT RELATED ONLY
1 821.00	VON BRAUN, DON	JUN 18, 1997@12:00	
Enter E-CODE: E818.0	E818.0	MV TRAFF ACC NEC-DRIVER	
...OK? Yes//	<RETURN>	(Yes)	

ED Edema Measurement

The edema measurement can be entered with the ED mnemonic. The value entered must be one of the following: 0, 1+, 2+, 3+, or 4+.

MNEMONIC: ED	EDEMA Measurement	ALLOWED	VISIT RELATED ONLY
VALUE: 1+			

EDC Expected Date of Confinement

The EDC mnemonic is used for capturing the expected date of confinement. You will be prompted to confirm the patient's name and enter the EDC and the determination method. The choices for determination method are:

- 0 Unknown Method
- 1 Sonogram
- 2 Dates
- 3 Clinical Parameters

MNEMONIC: EDC	Expected Date of Confinement	ALLOWED	NON-VISIT/VISIT MNEMONIC
NAME: SMITH, WHITNEY//	<RETURN>		
EDC: 8/13/97	(AUG 13, 1997)		
HOW EDC DETERMINED: 2	DATES		

EFF Effacement

To record effacement, use the EFF mnemonic. The value entered must be in the range 0 to 100.

MNEMONIC: EFF	Effacement	ALLOWED	VISIT RELATED ONLY
VALUE: 45			

EKG EKG Diagnostic Procedure

EKG procedures can be entered with the EKG mnemonic. Results are recorded at the Value prompt and can be designated only as normal or abnormal.

MNEMONIC: EKG	EKG Diagnostic Procedure	ALLOWED	VISIT RELATED ONLY
VALUE: NORMAL			

EM Evaluation and Management (CPT)

An Evaluation and Management CPT can be captured with the EM mnemonic. You can make an entry by name or numerical code. Note that the code entered must be in the range of 99201 to 99499.

MNEMONIC: EM	Evaluation&Management (CPT)	ALLOWED	VISIT RELATED ONLY
EVALUATION AND MANAGEMENT CODE: 99201	OFFICE/OUTPATIENT VISIT, NEW OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A PROBLEM ...OK? Yes//	<RETURN>	(Yes)

ER Emergency Room Visit Record

Patient data for an emergency room visit can be entered with the ER mnemonic. Before using this mnemonic, you must have selected Emergency as the clinic type. If you have not, you can modify the clinic with the CL mnemonic. Several of the prompts for this mnemonic have limited response choices. These are listed below.

Urgency

E Emergent
U Urgent
N Non Emergent

Means of Arrival

A Ambulance
P Police
POV POV
T Taxi
W Walked
O Other

Entered ER by

A Ambulatory
W Wheelchair
S Stretcher
C Carried

Informant

Free text field up to 30 characters total.

Notified

R Relative
P Police
C Coroner

Disposition of Care

A Admit
T Transfer
D Discharge
O Other

```

MNEMONIC: ER      Emergency Visit Record (EVR)   ALLOWED   VISIT RELATED ONLY
URGENCY (emergent,urgent,non emergent): U  URGENT
MEANS OF ARRIVAL: T  TAXI
ENTERED ER BY: A  AMBULATORY
INFORMANT: MARY MARTINEZ,RN
NOTIFIED: R  RELATIVE
DISPOSITION OF CARE: D  DISCHARGE
DEPARTURE DATE&TIME: T@1230  (JUN 18, 1997@12:30)
LEFT AREA: T@1230  (JUN 18, 1997@12:30)

```

EX Examinations

The EX mnemonic provides a means for recording a type of exam that was performed during a patient visit. The specific results of the exam are not recorded, but a choice of Normal or Abnormal may be entered. Some of the exam types are reported on the health summary in the Health Maintenance Reminders component, along with the date on which the exam was performed and a due date for the next exam. The following exam types are available:

- Abdomen Exam 09
- Audiometric Screening 23
- Audiometric Threshold 24
- Breast Exam 06
- Chest Exam 07
- Dental Exam
- Diabetic Exam 22
- Diabetic Eye Exam 03
- Diabetic Foot Check 29
- Diabetic Foot Exam, Complete 28
- Ear Exam 02
- Eye Muscle Balance Exam 18
- General Development Exam 16
- General Exam 01
- Hearing Exam 17
- Heart Exam 08
- Hernia Exam 10
- Mouth Exam 04
- Neck Exam 05
- Neurological Exam 11
- Ortho Exam 12
- Oto Exam 21
- Pelvic Exam 15
- Rectal Exam 14
- Scoliosis Screening 27
- Sex Development Exam 20
- Tonometry 26
- Tympanogram 25
- Vision Exam 19

```

MNEMONIC: EX      Examinations   ALLOWED   VISIT RELATED ONLY
Enter EXAM Type: VISION EXAM   19
RESULT: N  NORMAL

```

FH Fundal Height

The FH mnemonic is used for entering the Fundal Height measurement. This measurement is recorded in centimeters and must be in the range 0 to 100. Note that when you enter the FH mnemonic, you will always be prompted to choose between FH and FHX, as shown below.

MNEMONIC: FH				
1	FH	Fundal Height	ALLOWED	VISIT RELATED ONLY
2	FHX	Family History	ALLOWED	NON-VISIT/VISIT MNEMONIC
CHOOSE 1-2: 1				
VALUE: 15				

FHX Family History

Medical data concerning family members that may be pertinent to the patient's health care can be entered into the patient's record with the FHX mnemonic. Because the ICD-9 diagnostic lookup coding system is invoked, historical surgical procedures of family members cannot be captured.

MNEMONIC: FHX	Family History	ALLOWED	NON-VISIT/VISIT MNEMONIC
***** FAMILY HISTORY *****			
04/12/95 DIABETES MELLITUS			
Enter FAMILY HISTORY Diagnosis: HYPERTENSION			
401.9 (HYPERTENSION NOS)			
UNSPECIFIED ESSENTIAL HYPERTENSION			
OK? Y// <RETURN>			
PROVIDER NARRATIVE: HYPERTENSION			

FL Flag Field

The FL mnemonic is used for entering a numeric code between 1 and 99 into a special Flag Field in the PCC Visit Record for keeping track of locally relevant data. For example, a facility might designate special areas within their outpatient clinic for which they wish to gather workload data. These special clinic areas can be identified on each visit by an entry into the Flag Field of the Visit Record.

MNEMONIC: FL	Flag Field	ALLOWED	VISIT RELATED ONLY
FLAG: 5			

FM Family Planning Method

The FM mnemonic is used for entering the family planning method only. To enter additional female reproductive factors, use the FP mnemonic. You will be prompted to confirm the patient's name then enter the contraception method and date begun, if known. For a list of methods that can be entered, see the description of the FP mnemonic that follows.

MNEMONIC: **FM** Family Planning Method ALLOWED NON-VISIT/VISIT MNEMONIC
 NAME: MILLER, ANITA// <RETURN>
 CONTRACEPTION METHOD: **11** HORMONE INJECTION
 CONTRACEPTION BEGUN: **JAN 1995** (JAN 1995)

FP Family Planning

Female reproductive factors and family planning data can be captured at the same time with the FP mnemonic. The reproductive factors include Last Menstrual Period (LMP), Family Planning (FP) Method, and Date Begun for that method.

The reproductive history is entered as one whole piece of data consisting of Gravidity (G), Parity (P), Living Children (LC), Spontaneous Abortions (SA), and Therapeutic Abortions (TA); for example, G5P3LC1SA1TA1. Caution should be used when entering this data as an incomplete entry would overlay a previously complete one.

When entering the type of contraception currently used, choose from the list below. You can enter the choice by code or name.

0	Education Only	6	Natural Techniques
1	Oral Contraceptives	7	Menopause
2	Intrauterine Device	8	None
3	Surgical Sterilization	9	Other
4	Barrier Methods	10	Hormonal Implant
5	Partner Sterilized	11	Hormone Injection

The EDC and EDC Determined prompts may be bypassed by pressing the RETURN key, as needed. If entering data into these fields, type a date at the EDC prompt and then select one of the following choices for entry in the How EDC Determined field:

0	Unknown Method	2	Dates
1	Sonogram	3	Clinical Parameters

```

MNEMONIC: FP           Family Planning      ALLOWED      NON-VISIT/VISIT MNEMONIC
NAME: FLINTSTONE,CLAUDIA// <RETURN>
REPRODUCTIVE HISTORY: G5P3LC1SA1TA1
LAST MENSTRUAL PERIOD: 6/1/97 (JUN 01, 1997)
CONTRACEPTION METHOD: 1 ORAL CONTRACEPTIVES
CONTRACEPTION BEGUN: 6/1/95 (JUN 01, 1995)
EDC: <RETURN>
HOW EDC DETERMINED: <RETURN>

```

FS Future Scheduled Encounter

From within the Data Entry system, you can enter a future appointment date and time along with the provider, priority, and reason for appointment.

```

MNEMONIC: FS Future Scheduled Encounter ALLOWED NON-VISIT/VISIT MNEMONIC
Select SCHEDULED ENCOUNTER DATE/TIME NEXT VISIT: 12/12/97@130
DEC 12,1997@13:30
PRIORITY: R ROUTINE
SCHED BY PROVIDER: JAS SMITH,JOE PHYSICIAN IHS JAS 100JAS
SCHED FOR FACILITY: SAN XAVIER HEALTH CENTER TUCSON SELLS 11
SCHED FOR PROVIDER: YOUNGERMAN,JOE PHYSICIAN IHS 013 100013
NARRATIVE: FOLLOW-UP WOMEN'S CLINIC VISIT

```

Note: It is recommended that you use the Scheduling package for entering this information.

FT Fetal Heart Tones

Fetal Heart Tones is a measurement of the fetal heart rate per minute. This measurement is usually found on a prenatal encounter form. The value for this measurement must be in the range of 0 to 400.

```

MNEMONIC: FT           Fetal Heart Tones      ALLOWED      VISIT RELATED ONLY
VALUE: 90

```

GP Eyeglass Prescription

Eyeglass prescription data is entered with this mnemonic. The data includes measurements for the sphere, cylinder, axis, and eyeglass frame as well as the papillary distance in the eye. If eyeglass prescription data is entered at your facility, each prescription must contain at least a sphere, cylinder, and axis reading. The form will record the prescription for the right eye first with the reading for left eye directly below it. An example of a complete prescription follows:

	Sphere		Cylinder	Axis
RX)	+1.25	-2.50	X5	for the right eye
	+1.50	-3.50	X175	for the left eye
Frame Consensus BLSL 50/22/5-1/4				
Add)	+1.00	+0.50	(This is a trifocal reading	
	-0.75	-0.30	and will not be entered.)	
			P.D.	6059

Sphere: The words *plano* and *sphere* are sometimes entered as a measurement. The word *plano* is the only word acceptable for coding in the eyeglass prescription. If the word *sphere* is used, press RETURN at the appropriate field.

Axis: The axis measurement consists of three digits. When entering the value, disregard the any leading zeroes and the X before the digits.

Add: There may also be a section of measurements that are prefaced with the word *Add*.

Frame Measurements: The frame measurements may also be recorded on the encounter form identifying the style and color of the frame to be used. These measurements are usually recorded as 50/22/5-1/4, representing the eye, bridge, and temple sizes of the frame for the glasses. The eye and bridge measurements are entered in millimeters and should be recorded as such; the temple size is entered in inches or press RETURN if no measurements have been recorded. If the temple measurement has been recorded in millimeters, it must be converted to inches by dividing the last three digits by 25.4; e.g., 50/22/140 (140 divided by 25.4 = 5.50).

