Medical scribe course

Introduction

SECTION 1: Roles and responsibilities

SECTION 2: The clinical environment

SECTION 3: Medical terminology

SECTION 4: Medical documentation

SECTION 5: Billing

Activity summary

- Activity title: Medical scribe course
- Release date: 2021-06-01
- Expiration date: 2024-06-01
- Estimated time to complete activity: 8 hours
- This course is accessible with any web browser.
- This course is jointly provided by Pacific Medical Training and Postgraduate Institute for Medicine (PIM). You may reach PIM at inquiries@pimed.com

Target audience

This activity has been designed to meet the educational needs of physicians, physician assistants, nurse practitioners, and registered nurses involved in the care of patients who will implement electronic health records into their practice.

This activity is also applicable to medical students (nursing and medical doctor program tracks) so that they may learn the additional skill of medical documentation.

Educational objectives

After completing this activity, the participant should be better able to:

- Describe the primary roles and responsibilities of a medical scribe.
- Underline the medical scribe's scope of care and ability to maintain integrity and patient privacy.

- Relate to the different clinical environments as a member of a multidisciplinary team.
- Apply medical terminology when documenting and communicating among healthcare professionals.
- Illustrate knowledge of common prefixes and suffixes used in medical terminology.
- Record basic anatomy in a precise manner.
- Acknowledge the importance of accurate documentation of patient-physician interactions whether using a paper chart or an electronic health record (EHR).
- Demonstrate the ability to document in real-time in an EHR and take handwritten notes to then later create the required record.
- Execute the standard order of documentation by using the acronym SOAP (subjective, objective, assessment, plan).
- Distinguish the difference between subjective and objective findings.
- Conduct thorough documentation of the chief complaint, history of present illness (HPI), review of symptoms, current medication regimen, allergies, medical history, and family history.
- Employ documentation of verifiable and reproducible information, such as laboratory results, the physical exam findings, and vital signs.
- Produce accurate documentation of emergency situations and procedures.
- Thoroughly interpret the medical decision of the provider via in-person communication or dictation.
- Identify and document the final diagnosis from the provider.
- Summarize the patient's disposition, plan, and discharge instructions as ordered from the provider.
- Describe the billing process and the International Classification of Disease Codes.

Faculty

- Judith Haluka, EMT-Paramedic – State of Pennsylvania

Disclosure of unlabeled use

This educational activity may contain discussion of published and/or investigational uses of agents that are not indicated by the Food and Drug Administration (FDA). The planners of this activity do not recommend the use of any agent outside of the labeled indications.

The opinions expressed in the educational activity are those of the faculty and do not necessarily represent the views of the planners. Please refer to the official prescribing information for each product for discussion of approved indications, contraindications, and warnings.

Disclaimer

Participants have an implied responsibility to use the newly acquired information to enhance patient outcomes and their own professional development. The information presented in this activity is not meant to serve as a guideline for patient management. Any procedures, medications, or other courses of diagnosis or treatment discussed or suggested in this activity should not be used by clinicians without evaluation of their patient's conditions and possible contraindications and/or dangers in use, review of any applicable manufacturer's product information, and comparison with recommendations of other authorities.