

HEADER FORMAT FOR TRANSCRIBED REPORTS
Sioux Falls VA Health Care System

Sample header for discharge summary (WORK TYPE 01):

\$HDR: DISCHARGE SUMMARY
PATIENT SSN:
DICTATED BY: LAST NAME, FIRST NAME
ATTENDING PHYSICIAN: LAST NAME, FIRST NAME
DICTATION DATE/TIME: 4-4-98@1300
ADMISSION DATE: 3-30-98
URGENCY: STAT or ROUTINE
TRANSCRIPTIONIST: LAST NAME, FIRST NAME
\$TXT

Sample header for progress note (WORK TYPE 04):

\$HDR: PROGRESS NOTES
PATIENT SSN:
DICTATED BY: LAST NAME, FIRST NAME
EXPECTED COSIGNER: LAST NAME, FIRST NAME
DICTATION DATE/TIME: 4-4-98@1300
VISIT DATE: 4-4-98
LOCATION: PRIMARY CARE-PROVIDER LAST NAME
TITLE: AMB CARE NOTE
TRANSCRIPTIONIST: LAST NAME, FIRST NAME
\$TXT

Sample header for operation report (WORK TYPE 05):

\$HDR: OPERATION REPORT
PATIENT NAME: LAST NAME, FIRST NAME
PATIENT SSN:
SURGICAL CASE: 143342
OPERATION DATE: 02/12/2004
DICTATED BY: LAST NAME, FIRST NAME
ATTENDING SURGEON: LAST NAME, FIRST NAME
DICTATION DATE: 02/12/2004
TRANSCRIPTIONIST: LAST NAME, FIRST NAME
\$TXT

Sample header for Consultations (WORK TYPE 03):

| | |
|----------------------|-----------------------|
| \$HDR: | CONSULTS |
| PATIENT SSN: | |
| DICTATED BY: | LAST NAME, FIRST NAME |
| EXPECTED COSIGNER: | LAST NAME, FIRST NAME |
| DICTATION DATE/TIME: | 5-16-98@0925 |
| VISIT DATE: | 5-16-98 |
| LOCATION: | PODIATRY |
| TITLE: | CONSULT |
| CONSULT REQUEST #: | 4321 |
| TRANSCRIPTIONIST: | LAST NAME, FIRST NAME |
| \$TXT | |

Sample header for C&P exams (WORK TYPE 07):

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|---------------|-----------------------|
| \$HDR: | C&P EXAM |
| EXAM #: | 56789 |
| PATIENT: | LAST NAME, FIRST NAME |
| DICTATED BY: | LAST NAME, FIRST NAME |
| DATE OF EXAM: | 6-20-98 |
| STATUS: | COMPLETE |
| \$TXT | |

Sample header for Special Registry Exams (Agent Orange, Persian Gulf) (WORK TYPE 77):

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|----------------------|--------------------------|
| \$HDR: | PROGRESS NOTES |
| PATIENT SSN: | |
| DICTATED BY: | LAST NAME, FIRST NAME |
| EXPECTED COSIGNER: | LAST NAME, FIRST NAME |
| DICTATION DATE/TIME: | 7-23-02@0800 |
| VISIT DATE: | 7-23-02@0700 |
| LOCATION: | C&P – PROVIDER LAST NAME |
| TITLE: | AO OR PERSIAN GULF EXAM |
| TRANSCRIPTIONIST: | LAST NAME, FIRST NAME |
| \$TXT | |

Sioux Falls VA Health Care System does not use footers.