The following parameters apply to the prompts that appear when using the GP mnemonic:

- Sphere: A number between -28.00 and +16.00, include the + or – or plano
- Cylinder: A number between -9.50 and +9.50
- Axis: A whole number between 0 and 180
- Prism: A number between .25 and 50 followed by a prism base direction—BU (base up), BD (base down), BI, or BO.
- Reading Add: A number between .74 and 9.99 (decimal point required)
- Pup. Dist.: A whole number between 40 and 80

MNEMONIC: GP	Eyeglass Prescription	ALLOWED	VISIT RELATED ONLY
READING ONLY: NO			
DRE SPHERE: +1.25			
DRE CYLINDER: -2.50			
DRE AXIS: 5			
DLE SPHERE: +1.50			
DLE CYLINDER: -3.50			
DLE AXIS: 175			
READING ADD. R: 1.00			
READING ADD. L: .75			
EYE SIZE: 50			
BRIDGE: 22			
TEMPLE: 5.25			
PUP. DIST. NEAR: 60			
PUP. DIST. FAR: 59			

GWT Gram Weight

The GWT mnemonic allows a patient's weight to be entered in grams. Be sure that the provider has specified grams as the unit of measure on the encounter form before using this mnemonic. The value entered must be in the range 1000 to 340000. Fractions and decimals are allowed.

MNEMONIC: GWT	Gram Weight	ALLOWED	VISIT RELATED ONLY
VALUE: 15000			

HBS Historical Blood Sugar Entry

This mnemonic allows for the recording of a past blood sugar test. The mnemonic records only that the test was performed on the date specified. Test results are not captured. The location of the test may be recorded also. The information entered will be included in the patient's V Lab file.

MNEMONIC: HBS	Historical Blood Sugar Entry	ALLOWED	NON-VISIT/VISIT	MNEMONIC
Enter Date of Historical Blood Sugar: 5/1/96 (MAY 01, 1996@12:00)				
TYPE: 0// <RETURN>				
LOC. OF ENCOUNTER: 000199	SELLS UNDES	TUCSON	SELLS	99
OUTSIDE LOCATION: <RETURN>				
Updating V Lab file...				

HC Head Circumference

The HC mnemonic allows for the entry of the head circumference measurement to be entered. The value is entered in inches and must be in the range 10 to 30. Decimals and fractions may be used and must be a multiple of 1/8.

MNEMONIC: HC VALUE: 15

HCBC Historical CBC Entry

The HCBC is used for entering historical CBC laboratory tests for a patient. No results are recorded—only that the patient had the lab test and the approximate date of the test.

MNEMONIC: HCBC Historical CBC Entry ALLOWED NON-VISIT/VISIT MNEMONIC Enter Date of Historical CBC: JAN 1997 (JAN 01, 1997@12:00) TYPE: 0// <RETURN> OTHER LOC. OF ENCOUNTER: 000198 SELLS OTHER TUCSON SELLS 98 OUTSIDE LOCATION: <RETURN> Updating V Lab file...
--

HCT Hematocrit Ordered

Hematocrit is a laboratory test and should only be entered using the Data Entry system if the Laboratory package is not in use at your site. If the Laboratory package is not in use, the HCT mnemonic can be used to record that a hematocrit test was ordered. Results of the test are not captured.

MNEMONIC: HCT 20 Hematocrit Ordered ALLOWED VISIT RELATED ONLY

HE Hearing

This mnemonic allows hearing test results to be entered. The value can be recorded only as normal (N) or abnormal (A).

MNEMONIC: HE VALUE: N
--

HEKG Historical EKG

Historical EKG procedures can be entered with the HEKG mnemonic.

```

MNEMONIC: HEKG           Historical EKG      ALLOWED      NON-VISIT/VISIT MNEMONIC
Enter Date of Historical EKG:  JUNE 1996  (JUN 01, 1996@12:00)
TYPE: 0// <RETURN>  OTHER
LOC. OF ENCOUNTER: 000199           SELLS UNDES      TUCSON      SELLS      99
OUTSIDE LOCATION: TUCSON MEDICAL CENTER
Updating V Diagnostic Procedure file...

VALUE: NORMAL

```

HEX Historical Examination

To record past examinations for a patient, the HEX mnemonic can be used. Various types of examinations can be entered. If a visit does not exist for the date specified for the exam, a visit will be created. A list of exam types appears on page 15.

```

MNEMONIC: HEX           Historical Examination  ALLOWED      NON-VISIT/VISIT MNEMONIC
Enter Date of Historical Exam:  2/1/95  (FEB 01, 1995@12:00)
TYPE: 0// <RETURN>  OTHER
LOC. OF ENCOUNTER: SAN XAVIER HEALTH CENTER           TUCSON      SELLS      11
Enter EXAM Type: VISION EXAM                        19
RESULT: A  ABNORMAL
Enter EXAM Type: <RETURN>

```

HF Health Factors

Various factors that have an impact on a patient's health can be recorded in the patient's record. The HF mnemonic allows you to enter these factors, which are displayed on the Adult Regular health summary. The level/severity, quantity, and provider can also be entered, as applicable.

The health factors that can be entered are:

- CAGE ¼
- CAGE 2/4
- CAGE ¾
- CAGE 4/4
- High Tolerance
- Low Tolerance
- Medium Tolerance
- Cessation-Smokeless
- Cessation-Smoker
- Current Smokeless
- Current Smoker
- Non-Tobacco User
- Previous Smokeless
- Previous Smoker
- Smoker In Home
- TB - TX Complete
- TB - TX Incomplete
- TB - TX Unknown
- TB - TX Untreated

The choices for the Level/Severity prompt are:

M Minimal
MO Moderate
H Heavy/Severe

MNEMONIC: HF	Health Factors	ALLOWED	VISIT RELATED ONLY		
Enter HEALTH FACTOR: CURRENT SMOKER					
LEVEL/SEVERITY: M MINIMAL					
PROVIDER: JAS	SANCHEZ, JOELLE	PHYSICIAN	IHS	JAS	100JAS
QUANTITY: 2					
Adding Health Status Entry.					

HHCT Historical Hematocrit

The HCT mnemonic allows for the entry of a hematocrit test that was performed in the past. This mnemonic records only that the test was performed, not the test results. The date that the test was performed as well as the location may be recorded. This data is recorded in the patient's V Lab file.

MNEMONIC: HHCT	Historical Hematocrit (HCT)	ALLOWED	NON-VISIT/VISIT MNEMONIC		
Enter Date of Historical Hematocrit (HCT): 5/15/96 (MAY 15, 1996@12:00)					
TYPE: 0// I IHS					
LOC. OF ENCOUNTER: SAN XAVIER	HEALTH CENTER	TUCSON	SELLS	11	
Updating V Lab file...					

HIM Historical Immunizations

A patient's immunization record may be updated by using the HI mnemonic to record past immunizations not previously recorded or immunizations administered at another facility. An Event visit for the immunization date entered is automatically created if no visit exists for that date. The patient's immunization history is displayed, which allows the operator to verify the data and avoid duplicate entries. The following items are required entries and must be identified when using this mnemonic: Date of Immunization (the month and year if the exact date is not available), Immunization Type, Series (for OPV and DPT), and the name of the facility where the immunization was administered, if known. To modify or correct a historical immunization, you will need to switch to Modify (MOD) mode and then use the IM mnemonic.

MNEMONIC: HIM	Historical Immunization	ALLOWED	NON-VISIT/VISIT MNEMONIC		
Immunization Record					
TD-ADULT	2	01/02/95	SELLS	HOSPITAL/CLINIC	
INFLUENZA		11/02/88	SELLS	HOSPITAL/CLINIC	
		12/24/86	SELLS	HOSPITAL/CLINIC	
PNEUMO-VAC		03/27/97	SELLS	HOSPITAL/CLINIC	

```

Enter Date of Historical Immunization: 5/1/96 (MAY 01, 1996@12:00)
TYPE: 0// I IHS
LOC. OF ENCOUNTER: SELLS HOSPITAL/CLINIC      001      TUCSON      SELLS      01
Enter IMMUNIZATION Type: MMR MEASLES,MUMPS,RUBELLA (MMR)      MMR      17
      SERIES: 1 SERIES 1
Enter IMMUNIZATION Type: <RETURN>

```

HL Hospital Location

To specify the location within a hospital where a visit occurred, the HL mnemonic can be used. The list of choices available is locally defined and maintained.

```

MNEMONIC: HL      Hospital Location      ALLOWED      VISIT RELATED ONLY
HOSPITAL LOCATION: PEDIATRICS

```

HLAB Historical Lab Test

Any historical lab test can be recorded for a patient with the HLAB mnemonic. The date of the test, test type, location given, results, and site may be recorded, if known. If the exact date is not known, the year is required as a minimum entry.

```

MNEMONIC: HLAB      Historical Lab Test      ALLOWED      NON-VISIT/VISIT MNEMONIC
Enter Date of Historical Lab Test: 4/1/96 (APR 01, 1996@12:00)
TYPE: 0// <RETURN> OTHER
LOC. OF ENCOUNTER: 000199      SELLS UNDES      TUCSON      SELLS      99
OUTSIDE LOCATION: <RETURN>
Enter LAB TEST Type: CREATININE
      1 CREATININE
      2 CREATININE CLEARANCE
      3 CREATININE, FLUID
CHOOSE 1-3: 1
RESULTS: <RETURN>
SITE: <RETURN>
Enter LAB TEST Type: <RETURN>

```

HLST Health Status

Factors that affect a patient's health can be entered with the HLST mnemonic. The factors that have already been entered for the patient display for reference prior to entry of new items. For a list of the items that can be entered, refer to the HF–Health Factors mnemonic description. The HF mnemonic is identical to the HLST mnemonic—only the terminology is different.

```

MNEMONIC: HLST      Health Status      ALLOWED      NON-VISIT/VISIT MNEMONIC
*****PCC HEALTH FACTORS*****

-- TOBACCO --
05/23/95  CURRENT SMOKER (MINIMAL)

Select HEALTH STATUS HEALTH FACTOR: TB - TX COMPLETE
DATE NOTED: T  (JUN 19, 1997)
LEVEL/SEVERITY: <RETURN>
QUANTITY: <RETURN>

```

HMSR Historical Measurement

Historical measurements can be added with the HMSR mnemonic. Keep in mind that when entering measurements, once you have specified the measurement type, the value is a required response and must be entered before you can continue. The date is also a required response, but if the exact date is unknown, the month and year or year only can be entered. For a list of the measurement types, refer to the description of the MEAS mnemonic.

```

MNEMONIC: HMSR      Historical Measurement  ALLOWED      NON-VISIT/VISIT MNEMONIC
Enter Date of Historical Measurement: JAN 1997  (JAN 01, 1997@12:00)
TYPE: 0// <RETURN>  OTHER
LOC. OF ENCOUNTER: 000199      SELLS UNDES  TUCSON      SELLS      99
OUTSIDE LOCATION: UNIVERSITY MEDICAL CENTER
Enter MEASUREMENT Type: BP      BLOOD PRESSURE
VALUE: 120/80
Enter MEASUREMENT Type: <RETURN>

