



View Clinical Notes in MyChart

Most provider notes are now available in MyChart.*

How Providers Use Notes to Document Your Healthcare

Your healthcare team records details of your ongoing care and clinical status using notes in your electronic medical record. Various types of notes are created during outpatient care, a surgery or procedure, a visit to the emergency department or a hospital stay.

The main function of a note is to provide a concise, comprehensive summary of a patient's condition for all members of the healthcare team. Notes are used for documenting clinical observations, diagnostic tests ordered, and care delivered. There may be suspected conditions listed in a note that are not confirmed diagnoses. Although patient education is not the purpose of progress notes, we hope that the release of this information into MyChart will enable you to become more involved and knowledgeable regarding your healthcare.

*Certain types of notes are not available in MyChart, for example, Behavioral Health and notes for teens age 13-17.



Abbreviations of Clinical Terminology

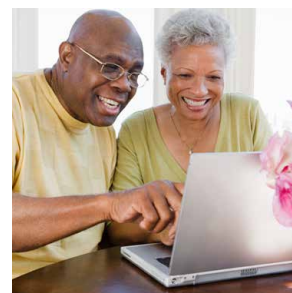
It is important to understand that notes are written in a way for your doctor and other health professionals on your care team to quickly understand your current medical condition. Because of this, the language may be abbreviated. Below are the definitions for some commonly used clinical abbreviations:

BMP:	Basic metabolic panel	I&D:	Incision and drainage
BP:	Blood pressure	IMP:	Impression
C&S:	Culture and sensitivity <i>(performed to detect infection)</i>	LBP:	Low back pain
C/O:	Complains of	N/V:	Nausea or vomiting
CBC:	Complete blood count	P:	Pulse
CC:	Chief complaint	PMH:	Past medical history
Chem panel:	Chemistry panel <i>(a blood test that indicates the status of the liver, kidneys, and electrolytes)</i>	PRN:	As needed
DDX:	Differential diagnosis <i>(the possible diagnoses being considered)</i>	R/O:	Rule out
DM:	Diabetes mellitus	SH:	Social history
DOE:	Dyspnea on exertion <i>(shortness of breath with activity)</i>	SOB:	Shortness of breath
ETOH:	Alcohol intake history	SQ:	Subcutaneous <i>(underneath the skin)</i>
H&P:	History and physical	T:	Temperature
HPI:	History of present illness	UA:	Urinalysis
		URI:	Upper respiratory infection
		VSS:	Vital signs are stable
		Wt:	Weight

Locating Your Providers' Notes in MyChart

Notes can be found in the “**Upcoming & Past Appointments**” section of the “**Appointments**” menu in MyChart. Click on a particular visit to view your After Visit Summary and any available provider notes.

You can also access notes from the “**Health**” menu by selecting “**Admissions & Visit Summary/Notes.**”



Questions or Concerns?

If you have questions regarding a particular note, please address it with your provider at your next appointment.

If you feel that health information we have about you is incorrect, you have the right to ask us to amend your medical records:

In MyChart: Select “Request for Amendment of Protected Health Information” from the Health menu in MyChart to complete this form electronically.

By Mail: Your request for an amendment must be in writing, signed, and dated. It must specify the records you wish to amend, identify the Cleveland Clinic facility that maintains those records, and give the reason for your request. You must address your request to the Privacy Official of the Cleveland Clinic hospital or facility that maintains the records you wish to amend or to the Privacy Office CC30, The Cleveland Clinic Foundation, 9500 Euclid Ave., Cleveland, Ohio 44195.

Cleveland Clinic will respond to you within 60 days. We reserve the right to deny your request; In the event we do deny your request, we will explain why and outline your options.

For more information, please contact the Cleveland Clinic Privacy Office at 216.444.1709 or toll-free at 800.223.2273, ext. 41709.