

## **University of Chicago Medicine Clerkship Note-Writing Policies for IM Residency Program**

Clerkship students are expected to write a note for each of their inpatients every day. These notes include an admission H&P and a daily progress note. In some instances, these notes may be used for billing purposes as the note of record. If the note will be used as the note of record, the student should route it to the intern or resident. If they will not be used, they do not route the notes to anyone. **Residents may only use student notes for billing if they directly observe the student performing the history and physical.**

### **Specific Goals for Notes:**

**H&P:** Our goal is that at least **one time during each 2-week block**, the senior resident will observe the student taking the history and physical and use their note as the note of record. In these instances, the student should route the note directly to the resident.

**SOAP/Progress Note:** If the resident or intern directly observes the student with their patient during pre-rounding they may use these notes as the note of record. How often this occurs will depend on the workflow of your team. These notes should be routed directly to the resident or intern. Plan ahead with the student, if they will be attending preceptor group or clinic most of the day you shouldn't count on them for these notes. Students should not be working on notes at home or after they are finished for the day.

**Coding Queries:** Student should not be receiving these or completing them. They should be forwarded to the resident or attending.

### **Pritzker SOM Medical Student Note-Writing Guidelines Applicable to IMR**

- a. The primary purpose of students completing patient documentation is for their education, not for completing necessary documentation services.
- b. Students will only be expected to document notes on patients with whose care they are intimately involved (patients they are following and assigned i.e. they should not be used as scribes).
- c. Students should not be expected to craft notes that satisfy specific billing requirements, but rather, notes that are of high quality for patient care purposes and communication.
- d. The attending physician will have the primary responsibility for the content, accuracy, and completeness of the documentation.

- e. When residents directly supervise and observe students performing evaluations that they will use for documentation, students should lead the history-taking and physical exam. It should not be a shadowing experience.