```

HPAP Historical Pap Smear

This mnemonic allows for the entry of a pap smear that was performed on a previous date. Unlike other mnemonics used for entering historical data, the HPAP mnemonic records that a pap smear was performed and allows results to be entered into a free-text field. The date and location may also be recorded. The information is entered into a patient's V Lab File.

```

MNEMONIC: HPAP   Historical PAP Smear   ALLOWED   NON-VISIT/VISIT MNEMONIC

                        PAP SMEAR RESULTS

Patient Name: FLINTSTONE,DIANE      Patient Age:   28.6 years

      Date/Time of Visit              Pap Smear Result
      -----
      APR 02, 1996@12:00              WNL

Enter Date of Historical Pap Smear: 1/1/97 (JAN 01, 1997@12:00)
TYPE: 0// I IHS
LOC. OF ENCOUNTER: WHITE RIVER          ABERDEEN   ROSEBUD   61
OUTSIDE LOCATION: <RETURN>
Updating V Lab file...

RESULTS: WNL

```

HRAD Historical Radiology

The HRAD mnemonic is used for entering historical radiology procedures. The date, location, and impression as well whether the result is normal or abnormal can be recorded. At the Date field, at least the year must be entered if the exact date is unknown.

```

MNEMONIC: HRAD Historical Radiology Procedure ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical Radiology Procedure: 2/15/97 (FEB 15, 1997@12:00)
TYPE: 0// <RETURN> OTHER
LOC. OF ENCOUNTER: 000199          SELLS UNDES   TUCSON   SELLS       99
OUTSIDE LOCATION: ST MARY'S HOSPITAL
Enter RADIOLOGY PROCEDURE Type: ANKLE 2 VIEWS          (Detailed) CPT:73600
IMPRESSION: <RETURN>
ABNORMAL: A ABNORMAL
Enter RADIOLOGY PROCEDURE Type: <RETURN>

```

HRX Historical RX

The HRX mnemonic is utilized to enter a medication prescribed or dispensed on a date prior to the date of the visit being processed. The medication may have been prescribed and dispensed at your facility but not entered into the computer at that time, or it may have been prescribed and dispensed by an outside provider and pharmacy.

```

MNEMONIC: HRX           Historical RX           ALLOWED           NON-VISIT/VISIT MNEMONIC
Enter Date of Historical RX: T-7 (NOV 22, 1998@12:00)
  TYPE: I// IHS
  LOC. OF ENCOUNTER: SELLS HOSPITAL                TUCSON                SELLS    01

Enter the DRUG Name, if you CANNOT find an exact match in the DRUG File
Choose 'OUTSIDE DRUG' as the drug name and you will be prompted to enter the
text of the drug name later.
If OUTSIDE DRUG is not in your Drug table, it can be added by your site
manager.

Enter DRUG Name: OUTSIDE DRUG
  NAME OF NON-TABLE DRUG: MODURETIC 25MG TAB
  SIG: T1TD AT BEDTIME
  QUANTITY: 90
  DAYS PRESCRIBED: 90
  DATE DISCONTINUED:
  DATE DISPENSED (IF KNOWN): T-7
  OUTSIDE PROVIDER NAME: DR. JOHNSON

```

HS Historical Skin Test

To enter a skin test that was performed on a previous visit or at another facility, use the HS mnemonic. In addition to the date of the test and the location where it was performed, the reading/result may be entered. An "Event" visit file for the skin test read date is automatically created if there is no existing visit for that date. The following items are required: Date of skin test(s) reading, skin test type, e.g., PPD, Cocci, etc., readings and/or result, and the facility name where the skin test was read, if known. To modify or correct a historical skin test, select the option MOD-MODIFY DATA and use the ST mnemonic. Like the Immunization record, the system will display the patient's skin test history, which should be verified by the Operator to avoid duplication of entry.

```

MNEMONIC: HS           Historical Skin Test           ALLOWED           NON-VISIT/VISIT MNEMONIC
                               Skin Test Record
RUBBLE, MARCIA                Aug 29 1946 (51 Years)                FEMALE

  Date          Skin Test          Reading          Result          Date Read
  -----
0 Apr 15 1987          PPD 2          0
Press 'RETURN' To Continue: <RETURN>
Enter Date of Historical Skin Test: 3/14/96 (MAR 14, 1996@12:00)
  TYPE: O// I IHS
  LOC. OF ENCOUNTER: YAQUI HEALTH CENTER                TUCSON TRIBE/638    YAQUI    10
Enter SKIN TEST Type: COCCI

```

```

READING: 3
RESULTS: N  NEGATIVE
DATE READ: 3/30/96  (MAR 30, 1996)
Enter SKIN TEST Type: <RETURN>

```

HT Height

The height measurement in inches is entered with the HT mnemonic. The value must be in the range of 10 to 90. Fractions and decimals are allowed.

```

MNEMONIC: HT           Height in Inches      ALLOWED      VISIT RELATED ONLY
VALUE: 69

```

HUA Historical UA

The HUA mnemonic allows for a urinalysis test that was performed on a previous date to be recorded for a patient. Results are not captured, only that the test was given on a particular date. The location may be recorded also.

```

MNEMONIC: HUA      Historical UA entry      ALLOWED      NON-VISIT/VISIT MNEMONIC
Enter Date of Historical UA: 1/1/97  (JAN 01, 1997@12:00)
TYPE: 0// C  CONTRACT
LOC. OF ENCOUNTER: UNIVERSITY HOSPITAL              TUCSON      SELLS      96
OUTSIDE LOCATION: UA HOSPITAL
Updating V Lab file...

```

IM Immunizations

Use the IM mnemonic for entering immunizations that were given during a patient's visit and recorded on the Encounter form.

```

MNEMONIC: IM           Immunizations      ALLOWED      VISIT RELATED ONLY
Enter IMMUNIZATION Given: OPV  SABIN TRIVALENT (OPV)              OPV      06
SERIES: 1  SERIES 1
LOT: <RETURN>

```

IOP ICD Operation Narrative

This mnemonic allows the standard ICD-9 code operation narrative to be automatically entered for the provider narrative. The operator does not have to re-type the narrative, thereby saving data entry time. Caution is advised as provider narratives should always be entered exactly as the provider recorded them on the Encounter Form.

MNEMONIC: **IOP** ICD Operation Narrative ALLOWED VISIT RELATED ONLY

This is the MNEMONIC which will automatically stuff the ICD Operation Narrative into the Provider Narrative field!

Enter CPT CODE: **12011** REPAIR SUPERFICIAL WOUND(S)
 SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE,
 LIPS AND/OR MUCOUS MEMBRANES; 2.5 CM OR LESS
 ...OK? Yes// **<RETURN>** (Yes) SKIN SUTURE NEC *****ICD*****
 OPERATING PROVIDER: JAS SMITH, JOHN PHYSICIAN IHS JAS 100JAS
 DIAGNOSIS: **873.50** 873.50 OPEN WND FACE NOS-COMPL
 ...OK? Yes// **<RETURN>** (Yes)
 ANESTHESIA ADMINISTERED: **Y** YES
 ASA-PS CLASS: **<RETURN>**

IP Inpatient

This mnemonic is used for entering data from IHS form HRSA 44-1 Clinical Record Brief-IHS Inpatient Services.

Admission Type

- Direct Admission 1
- Trans-Non IHS Hospital Admission 2
- Trans-IHS Hospital Admission 3
- Referred From IHS Clinic Admission 4
- Other Admission 5

Admitting Service/Discharge Service

- Alcoholism 15
- Dental 01
- ENT 02
- Family Practice 17
- General Medicine 03
- Gynecology 05
- Internal Medicine 06
- Mental Health 12
- Newborn 07
- Obstetrics 08
- Ophthalmology 09
- Orthopedics 10
- Other 14
- Pediatrics 11
- Plastic Surgery 16
- Podiatry 19
- Surgery 04
- TB 13
- Urology 18

Discharge Type

- Regular Discharge 1
- Transferred 2
- Irregular Discharge 3
- Death w/in 48 Hrs w/ Autopsy 4
- Death W/I 48 Hrs w/o Autopsy 5
- Death After 48 Hrs w/ Autopsy 6
- Death After 48 Hrs w/o Autopsy 7
- Irregular (AMA) 3

MNEMONIC: IP

1	IP	Hospitalization Information	ALLOWED	VISIT RELATED ONLY
2	IPO	Inactivate a Problem	ALLOWED	NON-VISIT/VISIT MNEMONIC
3	IPV	ICD Narrative Purpose of Visit	ALLOWED	VISIT RELATED ONLY

CHOOSE 1-3: **1**Enter Date of Discharge: **T-1** (JUN 11, 1997) JUN 11, 1997ADMISSION TYPE: **1** DIRECT ADMISSION 1ADMITTING SERVICE: **INTERNAL MEDICINE** 06DISCHARGE TYPE: **REGULAR DISCHARGE** DISCHARGE 1NUMBER OF CONSULTS: **3**ADMITTING DX: **DIABETIC NEPHRITIS**(DIABETIC|DIABETES NEPHRITIS)

.

583.81 (NEPHRITIS NOS IN OTH DIS)

NEPHRITIS AND NEPHROPATHY, NOT SPECIFIED AS ACUTE OR CHRONIC, IN DISEASES CLASSIFIED ELSEWHERE

OK? Y// <RETURN>

Note: After you have finished making entries for the IP mnemonic, you will still need to enter the provider (PRV) and purpose of visit (PV) to complete this visit record.

IPO Inactivate Problem

An operator can change the status of a problem from Active to Inactive using the IPO mnemonic. The patient's problem list displays on the screen for the operator to verify the correct problem number.

```

MNEMONIC: IPO      Inactivate a Problem      ALLOWED      NON-VISIT/VISIT MNEMONIC

***** ACTIVE PROBLEMS AND NOTES *****

SE1      03/15/97  PNEUMONIA RSV
SE2      05/21/97  DIABETES MELLITUS
SE2SE1   06/30/97  CONTROLLED WITH LIFESTYLE MODIFICATIONS

***** No INACTIVE Problems on file for this Patient

Enter Problem Number: SE1

Inactivating Problem SE1 ...

```

IPV ICD Narrative Purpose of Visit

This mnemonic is an alternative to using the PV Purpose of Visit mnemonic. It allows the standard ICD-9 code narrative to automatically be entered for the provider narrative also. The operator does not have to re-type the narrative thereby saving data entry time. Caution is advised as provider narratives should always be entered exactly as the provider stated on the form.

```

MNEMONIC: IP

This is the MNEMONIC that automatically stuffs the ICD Narrative in the
Provider Narrative field!!

Enter PURPOSE of VISIT: DIABETES MELLITUS

250.00 (DM UNCOMPL/T-II/NIDDM, NS UNCON)
DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION/TYPE II/NON-INSULIN
DEPENDENT/ADULT-ONSET, OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
  OK? Y// <RETURN>
  DM UNCOMPL/T-II/NIDDM, NS UNCON      *****ICD*****
  CAUSE OF DX: <RETURN>
Enter PURPOSE of VISIT: <RETURN>

```

KWT Kilogram Weight

This mnemonic allows a patient's weight to be entered in kilograms. Before using the KWT mnemonic, be sure that the provider has indicated kilograms as the unit of measure for the patient's weight. The value entered must be in the range of 1 to 340. Fractions and decimals are allowed.

```

MNEMONIC: KWT      Kilogram Weight      ALLOWED      VISIT RELATED ONLY
VALUE: 125

```

LAB Lab Test Entry

Lab tests and results can be entered from within the Data Entry system. However, lab tests should only be entered with this mnemonic if the Laboratory system is not being used at your facility. If using this mnemonic, it is recommended that lab personnel enter the lab tests to ensure accurate entry of results.

MNEMONIC: LAB Lab Test ALLOWED VISIT RELATED ONLY Enter LAB TEST: CREATININE 1 CREATININE 2 CREATININE CLEARANCE 3 CREATININE, FLUID CHOOSE 1-3: 1 RESULTS: <RETURN> ABNORMAL: N SITE: <RETURN> Enter LAB TEST: <RETURN>

LMP Last Menstrual Period

The LMP mnemonic is used for recording the date of a female patient's last menstrual period. You will be prompted to confirm the patient's name then enter the date.

