Cheatography

BPA 610 Cheat Sheet by NoelleEvelyn via cheatography.com/168075/cs/41457/

| Definitions to know | | |
|----------------------------|--|--|
| Cytotechn- ologist | Examines cellular abnormalities | |
| Pylorotomy | Perfformed in gastrointestinal system | |
| Thoraces | Chest | |
| Rhinorrhea | Drainage from the nose | |
| Cranio- plasty | Surgical repair of the skull | |
| Malaise | General sense of weakness, discomfort, fatigue or feeling run down that may occur alone or with another symptom | |
| Intradermal Injection | Places a small amount of a drug just under the outer layer of the skin | |
| Hypoth- ermia | Drop in body temperature during prolonged exposure to cold | |
| A compound fracture | A fracture of bone where the broken end has penetrated the skin | |
| Calpor- rhaphy | The repair of the vagina | |
| Arthralgia | Pain in a joint | |
| Gastroent- erology | The study of the stomach, intestines and associated diseases | |
| Lumbar | Lower back | |
| Chondr- ocostal | Cartilage and ribs | |
| Hypote- nsion | Decreased blood pressure | |
| Phlebe- ctomy | Removal of a vein or segment of a vein | |
| Living Will | Legal document addressed to patient's family and physicians stating what type of treatment the patient wishes or does not wish when terminally ill | |
| Melanoma | Cancerous Tumor | |
| The Hippocratic Oath | To use the form of treatment believed best for patient, refrain from harmful actions, keep patient's private information confidential | |
| Retention Schedule | Determining how long to keep patients records after they become inactive or closed | |

| Cell Phone Message | |
|--|--|
| Message for | doctor |
| Date | Current date |
| Patient name | patient name |
| Description | reason patient is calling |
| Next step | check box |
| Message taken by | Contestant number |
| - | |
| Procedures | |
| Obtained from new patients | Patients full legal name, address and telephone numbers, reason for visit |
| Numeric filing | Preserves patient confidentiality |
| Any information released from a medical record | Requires patient notification and approval |
| Со-рау | Portion of medical fees patient needs to pay at time of service |
| Exclusions | Noncovered services |
| HIPAA | Confidentiality, privacy, security of inform- ation, national standards for electronic healthcare transactions |
| Beneficiary | Person covered under insurance policy |
| Coordination of Benefits | Determines which of the policies will pay first when more than one policy covers the individual |
| Provider's Fee Schedule | Continous record of usual charges made for specific services |
| The guarantor | If divorced, the parent who has physical custody is responsible for payment |
| The appropriate time to discuss fees for financial concern | When scheduling an appointment |
| Medical history form includes: | social history, medical history, family history, review of symptoms and chief complaint |

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| SOAP Transcript | |
|-----------------|--|
| Subject | Patient name, date of birth, seen by, date, reason for visit, length of symptoms, extra info |
| Objective | History, meds, examination and what it showed, test perfformed |
| Asessment | Based on patient's report and physical examinatin diagnosis is |
| Plan | Future plan for patient |

| Abbreviations | |
|---------------|---------------------------------|
| Тх | Treatment |
| Dx | Diagnosis |
| Rx | Prescription |
| ENT | Ear, nose and throat |
| DOB | Date of birth |
| p.r.n | when necessary or as needed |
| DOS | date of service |
| OTC | over the counter |
| CPR | Cardiopulmonary resuscitation |
| H&P | history and physical |
| Pt | Patient |
| HR | heart rate |
| CC | Chief complaint |
| PPO | Preffered provider organization |
| Wt | Weight |
| N&V | nausea and vomiting |

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