<http://www.myphr.com/StartaPHR/what_is_a_phr.aspx>

WHAT IS A PERSONAL HEALTH RECORD (PHR)?

The PHR is a tool that you can use to collect, track and share past and current information about your health or the health of someone in your care. Sometimes this information can save you the money and inconvenience of repeating routine medical tests. Even when routine procedures do need to be repeated, your PHR can give medical care providers more insight into your personal health story.

Remember, you are ultimately responsible for making decisions about your health. A PHR can help you accomplish that.

Important points to know about a Personal Health Record:

You should always have access to your complete health information.

Information in your PHR should be accurate, reliable, and complete.

You should have control over how your health information is accessed, used, and disclosed.

A PHR may be separate from and does not normally replace the legal medical record of any provider.

Medical records and your personal health record (PHR) are not the same thing. Medical records contain information about your health compiled and maintained by each of your healthcare providers. A PHR is information about your health compiled and maintained by you. The difference is in how you use your PHR to improve the quality of your healthcare.

Take an active role in monitoring your health and healthcare by creating your own PHR. PHRs are an inevitable and critical step in the evolution of health information management (HIM). The book “The Personal Health Record” assists new users of PHRs in getting started, addressing current PHR trends and processes.

What Does Your PHR Contain?

The specific content of your health record depends on the type of healthcare you have received. Listed below are documents common to most health records and additional documents that accompany hospital stays or surgery.

Reports Common to Most Health Records:

Identification Sheet – A form originated at the time of registration or admission. This form lists your name, address, telephone number, insurance, and policy number.

Problem List – A list of significant illnesses and operations.

Medication Record – A list of medicines prescribed or given to you.

History and Physical – A document that describes any major illnesses and surgeries you have had, any significant family history of disease, your health habits, and current medications. It also states what the physician found when he or she examined you.

Progress Notes – Notes made by the doctors, nurses, therapists, and social workers caring for you that reflect your response to treatment, their observations and plans for continued treatment.

Consultation – An opinion about your condition made by a physician other than your primary care physician. Sometimes a consultation is performed because your physician would like the advice and counsel of another physician.

Physician’s Orders – Your physician’s directions to other members of the healthcare team regarding your medications, tests, diets, and treatments.

Imaging and X-ray Reports – Describe the findings of x-rays, mammograms, ultrasounds, and scans. The actual films are maintained in the radiology or imaging departments or on a computer.

Lab Reports – Describe the results of tests conducted on body fluids. Common examples include a throat culture, urinalysis, cholesterol level, and complete blood count (CBC). Surprisingly, your health record does not usually contain your blood type. Blood typing is not part of routine lab work.

Immunization Record – A form documenting immunizations given for disease such as polio, measles, mumps, rubella, and the flu. Parents should maintain a copy of their children’s immunization records with other important papers.

Consent and Authorization Forms – Copies of consents for admission, treatment, surgery, and release of information.

Additional Reports Common to Hospital Stays or Surgery:

Operative Report – A document that describes surgery performed and gives the names of surgeons and assistants.

Pathology Report – Describes tissue removed during an operation and the diagnosis based on examination of that tissue.

Discharge Summary – A concise summary of a hospital stay, including the reason for admission, significant findings from tests, procedures performed, therapies provided, response to treatment, condition at discharge, and instructions for medications, activity, diet, and follow-up care.

Your records may contain some or all of the documents above. Depending upon your illness or injury, you may use the services of the emergency room, intensive care unit, a physical therapist, or home health nurse. Often these specialized services have unique evaluation, measurement, and progress reports wich you may also find in your health record.