MNEMONIC: LMP Last Menstrual Period ALLOWED NON-VISIT/VISIT MNEMONIC NAME: SMITH, TESS// <RETURN> LAST MENSTRUAL PERIOD: 6/12/97 (JUN 12, 1997)
--

LS Level of Service

The LS mnemonic is used to enter data checked in the Level of Service box in the lower right hand area of the PCC Ambulatory Encounter Form. The choice of entries consists of: Brief, Limited, Intermediate, Extended, and Comprehensive. NOTE: With Data Entry Version 2.0, most facilities will begin entering the Evaluation and Management CPT code for each visit. When the Evaluation and Management CPT code is entered, there is no need to use the LS mnemonic to enter Level of Service.

MNEMONIC: LS Level of Service ALLOWED VISIT RELATED ONLY LEVEL OF SERVICE (PCC FORM): INTER INTERMEDIATE

MEAS Measurement Entry

Any measurement can be entered with the MEAS mnemonic. You will be prompted for the measurement type and value. The value is a required field and must be completed before you can continue.

The measurement types are:

AG	Abdominal Girth	HT	Height
AUD	Audiometry	PR	Presentation
BP	Blood Pressure	PU	Pulse
CXD	Cervix Dilatation	RS	Respiration
ED	Edema	STN	Station (Pregnancy)
EFF	Effacement	TMP	Temperature
FH	Fundal Height	TON	Tonometry
FT	Fetal Heart Tones	VC	Vision Corrected
HC	Head Circumference	VU	Vision Uncorrected
HE	Hearing	WT	Weight

MNEMONIC: MEAS Measurement Entry ALLOWED VISIT RELATED ONLY Select V MEASUREMENT TYPE: BP BLOOD PRESSURE VALUE: 120/80
--

MNN Modify Note Narrative

The MNN mnemonic allows the operator to make changes to the narrative portion of a note. Before using this mnemonic, the problem number that corresponds to the note must be clearly identified on the Encounter Form.

MNEMONIC: MNN Change Note Narrative ALLOWED NON-VISIT/VISIT MNEMONIC ***** ACTIVE PROBLEMS AND NOTES ***** SE1 05/02/86 ETOH SE2 04/12/95 RHEUMATOID ARTHRITIS SE2SE1 06/12/97 PT REFERRED TO PHYSICAL THERAPY SE2SE2 06/12/97 BEGAN MTX 6/1/97 SE3 11/13/86 HYPERTENSION ***** No INACTIVE Problems on file for this Patient Enter Problem Number: SE2 Select NOTE FACILITY: SELLS HOSPITAL/CLINIC// <RETURN> Select NOTE NMBR: 2// 2 PT REFERRED TO PHYSICAL THERAPY NOTE NARRATIVE: PT REFERRED TO PHYSICAL THERAPY// PHYSICAL THERAPY 3X/WK STATUS: A ACTIVE Select NOTE FACILITY: <RETURN>

MOD Switch to Modify Mode

When entering data with mnemonics, you may have a need to change one of the entries that you have made. To do so, you will need to use the MOD mnemonic to switch from Enter mode to Modify mode. Note that if you try to use the mnemonic that requires modification prior to selecting MOD for switching to Modify mode, you will not be able to correct the error. Instead, you may be entering new data or overwriting previously entered data. You can only switch to Modify for one mnemonic. To modify data for another mnemonic, you will need to use the MOD mnemonic again. A warning message indicates when you are switching between Enter and Modify modes, as shown in the following sample.

```

MNEMONIC:  MOD      Switch to Modify Mode      ALLOWED      VISIT RELATED ONLY

Switching to Modify Mode for ONE Mnemonic ONLY!

MNEMONIC:  MEAS      Measurement Entry      ALLOWED      VISIT RELATED ONLY
1  BP      VON BRAUN,EVA      JUN 19,1997@12:25      120/80
2  WT      VON BRAUN,EVA      JUN 19,1997@12:25      185

Choose:  2
        TYPE: WT// <RETURN>
        VALUE: 185// 158

Switching back to ENTER Mode!

```

MPO Modify Problem Narrative

A patient's active or inactive problem narrative can be changed with the MPO mnemonic. You can also change other problem item fields when using the mnemonic, as shown in the example that follows. Before using this mnemonic, be sure that the problem number and facility codes have been clearly identified on the Encounter Form in the Purpose of Visit or the Problem List Update section. The patient's problem list displays to assist with verifying the correct problem for modification.

```

MNEMONIC:  MPO      Correct/Modify Problem      ALLOWED      NON-VISIT/VISIT MNEMONIC

***** ACTIVE PROBLEMS AND NOTES *****

SE1      05/02/93      DIABETES MELLITUS
SE2SE1    05/02/93      DIABINESE 250MG
SE2      06/12/97      RHEUMATOID ARTHRITIS
SE3      07/31/97      HTN

***** No INACTIVE Problems on file for this Patient

Enter Problem Number: SE3
DIAGNOSIS: 401.9// <RETURN>
CLASS: <RETURN>
PROVIDER NARRATIVE: HTN// HYPERTENSION
DATE OF ONSET: <RETURN>
STATUS: ACTIVE// <RETURN>

```

NO Note

Providers often record treatment plans or notes on a patient's problem list. To add notes to an existing problem, use the NO mnemonic. Before adding a note, be sure that the problem number has been clearly identified on the Encounter Form. The patient's problem displays so that the problem number can be verified.

MNEMONIC: NO	Note	ALLOWED	NON-VISIT/VISIT MNEMONIC
***** ACTIVE PROBLEMS AND NOTES *****			
SE1	07/13/90	ANGIONEUROTIC EDEMA, FAMILIAL	
SE3	08/20/91	COMPOUND MYOPIC ASTIGMATISM	
SE4	07/17/96	HX OF ABNORMAL PAP SMEAR, CLASS III	
***** INACTIVE PROBLEMS AND NOTES *****			
SE2	12/15/85	TRACHOMA, FOLLICULAR	
Enter Problem Number: SE4			
Problem Number: SE4		Diagnosis: V13.8	
Add a new Problem Note for this Problem? N// YES			
Adding SELLS HOSPITAL/CLINIC Note #1			
NOTE NARRATIVE: LASER ABLATION OF CX			
Problem Number: SE4		Diagnosis: V13.8	
Problem Notes:			
SELLS HOSPITAL/CLINIC			
Note #1 6/12/97 LASER ABLATION OF CX			
Add a new Problem Note for this Problem? N// <RETURN> 0			

NT Narrative Text

The NT mnemonic permits entry of narrative information into the V Narrative Text File of the PCC. (There is no example available for display at this time.)

OHX Offspring History

Female patient information about offspring births and deaths is captured with this mnemonic. Although offspring history does not display on the standard Adult Regular health summary, it can be displayed on a locally defined custom health summary. A warning message appears if attempting to use this mnemonic with a male patient's record.

```

MNEMONIC: OHX      Offspring History      ALLOWED      NON-VISIT/VISIT MNEMONIC
Select OFFSPRING HISTORY DATE OF OFFSPRING BIRTH: 5/1/96      MAY 01, 1996
FIRST NAME: ANA
SEX: F      FEMALE
BIRTH WEIGHT: 7.5
GESTATIONAL AGE: 38
APGAR SCORE 1 MIN: 9
APGAR SCORE 5 MIN: 9
DATE OF DEATH: <RETURN>
CAUSE OF DEATH: <RETURN>
Select PERINATAL COMPLICATION: <RETURN>
Select NEONATAL COMPLICATION: <RETURN>

```

OLOC Outside Location

The OLOC mnemonic is used for entering an outside location for a patient's visit. Outside Location is a free-text field for a minimum of 2 to a maximum of 50 characters.

```

MNEMONIC: OLOC      Outside Location      ALLOWED      VISIT RELATED ONLY
OUTSIDE LOCATION: ST JOSEPH'S HOSPITAL

```

OP Operations

Procedures performed on a patient can be entered with the OP mnemonic. Only critical procedures are captured for display on the patient's health summary.

```

MNEMONIC: OP      Operations      ALLOWED      VISIT RELATED ONLY
Enter CPT CODE: 33200      INSERTION OF HEART PACEMAKER
      INSERTION OF PERMANENT PACEMAKER WITH EPICARDIAL ELECTRODE(S); BY
      THORACOTOMY
      ...OK? Y
PROVIDER NARRATIVE: HEART PACEMAKER INSERTION      HEART PACEMAKER INSERTION
OPERATING PROVIDER: SCOONER,JOE      PHYSICIAN      IHS      JAS
      100JAS
DIAGNOSIS: CARDIAC DYSRHYTHMIA(CARDIAC|HEART/HEARTBURN
DYSRHYTHMIA/DYSRHYTHMIAS)
The following matches were found:
  1: 427.89 (CARDIAC DYSRHYTHMIAS NEC)
      OTHER SPECIFIED CARDIAC DYSRHYTHMIAS
  2: 427.9 (CARDIAC DYSRHYTHMIA NOS)
      CARDIAC DYSRHYTHMIA, UNSPECIFIED

Select 1-2: 2
Enter CPT CODE: <RETURN>

```

PAP Pap Smear Ordered

To record that a pap smear was ordered for a female patient, use the PAP mnemonic. This entry indicates only that a pap was ordered. Results are not captured. This mnemonic should be used only if your facility is not using the Laboratory or Women's Health package.

MNEMONIC: PAP	31 PAP Smear Ordered	ALLOWED	VISIT RELATED ONLY
----------------------	----------------------	---------	--------------------

PCP Primary Care Provider

If a patient is assigned a specific provider for all visits, this provider can be captured with the PCP mnemonic. The provider's name will display on the Adult Regular health summary in the Demographics section. PCP will rarely be used and should not be confused with the PRV mnemonic that is required for all visits. (Note that this mnemonic is the same as the DP-Designated Provider. Only the terminology is different.)

MNEMONIC: PCP	Primary Care Provider	ALLOWED	NON-VISIT/VISIT	MNEMONIC
PERSONAL PHYSICIAN: COOPER,TERI		PHYSICIAN	IHS TAC	100TAC

PCPT Procedure Entry (CPT)

The PCPT mnemonic is used for entering a procedure CPT code. The CPT code can be entered by using the name, as shown in the example below, or the numerical code.

MNEMONIC: PCPT Procedure Entry (CPT) ALLOWED VISIT RELATED ONLY Enter CPT CODE: DTP IMMUNIZATION (DTP/DTPHIB IMMUNIZATION/IMMUNIZATIONS) The following 3 matches were found: 1: 90701 (90701) DTP IMMUNIZATION IMMUNIZATION, ACTIVE; DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE (DTP) 2: 90711 (90711) COMBINED VACCINE IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND PERTUSSIS (DTP) AND INJECTABLE POLIOMYELITIS VACCINE 3: 90720 (90720) DTP/HIB VACCINE IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND PERTUSSIS (DTP) AND HEMOPHILUS INFLUENZA B (HIB) VACCINE Press <RET> or Select 1-3: 1 PROVIDER NARRATIVE: DTP IMMUNIZATION OPERATING PROVIDER: CULVER, THOMAS PHYSICIAN IHS TAC 100TAC DIAGNOSIS: <RETURN> Enter CPT CODE: <RETURN>

PED Patient Education

Health education received by a patient can be recorded using the PED mnemonic. The education topic should be noted on the Encounter Form and will display on the Adult Regular health summary. This data should not be entered unless the education topic has been initialized by the provider in the Patient Education section of the form. Each facility is responsible for establishing and maintaining their own database of patient education topics. The patient's level of understanding can be entered as well as CPT codes. The choices available for patient's level of understanding are:

- Poor
- Fair
- Good
- Group—No Assessment
- Refused

MNEMONIC: PED	Patient Education	ALLOWED	VISIT RELATED ONLY		
Enter PATIENT EDUCATION Topic: DM-DIET					
PROVIDER: JS	SCOTT, JOHN	PHYSICIAN	IHS	JS	100JS
LEVEL OF UNDERSTANDING: GOOD GOOD					
INDIVIDUAL/GROUP: I INDIVIDUAL					
LENGTH OF EDUC (MINUTES): 15					
CPT CODE: <RETURN>					
NARRATIVE (optional): <RETURN>					

PHN Public Health Nursing

Patient data resulting from public health nursing visits can be entered using the PHN mnemonic. You will be prompted to enter data in several fields. The choices for entry at the Level of Intervention and Type of Decision Making prompts are listed below. The remaining fields are free-text fields. The entry can be up to a maximum of 200 characters in length for each.

