Section 4: Documentation
Your Name:_____

1. Only use blue or black ink for documentation of patient care. ☐ True ☐ False

2. You may document observations from another staff member if you state the source of the information. ☐ True ☐ False

3. Any abbreviation approved by the American Medical Association may be used in your documentation. ☐ True ☐ False

4. Never document subjective information, such as the patient's level of compliance with treatment recommendations. ☐ True ☐ False

5. Only use the chart for documentation of actual patient care. Telephone communication with the patient should only be documented in a telephone log. ☐ True ☐ False

6. Always date your chart entries as the date of service. ☐ True ☐ False

7. If you don't document an action, it didn't occur. ☐ True ☐ False

8. You may "white out" part of an entry as long as you do not write over that portion of the document. ☐ True ☐ False

9. You may use blank spaces in your documentation as long as you remember to go back and fill in the missing information later. ☐ True ☐ False

10. Documentation is usually most accurate if it is performed directly after patient care is provided. ☐ True ☐ False

11. What do the following acronyms stand for?

a. LRQ
b. OU
c. URI
d. S/S
e. QID
f. ā
g. HX
h. HTN
i. IBS
j. U & C

12. Mary comes into the Health Center seeking medical care. She complains of a stomach ache and nausea that started three days ago. When asked where the pain was most severe, she points to the left upper quadrant of her stomach. She has been treating herself with antacids four times a day. She says that she has a history of irritable bowel syndrome and would like a prescription for Prilosec to take every day. How would you document this patient intake?

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