Level of Intervention

P Primary
S Secondary
T Tertiary

Type of Decision Making

S Straightforward
L Low Complexity
M Moderate Complexity
H High Complexity

MNEMONIC: PHN	Public Health Nursing Form	ALLOWED	VISIT RELATED ONLY
LEVEL OF INTERVENTION: P PRIMARY			
TYPE OF DECISION MAKING: S STRAIGHTFORWARD			
PSYCHO/SOCIAL/ENVIRON: PT IS DEPRESSED SECONDARY TO OTHER MEDICAL PROBLEMS			
NSG DX: DEPRESSION, DIABETES, HYPERTENSION			
SHORT TERM GOALS: CONTINUE TO MONITOR MEDICATION			
LONG TERM GOALS: ADMISSION TO NURSING HOME			

PHX Personal History

When a provider wants to capture data that is pertinent to the patient's health but has not otherwise been recorded, the PHX mnemonic can be used to capture personal history data. Many times judgment calls will be required by the data entry operator based on the narrative that has been written on the Encounter Form; for example, the notation "Attempted suicide 1993" indicates a personal history item with the date of onset as 1983. Although personal history items are not displayed on the Adult Regular health summary, they can be displayed on a locally defined custom health summary.

```

MNEMONIC: PHX      Personal History      ALLOWED      NON-VISIT/VISIT MNEMONIC
***** NO PERSONAL HISTORY ON FILE *****
Enter PERSONAL HISTORY Diagnosis: 977.9  977.9      POISON-MEDICINAL AGT NOS
...OK? Yes// <RETURN> (Yes)
DATE NOTED: JUN 13,1997// <RETURN> (No Editing)
PROVIDER NARRATIVE: SUICIDE ATTEMPT--DRUG OVERDOSE
DATE OF ONSET: 1993 (1993)

```

PL Problem List

A problem list update menu is accessible with the PL mnemonic. The patient's problem list displays on the screen with action commands listed across the bottom. A patient's problem list is updated in the same way that the problem list mnemonics are used—with text prompts. Only the method of selecting action items is different. Additional features available from this menu include a health summary and face sheet display from within this menu. The detailed display shows the complete data for the problem you select. An example of adding a problem is shown in the example below.

```

MNEMONIC: PL      Problem List Update Menu      ALLOWED      NON-VISIT/VISIT MNEMONIC
Location where Problem List update occurred: SELLS HOSPITAL/CLINIC// <RETURN>
001 TUCSON      SELLS      01
Date Problem List Updated: T (JUN 19, 1997)

Problem List Update      Jun 19, 1997 14:46:43      Page:      1 of      1
-----
Patient Name: VON BRAUN,CHASE      DOB: MAY 27, 1953      Sex: M      HRN: 10271
-----
1) Problem ID:      SE1      DX: 401.1      Status: ACTIVE Onset:
   Provider Narrative: HYPERTENSION
2) Problem ID:      SE2      DX: 706.1      Status: ACTIVE Onset:
   Provider Narrative: ACNE VULGARIS
3) Problem ID:      SE3      DX: 303.90      Status: ACTIVE Onset:
   Provider Narrative: ALCOHOLISM
4) Problem ID:      TI1      DX: V07.8      Status: INACTIVE Onset:
   Provider Narrative: GIVEN BCG AS NEWBORN AT SAN XAVIER

Enter ?? for more actions      >>>
AP  Add Problem      IP  Inactivate Problem      RN  Remove Note
EP  Edit Problem      DD  Detail Display      HS  Health Summary
DE  Delete Problem      NO  Add Note      FA  Face Sheet
AC  Activate Problem      MN  Edit Note      Q   Quit
Select Action: +// AP

```

Adding a new problem for VON BRAUN,CHASE.

Enter Problem Diagnosis: **DIABETES MELLITUS**

250.00 (DM UNCOMPL/T-II/NIDDM,NS UNCON)

DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION/TYPE II/NON-INSULIN
DEPENDENT/ADULT-ONSET,OR UNSPECIFIED TYPE,NOT STATED AS UNCONTROLLED

OK? Y// <RETURN>

PROVIDER NARRATIVE: = DIABETES MELLITUS

DATE OF ONSET: <RETURN>

NMBR: 4// <RETURN>

CLASS: <RETURN>

STATUS: A// <RETURN> ACTIVE

Add a new Problem Note for this Problem? N// <RETURN> 0

[The problem list update menu displays again.]

Tip: Remember to enter Q to quit the problem list menu and return to the Mnemonic prompt.

PO Problem Only

The Problem Only mnemonic is used for adding new active or inactive problems to a patient's problem list. Problems to be added to a patient's problem list will be written in the Purpose of Visit section of the Encounter Form with the problem status marked as A (active) or AI (inactive). For more information on the problem list, refer to the PCC Forms and Health Summary manuals.

MNEMONIC: **PO** Problem Only ALLOWED NON-VISIT/VISIT MNEMONIC

***** ACTIVE PROBLEMS AND NOTES *****

SE1 03/29/95 DM II

SE2 12/15/96 HTN

***** No INACTIVE Problems on file for this Patient

Enter Problem Diagnosis: **MONONUCLEOSIS**

(MONONUCLEOSIS)

.

075. (INFECTIOUS MONONUCLEOSIS)

INFECTIOUS MONONUCLEOSIS

OK? Y// <RETURN>

PROVIDER NARRATIVE: =

DATE OF ONSET: **6/8/97** (JUN 08, 1997)

NMBR: 3// <RETURN>

CLASS: <RETURN>

STATUS: A// <RETURN> ACTIVE

Add a new Problem Note for this Problem? N// <RETURN> 0

PPV POV and Problem Entry

The PPV mnemonic allows a purpose of visit to be added as a problem on the patient's problem without having to re-enter the narrative. PPC can only be used in data entry modes that create visits. You will not be able to use it when entering non-visit data only. Before using this mnemonic, be sure the provider has indicated on the Encounter Form that the purpose of visit is also a problem by writing A or AI in the A-AI-C column next to the purpose of visit narrative.

MNEMONIC: **PPV** P O V and PROBLEM entry ALLOWED VISIT RELATED ONLY

This mnemonic will automatically generate a PROBLEM on the PROBLEM LIST. Use the PV mnemonic to enter POV's only!

***** ACTIVE PROBLEMS AND NOTES *****

SE1 03/29/95 DIABETES MELLITUS
SE2 05/15/96 CHRONIC UTI

***** INACTIVE PROBLEMS AND NOTES *****

TR1 1/12/97 PNEUMONIA

Enter PURPOSE of VISIT: **CARDIAC DYSRHYTHMIA**
(CARDIAC|HEART/HEARTBURN DYSRHYTHMIA/DYSRHYTHMIAS)
..

The following matches were found:

- 1: 427.89 (CARDIAC DYSRHYTHMIAS NEC)
 OTHER SPECIFIED CARDIAC DYSRHYTHMIAS
- 2: 427.9 (CARDIAC DYSRHYTHMIA NOS)
 CARDIAC DYSRHYTHMIA, UNSPECIFIED

Select 1-2: **2**

PROVIDER NARRATIVE: =
MODIFIER: <RETURN>
CAUSE OF DX: <RETURN>

Now creating PROBLEM on PROBLEM LIST ...

NMBR: 3// <RETURN>

CLASS: <RETURN>

DATE OF ONSET: <RETURN>

STATUS: A// <RETURN> ACTIVE

Select NOTE FACILITY: **SELLS H** SELLS HOSPITAL/CLINIC 001 TUCSON SELLS 01

Select NOTE NMBR: 1// <RETURN>

NOTE NARRATIVE: **REFERRED TO CARDIOLOGIST FOR EVAL**

Select NOTE FACILITY: <RETURN>

PR Presentation (Pregnancy)

A female patient's pregnancy presentation can be captured using the PR mnemonic. The choices for entry are listed below. They can be entered by number, name, or abbreviation.

1	Vertex (VT)	6	Face (FA)
2	Complete Breach (CB)	7	Unspecified Breach (UB)
3	Double Footling (DF)	8	Transverse (TR)
4	Single Footling (SF)	9	Other (OT)
5	Frank Breach (FB)	10	Unknown (UNK)

MNEMONIC: PR Presentation (Pregnancy)	ALLOWED	VISIT RELATED ONLY
VALUE: 2 COMPLETE BREACH		

PRV Providers (Primary/Secondary)

This mnemonic is used to record each person who provides health-care services to a patient during a visit. A primary provider is required for each patient visit and must be recorded on the Encounter form. Secondary providers are optional and can be entered with the PRV if written on the Encounter Form. You can enter the provider's code, initials, or entire name. The date and time that the provider saw the patient can also be entered utilizing the PRV mnemonic. These data fields are entered only at facilities that are conducting Waiting Time Studies. The PCC Data Entry Site Parameters determine whether the data entry operator is prompted for Date and Time when using this mnemonic.

MNEMONIC: PRV Providers (Primary/Secondary) ALLOWED VISIT RELATED ONLY Enter PROVIDER (code/initials or name): TAC COOPER, TERI PHYSICIAN IHS TAC 100TAC P)primary or S)econdary: P PRIMARY Date Provider Seen: Jun 13, 1997// <RETURN> (JUN 13, 1997) Time Provider Seen: 1:45 Jun 13, 1997@1:45 (JUN 13, 1997@13:45) Enter a SECONDARY PROVIDER (code/initials or name): MSM MIRANDA, MARIA REGISTERED NURSE IHS MSM 101MSM Date Provider Seen: Jun 13, 1997// <RETURN> (JUN 13, 1997) Time Provider Seen: 2:00 Jun 13, 1997@2:00 (JUN 13, 1997@14:00) Enter a SECONDARY PROVIDER (code/initials or name): <RETURN>

PRX Prescribed RX

The PRX mnemonic is used at sites that either do not have a Pharmacy or are not utilizing an automated Pharmacy system for entry of medications. Data entry staff utilize this mnemonic to enter meds directly into the PCC V-Medication File. This mnemonic is similar to the RX mnemonic but fewer data fields are entered using PRX.

MNEMONIC: PRX Prescription RX ALLOWED VISIT RELATED ONLY Select V MEDICATION: GLIPIZIDE 1 GLIPIZIDE 10MG TAB 2 GLIPIZIDE 5MG TAB CHOOSE 1-2: 1 Outside Drug Name (OPTIONAL): SIG: T2TD WITH MEALS QUANTITY: 60 DAYS PRESCRIBED: 30
--

PT Physical Therapy

Facilities that have a therapist on staff and use form HRSA 464-PCIS Brief Visit Record for documenting physical therapy visits should use the PT mnemonic to capture the physical therapy treatment provided. The physical therapist will enter the appropriate code for data entry in the box on the right side of the form labeled *Coding*. The physical therapist is responsible for establishing and maintaining the list of physical therapy codes.

MNEMONIC: PT Physical Therapy ALLOWED VISIT RELATED ONLY Enter PHYSICAL THERAPY CPT Code: EXERCISE-ANKLE 97110 QUANTITY: 1 Enter PHYSICAL THERAPY CPT Code: <RETURN>

PU Pulse

This is an optional data item that does not print on the Adult Regular Health Summary although it can be used on a customized health summary. The value entered must be in the range 30 to 250.

MNEMONIC: PU Pulse ALLOWED VISIT RELATED ONLY VALUE: 75
--

PV Purpose of Visit

The purpose of visit is the most important data item recorded for a patient's visit. Every Encounter Form must have a purpose of visit recorded before it can be processed by the data entry staff. This data item is entered on the purpose of visit section on the Encounter Form in a narrative format by the provider. This section is also used to create and update a patient's problem list. The purpose of visit is entered in two parts: (1) to obtain the ICD-9 code, and (2) to maintain the provider's narrative verbatim. The second entry, the provider's narrative, displays on the Adult Regular health summary. For more information on the purpose of visit or the problem list, refer to the PCC Forms manual.

During entry of the purpose of visit, you will be prompted for a modifier and a cause of diagnosis. These are optional fields that are used as needed, depending on the provider's diagnosis. The choices available for entry at each of these prompts are listed below.

Modifiers

C	Consider	M	Maybe, Possible, Perhaps	R	Resolved
D	Doubtful	O	Rule Out	S	Suspect, Suspicious
F	Follow Up	P	Probable	T	Status Post

Cause of DX

- Hospital Acquired
- Alcohol Related
- Battered Child
- Employment Related
- Domestic Violence Related

```

MNEMONIC: PV           Purpose of Visit      ALLOWED      VISIT RELATED ONLY
Enter PURPOSE of VISIT: PNEUMONIA

486. (PNEUMONIA, ORGANISM NOS)
PNEUMONIA, ORGANISM UNSPECIFIED

OK? Y// <RETURN>

PROVIDER NARRATIVE: PNEUMONIA PNEUMONIA
MODIFIER: <RETURN>
CAUSE OF DX: <RETURN>
Enter PURPOSE of VISIT: <RETURN>

```

Tip: At the Provider Narrative prompt, if the narrative that you wish to enter from the encounter form is identical to the text that you entered at the Purpose of Visit prompt to obtain the ICD code, then you may enter the equal symbol (=) to duplicate the text that you typed in at the Purpose of Visit prompt. This will greatly save keystrokes.

If the diagnosis is an injury, several different prompts will appear requesting specific information about the injury. It is very important that you complete these fields in order to maintain records and generate statistical reports on accidents in your Area. The three additional prompts that appear are: Cause of Injury, Place of Accident, and Date of Injury. The Cause of Injury field allows an E-code to be recorded for the visit. Data for each of these items should be recorded on the Encounter Form by the provider and then entered into the system by data entry staff using the PV mnemonic.

For the Place of Accident prompt, choose from the following:

- | | | | |
|---|---------------------|---|----------------------|
| A | Home—Inside | G | Street/Highway |
| B | Home—Outside | H | Public Building |
| C | Farm | I | Resident Institution |
| D | School | J | Hunting/Fishing |
| E | Industrial Premises | K | Other |
| F | Recreational Area | L | Unknown |

An example of an injury-related visit is provided below. Note the use of the equal symbol at the Provider Narrative prompt to duplicate the text used at the Purpose of Visit Prompt.

```

MNEMONIC: PV           Purpose of Visit      ALLOWED      VISIT RELATED ONLY
Enter PURPOSE of VISIT: LACERATION HAND

882.0 (OPEN WOUND OF HAND)
  OPEN WOUND OF HAND EXCEPT FINGERS ALONE, WITHOUT MENTION OF
  COMPLICATION

OK? Y// <RETURN>

PROVIDER NARRATIVE: = LACERATION HAND
MODIFIER: <RETURN>
CAUSE OF INJURY: DOG BITE( BITE/BITEMPORAL/BITES DOG )
..
E906.0 (DOG BITE)
DOG BITE

OK? Y// <RETURN>

PLACE OF ACCIDENT: B  HOME-OUTSIDE
DATE OF INJURY: T  (JUN 13, 1998)
CAUSE OF DX: <RETURN>
Enter PURPOSE of VISIT: <RETURN>

```

RAD Radiology

Radiology procedures can be entered into the system with the RAD mnemonic. The impression and an indication of whether the result is normal/abnormal can be recorded. It is recommended that radiology staff enter this data to ensure that the procedures and impressions are entered accurately. This mnemonic should not be used if the radiology package is operational at your facility.

```

MNEMONIC: RAD      Radiology      ALLOWED      VISIT RELATED ONLY
Enter Radiology Procedure: MAMMOGRAM BILATERAL( BILATERAL MAMMOGRAM )
76091 (76091)
      MAMMOGRAM, BOTH BREASTS
      MAMMOGRAPHY; BILATERAL
OK? Y// <RETURN> ES MAMMOGRAM BILAT
(Detailed) CPT:76091
      IMPRESSION: NORMAL
      ABNORMAL: N  NORMAL

```

RF Reproductive Factors

The RF mnemonic is used to enter reproductive factors for a female patient. The data entered include gravidity, parity, live children, spontaneous abortions, and therapeutic abortions. The data is recorded as a single entry with abbreviations for each data item followed by the corresponding number; for example: G5P3LC1SA1TA1.

```

MNEMONIC: RF      Reproductive Factors      ALLOWED      NON-VISIT/VISIT MNEMONIC
NAME: RUBBLE, LORRAINE// <RETURN>
REPRODUCTIVE HISTORY: G2P2LC2SA0TA0

```

RNO Remove Note Narrative

When a provider indicates on the Encounter Form that a problem note should be removed, the RNO mnemonic should be used. Notes are linked to problems and must be clearly identified by number in the top section of the Encounter Form under Problem List Update–Remove before a delete is performed by the data entry operator. The provider will use the patient's health summary to identify the entire problem number and note to be deleted; for example, SX1SX1. For reference, the patient's problem list displays prior to deletion of the note.

```

MNEMONIC: RNO      Remove Note from Problem      ALLOWED      NON-VISIT/VISIT MNEMONIC
***** ACTIVE PROBLEMS AND NOTES *****

SE1      12/04/89    DIABETES MELLITUS
SE1SE1    12/04/89    FAMILY HISTORY OF DIABETES
SE2      11/29/93    HTN

***** INACTIVE PROBLEMS AND NOTES *****

SE3      06/13/97    CHRONIC UTI X 3
SE3SE1    06/13/97    CONSIDER IVP AFTER NEXT EPISODE

Enter Problem Number: SE1

```

Select NOTE FACILITY: SELLS HOSPITAL/CLINIC// <RETURN>
 Select NOTE NMBR: 1// <RETURN>

Are you sure you want to remove Note Number 1? (Y/N) Y
 Select NOTE FACILITY: <RETURN>

RPO Remove Problem Entry

The RPO mnemonic is used when a provider indicates that an active or inactive problem is to be removed from the patient's problem list. The provider must write the entire problem number from the health summary in the Remove box under the Problem List Update section at the top of the Encounter Form. A removed problem is deleted from the system as well as any notes linked to it.

```

MNEMONIC: RPO   Remove Problem entry   ALLOWED   NON-VISIT/VISIT MNEMONIC
*****
***** ACTIVE PROBLEMS AND NOTES *****
SE1      01/26/97  DEPRESSIVE DISORDER  (ONSET: 02/07/95)
SE2      03/21/97  NACROLEPSY
SX1      01/26/97  MILD ANEMIA

***** INACTIVE PROBLEMS AND NOTES *****
SX2      02/05/86  DYSFUNCTIONAL UTERINE BLEED

Enter Problem Number: SX1
Are you sure that you want to remove Problem Number SX1 ? (Y/N) Y
Removing Problem SX10 ...
  
```

RS Respiration

The patient's respiration rate is recorded with the RS mnemonic. The value entered must be in the range 8 to 90.

```

MNEMONIC: RS      Respiration   ALLOWED   VISIT RELATED ONLY
VALUE: 40
  
```

RX Medications

This mnemonic is used for recording medications dispensed only if the Pharmacy module is not in use at your facility. The provider will note the prescription name, SIG, quantity, and days under the Medications section on the lower portion of the Encounter Form. Medications are displayed on the Adult Regular health summary.

MNEMONIC: RX	Medications	ALLOWED	VISIT RELATED ONLY
Select V MEDICATION: IBUPROFEN			
1	IBUPROFEN 400MG TAB	MS102	
2	IBUPROFEN 400MG TAB U/D		
3	IBUPROFEN 800MG TAB		
CHOOSE 1-3: 3			
Outside Drug Name (OPTIONAL): <RETURN>			
SIG: TAKE EVERY 6 HOURS FOR PAIN AS NEEDED			
QUANTITY: 60			
DAYS PRESCRIBED: 15			
EVENT DATE&TIME: <RETURN>			
ORDERING PROVIDER: LAWRENCE, BRADLEY		PHYSICIAN	IHS 067 100067
CLINIC: 01 GENERAL		01	
ENCOUNTER PROVIDER: <RETURN>			

SHX History of Surgery

When a provider documents a past surgical procedure in the purpose of visit section of the Encounter Form, the SHX mnemonic is used to capture that information. Keep in mind that this mnemonic is to be used for historical procedures only. You will enter the provider's narrative in addition to a date for the procedure. If the exact date is unknown, at least the year the procedure was performed is required for an entry. These historical surgeries appear on the Adult Regular health summary.

MNEMONIC: SHX	History of Surgery	ALLOWED	NON-VISIT/VISIT MNEMONIC
***** SURGICAL HISTORY *****			
01/31/97 APPENDECTOMY			
Enter Date of Historical Procedure/Operation: 1986 (JAN 01, 1986@12:00)			
TYPE: 0// <RETURN> OTHER			
LOC. OF ENCOUNTER: 000198		SELLS OTHER	TUCSON SELLS 98
OUTSIDE LOCATION: <RETURN>			
Enter CPT CODE: SPLENECTOMY			
The following matches were found:			
1:	41.43 (PARTIAL SPLENECTOMY)		
	PARTIAL SPLENECTOMY		
2:	41.5 (TOTAL SPLENECTOMY)		
	TOTAL SPLENECTOMY		
Select 1-2: 2			
PROVIDER NARRATIVE: REMOVAL OF SPLEEN			

SPV Purpose of Visit with Stage Prompt

The SPV mnemonic is identical to the PV mnemonic except that an additional prompt, Stage, is included. The entry for Stage must be a number between 0 and 9. No decimals are allowed. For more information on purpose of visit, see the description of the PV mnemonic.

```

MNEMONIC: SPV      POV with Stage Prompted   ALLOWED   VISIT RELATED ONLY
Enter PURPOSE of VISIT: MALIGNANT NEOPLASM OF ENDOCERVIX
( ENDOCERVIX MALIGNANT NEOPLASM/NEOPLASMS )

The following word was not used in this search:
  OF
.
180.0 (MALIG NEO ENDOCERVIX)
MALIGNANT NEOPLASM OF ENDOCERVIX

OK? Y// <RETURN>

PROVIDER NARRATIVE: =
Enter the STAGE: 6
MODIFIER: <RETURN>
CAUSE OF DX: <RETURN>
Enter PURPOSE of VISIT: <RETURN>

```

ST Skin Test

This mnemonic is used to enter skin tests reading(s) and results. A reading and/or results is required before an entry is made. Provider initials do not indicate a reading or results. To record only that a skin test was placed, use the STP mnemonic. A PPD reading and/or result is written on the last line of the Orders/Initials column. All other skin tests are written on the last line of the Medications/Treatments Procedures/Patient Education section.

For the Reading prompt, the value entered must be in the 0 to 40 range. Select from the following choices for an entry at the Results prompt:

P Positive
 N Negative
 D Doubtful
 O No Take

```

MNEMONIC: ST      Skin Test      ALLOWED   VISIT RELATED ONLY
Enter SKIN TEST Type: PPD      21
READING: 0
RESULTS: N  NEGATIVE
DATE READ: Jun 16, 1997// <RETURN> (JUN 16, 1997)

```

STG Stage in Purpose of Visit

To record the stage only for a purpose of visit, the STG mnemonic can be used. After entering the STG mnemonic, all purposes of visit entered will display. In the case of multiple purposes for a single visit, you will enter the stage for only one purpose of visit at a time. At the Stage prompt, enter a number between 0 and 9. Decimals are not allowed.

MNEMONIC: STG	Stage in Purpose of Visit	ALLOWED	VISIT RELATED ONLY
1 174.3	MILLER, CELESTE	JUN 23, 1997@09:00	
STAGE: 4			

STN Station (Pregnancy)

The station measurement for a pregnancy can be entered with the STN mnemonic. The value entered must be between -6 and 4.

MNEMONIC: STN	Station (Pregnancy Meas)	ALLOWED	VISIT RELATED ONLY
VALUE: 3			

STP Skin Test Placed

The STP mnemonic is used to record that a skin test was placed during a visit. No results or reading are entered when using this mnemonic. You will have the choice of the following skin test types:

- Cocci
- Mono-Vac
- PPD
- Schick
- Tine

MNEMONIC: STP	Skin Test Placed (No Reading)	ALLOWED	VISIT RELATED ONLY
Enter SKIN TEST Type: PPD 21			

TA Type of Appointment

The TA mnemonic is for entering whether the patient's appointment was Short, Medium, or Long.

MNEMONIC: **TA** Type of Appointment (S/M/L) ALLOWED VISIT RELATED ONLY

TYPE OF APPOINTMENT (S/M/L): **M** MEDIUM

TC Tran Code (Chargemaster)

The TC mnemonic is for entering one or more Chargemaster Transaction Codes from a Superbill or other form of billing document. A Chargemaster Transaction File must be loaded at your site in order to make use of this mnemonic.

MNEMONIC: **TC** Chargemaster Transaction Code ALLOWED VISIT RELATED ONLY

Enter (TC) TRANSACTION CODE: **10100095** X-R, TMJ, OPEN/CLSD MOUTH;BI

Enter (TC) TRANSACTION CODE: **10100110** X-R, PHARYNX, LARYNX, W/FLUO

Enter (TC) TRANSACTION CODE: **10100055** X-RAY, ORBITS, COMP, MIN 4VS

TD Type of Decision Making

The type of decision making is recorded primarily for public health nursing visits. The prompt appears when using the PHN mnemonic. To record only the type of decision making, use the TD mnemonic. The entry choices are the following:

- S Straightforward
- L Low Complexity
- M Moderate Complexity
- H High Complexity

MNEMONIC: **TD** Type of Decision Making ALLOWED VISIT RELATED ONLY

LEVEL OF DECISION MAKING: **S** STRAIGHTFORWARD

TE Tran Code with Entry of Encounter Provider (Chargemaster)

The TC mnemonic is for entering one or more Chargemaster Transaction Codes, including the identification of the Ordering Provider, from a Superbill or other form of billing document. A Chargemaster Transaction File must be loaded at your site in order to make use of this mnemonic.

MNEMONIC: TE	Chargemaster TC with Enc Prov	ALLOWED	VISIT RELATED ONLY
Enter (TE) TRANSACTION CODE: 26000800 IPECAC ADMINISTRATION			
EVENT DATE AND TIME: T-1 (NOV 28, 1998)			
ENCOUNTER PROVIDER: GM MARTIN, GRETCHEN			

TM Time of Visit

To correct a visit time, use the TM mnemonic. Time is a required entry for a patient visit and is entered at the Time of Visit prompt when a visit is created. If you have entered an incorrect time, the TM can be used to make the change.

MNEMONIC: TM	Time of Visit	ALLOWED	VISIT RELATED ONLY
Enter new time: 1130// 1145			
Now changing time... (JUN 16, 1997@11:45)			

TMP Temperature

This mnemonic is used to enter the patient's temperature at the time of the visit. The value is entered in degrees Fahrenheit and must be in the 94 to 109.9 range. The patient's temperature will not display on the Adult Regular health summary, but can be selected for display on a locally defined custom health summary.

MNEMONIC: TMP	Temperature	ALLOWED	VISIT RELATED ONLY
VALUE: 99.3			

TON Tonometry

This mnemonic is used to record the intraocular tension of a patient's eyes. Tonometry is rarely entered into the system since only facilities with an optometrist utilize this data. The tonometry reading is recorded in the Medications/Treatments/Procedures/Patient Education section of the Encounter Form. The reading is entered with the right eye measurement first followed by a slash and then the reading for the left eye, as shown in the example below. The values must be between 0 and 80.

MNEMONIC: TON	Tonometry	ALLOWED	VISIT RELATED ONLY
VALUE: 20/21			

TP Treatments Provided

This optional data item is located in the Medications/Treatments/Procedures/Patient Education section of the Encounter Form. The treatment provided is recorded on the form with a 3-digit code. Since this section of the Encounter Form is used for multiple purposes, providers must indicate TP next to the code for the treatment to be captured; for example, TP 906. Since the PCC requires this data to be entered as a 6-digit code, 3 zeroes must precede the 3-digit code; for example, 000906 would be entered for the example given above. Treatments provided are primarily used by CHNs. Each facility is responsible for establishing and maintaining this list of codes for treatments provided.

MNEMONIC: TP	Treatments Provided	ALLOWED	VISIT	RELATED ONLY
Enter TREATMENT Type: RA-PAIN MANAGEMENT		000918	1	
HOW MANY: 1// <RETURN>				
PROVIDER: JS	SCHMIDT, JULIANN	REGISTERED NURSE	IHS	JS 101JS

UA Urinalysis Order–No Results

The UA mnemonic is used for recording the order for a urinalysis test. This mnemonic is to be used only if the Laboratory module is not in use at your facility. Also, the UA mnemonic should not be used unless the second box under the Orders/Initials on the Encounter Form is checked and initialed. The Adult Regular health summary contains a section called Most Recent Laboratory Data under which the UA test order will display.

MNEMONIC: UA	49 Urinalysis Ordered	ALLOWED	VISIT	RELATED ONLY
---------------------	-----------------------	---------	-------	--------------

UCD Underlying Cause of Death

The underlying cause of death for a patient can be captured with the UCD mnemonic. At the prompt, enter the narrative for lookup, as shown below, or the ICD diagnostic code, if known.

MNEMONIC: UCD	Underlying Cause of Death	ALLOWED	NON-VISIT/VISIT	MNEMONIC
UNDERLYING CAUSE OF DEATH: RENAL FAILURE				
586. (RENAL FAILURE NOS)				
RENAL FAILURE, UNSPECIFIED				
OK? Y// <RETURN>				

UOP Uncoded Procedure

To enter an uncoded procedure, use the UOP mnemonic. The provider narrative, operating provider, and diagnosis will be entered with this mnemonic.

MNEMONIC:	UOP	Uncoded Procedure	ALLOWED	VISIT RELATED ONLY
Entering Uncoded Procedure, please enter a narrative describing the PROCEDURE				
PROVIDER NARRATIVE: SUTURE LACERATION OF RIGHT UPPER ARM				
OPERATING PROVIDER: JCS SMITH, JANE PHYSICIAN IHS JAS 100JCS				
DIAGNOSIS: 880.03 880.03 OPEN WOUND OF UPPER ARM				
...OK? Yes// <RETURN> (Yes)				
Enter another Uncoded PROCEDURE? No// <RETURN> (No)				

UPV Uncoded Purpose of Visit

An uncoded purpose of visit is entered with the UPV mnemonic. You will be prompted for provider narrative, modifier, and cause of diagnosis. Multiple purposes of visit can be entered for a single visit.

MNEMONIC:	UPV	Uncoded Purpose of Visits	ALLOWED	VISIT RELATED ONLY
PROVIDER NARRATIVE: RECURRENT BLEEDING ULCER				
MODIFIER: <RETURN>				
CAUSE OF DX: <RETURN>				
Enter another Diagnosis/POV? No// <RETURN> (No)				

VC Vision Corrected

This mnemonic is used to enter vision data located in the Vision Corrected box on the right column of the Encounter Form. This box is divided into a R(ight) and L(ef) eye reading. Usually two numbers are entered in each half; for example, 20/30 and 20/40. Only the second number (denominator) in each half of the box is picked up and combined for one entry into the system; for example, 30/40 would be entered for the previous example. If one of the boxes on the form does not contain a reading you will enter only one value. To enter the reading for the right eye only, enter the number without a slash: 30. To enter the left eye only, type a slash followed by the reading: /40. The values must be between 10 and 999. The numerator may differ from the assumed value of 20. If so, the second prompt, Numerator on VC/VU, allows you to change the numerator value.

MNEMONIC:	VC	Vision Corrected	ALLOWED	VISIT RELATED ONLY
VALUE: 40/50				
NUMERATOR ON VC/VU: 20// <RETURN>				

VST Modify Visit File Information

The VST mnemonic is used to correct the visit file after the visit has been created and the mnemonic prompt has been reached. The data already entered will appear as the default values for the prompts. To change any data previously entered, type the corrected information at the prompt, as shown in the example below.

```
MNEMONIC: VST Visit File Data Modify ALLOWED VISIT RELATED ONLY
LOC. OF ENCOUNTER: SELLS HOSPITAL/CLINIC// <RETURN>
SERVICE CATEGORY: AMBULATORY// <RETURN>
TYPE: IHS// <RETURN>
CLINIC: GENERAL// DIABETIC
WALK IN/APPT: APPOINTMENT// <RETURN>
APPT DATE&TIME: JUN 1,1997@10:00// 6/17/97@1030
EVALUATION AND MANAGEMENT CODE: <RETURN>
CHECK OUT DATE&TIME: <RETURN>
HOSPITAL LOCATION: <RETURN>
LEVEL OF DECISION MAKING: <RETURN>
```

VU Vision Uncorrected

This mnemonic is used to enter the patient's uncorrected vision measurement, which is found in the Vision-Uncorrected box on the right column of the Encounter Form. This box is divided into a R(ight) and L(ef) eye reading. Usually two numbers are entered in each half of the box; for example, 20/30 and 20/40. Only the second number (denominator) in each half of the box is picked up and combined as one entry; for example, 30/40 for the sample given above. It is assumed that the first number (numerator) is 20. In instances where the numerator is a number other than 20, enter the correct value at the Numerator prompt. If one box on the form does not have a reading, only the reading recorded is entered. If the reading is for the right eye only, enter the reading without the slash: 30. If the reading is for the left eye only, precede the value with the slash: /40.

```
MNEMONIC: VU Vision Uncorrected ALLOWED VISIT RELATED ONLY
VALUE: 30/40
NUMERATOR ON VC/VU: 20// <RETURN>
```

WHAT Demographic and Visit Display

To view patient demographics and visit data already entered, use the WHAT mnemonic to display this information. This mnemonic is similar to DISP, but displays the data in a different format. Also, no dependent entry count is provided with WHAT.

```

MNEMONIC: WHAT Demographic and Visit Display ALLOWED NON-VISIT/VISIT MNEMONIC

You are currently processing the following Patient Visit:

Patient Name: SMITH,ELLIE          Chart #: 101506
Date of Birth: AUG 21, 1967        Sex: F
Visit Date: JUN 23, 1997@08:00:00
Location: SELLS HOSPITAL/CLINIC
Type: I                             Service Category: A
Clinic: GENERAL

===== MEASUREMENT'S =====
TYPE: TMP      VALUE: 101.2

TYPE: BP      VALUE: 120/30

===== PROVIDER'S =====
PROVIDER: SMITH, JON      PRIMARY/SECONDARY: PRIMARY
EVENT DATE AND TIME: JUN 23, 1997@08:15

PROVIDER: MIRANDA, MARIA  PRIMARY/SECONDARY: SECONDARY
EVENT DATE AND TIME: JUN 23, 1997@09:00

===== POV'S =====
POV: 460.      PROVIDER NARRATIVE: COLD WITH COUGH
FIRST/REVISIT: REVISIT

```

WHO Information on Patient

The WHO mnemonic provides a quick way to verify the patient for whom you are entering information and some brief visit items that have already been entered.

```

MNEMONIC: WHO Information on Patient ALLOWED NON-VISIT/VISIT MNEMONIC

You are currently processing the following Patient Visit:

Patient Name: MILLER,EDNA          Chart #: 101047
Date of Birth: NOV 18, 1970        Sex: F
Visit Date: JUN 23, 1997@08:00    Location: SELLS HOSPITAL/CLINIC
Type: I                             Service Category: A
Clinic: GENERAL

```

WT Weight

This mnemonic allows a patient's weight to be entered in pounds and ounces. Be sure that the provider has specified pounds as the unit of measure in the weight (WT) section on the Encounter Form before using this mnemonic. The value entered must be in the range of 2 to 750 pounds. Ounces may be entered by leaving a space between the pounds and ounces; for example: 10 6 for 10 pounds 6 ounces. Fractions and decimals are allowed in multiples of 1/16 (.0625).

MNEMONIC: WT	Weight in lbs/ozs	ALLOWED	VISIT RELATED ONLY
VALUE: 125			

XIT Quick Out

The XIT mnemonic allows you to leave the data entry process from the Mnemonic prompt regardless of whether the visit data entry is complete. You will be prompted to determine whether the visit information entered so far is to be deleted or saved. Remember that exiting an incomplete visit will result in an error that must be corrected prior to the data transmission process. Two sample dialogs are shown below. In the first example, the visit is saved. The visit is deleted in the second example.

Saving the Visit

MNEMONIC: XIT	Quick Out	ALLOWED	VISIT RELATED ONLY
This is the 'Quick Exit' from Data Entry Enter Mode. This visit will be deleted and you will be returned to the 'VISIT/DATE TIME' prompt.			
Do you wish to Proceed with the Deletion? Y// NO			
Do you still wish to EXIT this Visit? Y// <RETURN> ES			
WARNING - You may be leaving an INCOMPLETE VISIT!!			
Looking for ancillary data to merge into this visit...			

Deleting the Visit

MNEMONIC: XIT	Quick Out	ALLOWED	VISIT RELATED ONLY
This is the 'Quick Exit' from Data Entry Enter Mode. This visit will be deleted and you will be returned to the 'VISIT/DATE TIME' prompt.			
Do you wish to Proceed with the Deletion? Y// <RETURN> ES..			
Looking for ancillary data to merge into this visit...			

Appendix A

Required Data Items for a PCC Visit

- ❑ Location/Facility
- ❑ Type of Visit
- ❑ Service Category
- ❑ Date and Time
- ❑ Patient Identification
- ❑ Clinic (CL mnemonic)
- ❑ Primary Provider (PRV mnemonic)
- ❑ Purpose of Visit (PV mnemonic)

Appendix B

Data Entry Mnemonics Grouped by Type

(Bold print indicates the mnemonic is new with Version 2.0 of PCC Data Entry)

Administrative Data

AT	Activity and Travel Time
ER	Emergency Visit Record
FL	Flag Field
HL	Hospital Location
IP	Inpatient
PHN	Public Health Nursing

Billing/Chargemaster

CPE	CPT Codes with Entry of Encounter Provider
CPT	CPT Codes
DTC	Diagnostic Procedure Tran Code (Chargemaster)
EM	Evaluation and Management (CPT)
LS	Level of Service
PCPT	Procedure Entry (CPT)
TC	Tran Code (Chargemaster)
TD	Type of Decision Making
TE	Tran Code with Entry of Encounter Provider (Chargemaster)

Contract Health Service

CHA	CHS – Outpatient Form
CHH	CHS – Hospitalization Form
CHI	CHS – In-Hospital Form

Data Entry Utilities

CODE	Coding Guidelines Display
DHS	Display Health Summary
DISP	Visit Display
MOD	Switch to Modify Mode
VST	Modify Visit File Information
WHAT	Demographic and Visit Display
WHO	Information on Patient
XIT	Quick Out

Diagnosis/Purpose of Visit

ADX	Admitting Diagnosis
ECOD	Append an E-Code to a Purpose of Visit
IPV	ICD Narrative Purpose of Visit
PV	Purpose of Visit
SPV	Purpose of Visit with Stage Prompt
STG	Stage in Purpose of Visit
UPV	Uncoded Purpose of Visit

Examination

EX	Examinations
HE	Hearing

Historical Data

HEKG	Historical EKG
HEX	Historical Examination
HIM	Historical Immunizations
HHCT	Historical Hematocrit
HLAB	Historical Lab Test
HMSR	Historical Measurement
HPAP	Historical Pap Smear
HRAD	Historical Radiology
HRX	Historical Prescription
HS	Historical Skin Test
HUA	Historical UA

Immunizations/Skin Tests

IM	Immunizations
ST	Skin Test
STP	Skin Test Placed

Laboratory

BS	Blood Sugar
CBC	CBC Ordered
HBS	Historical Blood Sugar Entry
HCBC	Historical CBC Entry
HCT	Hematocrit Ordered
LAB	Lab Test Entry
PAP	Pap Smear Ordered
UA	Urinalysis Order–No Results

Measurements

AUD	Audiometry
BP	Blood Pressure
CHC	Centimeter Head Circumference
CHT	Centimeter Height
GWT	Gram Weight
HC	Head Circumference
HT	Height
KWT	Kilogram Weight
MEAS	Measurement Entry
PU	Pulse
RS	Respiration
TMP	Temperature
TON	Tonometry
VC	Vision Corrected
VU	Vision Uncorrected
WT	Weight

Medication

PRX	Prescribed RX
RX	Medications

Operation/Procedure

IOP	ICD Operation Narrative
OP	Operations
UOP	Uncoded Procedure

Other Clinical Data

DDS	Dental – Direct Services
EKG	EKG Diagnostic Procedure
GP	Eyeglass Prescription
NT	Narrative Text
PED	Patient Education
PT	Physical Therapy
RAD	Radiology
TP	Treatments Provided

Patient Related

BT	Blood Type Entry
DP	Designated Provider
FS	Future Scheduled Encounter
HF	Health Factors
HLST	Health Status
FHX	Family History
FM	Family Planning Method
FP	Family Planning
OHX	Offspring History
PCP	Primary Care Provider
PHX	Personal History
RF	Reproductive Factors
SHX	History of Surgery
UCD	Underlying Cause of Death

Prenatal

AG	Abdominal Girth
CXD	Cervix Dilation
ED	Edema Measurement
EDC	Expected Date of Confinement
EFF	Effacement
FH	Fundal Height
FT	Fetal Heart Tones
LMP	Last Menstrual Period
PR	Presentation (Pregnancy)
STN	Station (Pregnancy)

Problem List

APO	Activate an Inactive Problem
IPO	Inactivate Problem
MNN	Modify Note Narrative
MPO	Modify Problem Narrative
NO	Note
PL	Problem List
PO	Problem Only
PPV	POV and Problem Entry
RNO	Remove Note Narrative
RPO	Remove Problem Entry

Visit Related Data

CL	Clinic Type
OLOC	Outside Location
PRV	Providers (Primary/Secondary)
TM	Time of Visit

Waiting Time Studies

APPT	Appointment Date and Time
AL	Appointment Length
CKO	Check Out Date and Time
TA	Type of Appointment

Appendix C

IHS ICD-9 Coding Guidelines

Use of Both Alphabetic Index and Tabular List

- A. Use both the Alphabetic Index and the Tabular List when locating and assigning a code. Reliance on only the Alphabetic Index or the Tabular List leads to errors in code assignments and less specificity code selection.
- B. Locate each term in the Alphabetic Index and verify the code selected in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.

Level of Specificity in Coding

Diagnostic and procedure codes are to be used at their highest level of specificity.

- * Assign three-digit codes only if there are no four-digit codes within that code category.
- * Assign four-digit codes only if there is no fifth-digit subclassification for that category.
- * Assign the fifth-digit subclassification code for those categories where it exists.

Other (NEC) and Unspecified (NOS) Code Titles

Codes labeled "other specified" (NEC - not elsewhere classified) or "unspecified" (NOS - not otherwise specified) are used only when neither the diagnostic statement nor a thorough review of the medical record provides adequate information to permit assignment of a more specific code.

- * Use the code assignment for "other" or NEC when the information at hand specifies a condition but no separate code for that condition is provided.
- * Use "unspecified" (NOS) when the information at hand does not permit either a more specific or "other" code assignment.

When the Alphabetic Index assigns a code to a category labeled "other (NEC)" or to a category labeled "unspecified (NOS)", refer to the Tabular List and review the titles and

inclusion terms in the subdivisions under that particular three-digit category (or subdivision under the four-digit code) to determine if the information at hand can be appropriately assigned to a more specific code.

Acute and Chronic Conditions

If the same condition is described as both acute (sub-acute) and chronic and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (sub-acute) code first.

Combination Code

A single code used to classify two diagnosis or a diagnosis with an associated secondary process (manifestation) or an associated complication is called a combination code. Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

Assign only the combination code when the code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code may be used as a secondary code.

Multiple Coding of Diagnoses

Multiple coding is required for certain conditions not subject to the rules for combination codes.

Instruction for conditions that require multiple coding appear in the Alphabetic Index and the Tabular List.

A. Alphabetic Index: Codes for both etiology and manifestation of a disease appear following the subentry term, with the second code italicized and in slanted brackets. Assign both codes in the same sequence in which they appear in the Alphabetic Index.

B. Tabular List: Instructional terms, such as "Code also...," "Use additional code for any...," and "Note...," indicate when to use more than one code.

* "Code also underlying disease" - Assign the codes for both the manifestation and underlying cause. The codes for manifestations that are printed in italics cannot be used

(designated) as principal diagnosis. * "Use additional code, if desired, to identify manifestation , as .." - Assign also the code that identifies the manifestation, such as, but not limited to, the examples listed. The codes for manifestation that appear in italicized print cannot be used (designated) as principal diagnosis.

C. Apply multiple coding instructions throughout the classification where appropriate, whether or not multiple coding directions appear in the Alphabetic Index or the Tabular List. Avoid indiscriminate multiple coding or irrelevant information, such as symptoms or signs characteristic of the diagnosis.