



AYDIN ADNAN MENDERES UNIVERSITY COURSE INFORMATION FORM

Course Title		Medical Documentation II							
Course Code		TS102		Course Level		Short Cycle (Associate's Degree)			
ECTS Credit	6	Workload	154 (<i>Hours</i>)	Theory	4	Practice	0	Laboratory	0
Objectives of the Course		The effect of the medical record and documentation period on the quality of health care services, the qualitative and quantitative analysis of the documents used in the health institutions and the development of the documents are the ways of getting students. The collection of medical data, the registration of the data, the rules concerning the process of work and the legal regulations are to gain students.							
Course Content		Formation of patient files, forms and schedules forming files, analysis of quality and quantity of patient files, documents used by health institutions, forms, schedules. The responsibilities of medical records include legal status, confidentiality, security and patient privacy.							
Work Placement		N/A							
Planned Learning Activities and Teaching Methods				Explanation (Presentation), Discussion, Individual Study					
Name of Lecturer(s)									

Assessment Methods and Criteria

Method	Quantity	Percentage (%)
Midterm Examination	1	40
Final Examination	1	60

Recommended or Required Reading

1	Artukoğlu, M. Adil, Kaplan A., Yılmaz A., Tıbbi Dokümantasyon; Türk Sağlık Eğitim Vakfı, 2002.
2	Sümbüloğlu K., Sümbüloğlu V., Tıbbi Dokümantasyon, Ankara, 2002.
3	Balcı Erkan A., Tıbbi Dokümantasyon ve Tıbbi Arşivler, Dokuz Eylül Üniversitesi, 2001.
4	Sağlık Bakanlığı, ?Yataklı Tedavi Kurumları Tıbbi Kayıt ve Arşiv Hizmetleri Yönergesi?, 2001.
5	HUFFMAN, E., Medical Record Management, Bervyn, Illinois, 1985.
6	SHURKA, M., Health Information Management in Hospitals, (American Hospital Publishing Inc, 1994.

Week	Weekly Detailed Course Contents	
1	Theoretical	Basic rules and methods of medical documentation
2	Theoretical	Effect of medical documentation on health services
3	Theoretical	Examination of documents used in health institutions.
4	Theoretical	Examination of documents used in health institutions.
5	Theoretical	Standardization of patient files, preparation of file summaries
6	Theoretical	Borrowing and receiving patient Files, Removing, Preventing Placement Errors
7	Theoretical	Borrowing and receiving patient Files, Removing, Preventing Placement Errors
8	Theoretical	Patient records in institutions and organizations providing preventive and primary care services; Family Health Centers, Oral and Dental Health Centers, Family Planning and Mother and Child Health Centers, Public Health Institution
9	Intermediate Exam	MIDTERM
10	Theoretical	Patient records in institutions and organizations providing preventive and primary care services; Family Health Centers, Oral and Dental Health Centers, Family Planning and Mother and Child Health Centers, Public Health Institution
11	Theoretical	Qualitative and quantitative analysis of medical documents in health institutions
12	Theoretical	Standards on the protection and storage of documents in a health facility
13	Theoretical	Development methods of documents used in health institutions
14	Theoretical	Relationship between document management and corporate information
15	Theoretical	Analysis of administrative documents in health institutions
16	Theoretical	Analysis of administrative documents in health institutions

Workload Calculation

Activity	Quantity	Preparation	Duration	Total Workload
Lecture - Theory	14	2	4	84



Assignment	10	4	2	60
Midterm Examination	1	3	2	5
Final Examination	1	3	2	5
Total Workload (Hours)				154
[Total Workload (Hours) / 25*] = ECTS				6
*25 hour workload is accepted as 1 ECTS				

Learning Outcomes

1	Recognizes the effect of medical records on the quality of health care services.
2	Insure security and privacy of data. tender documents to user
3	Know patient files and complete its deficiencies.
4	It makes qualitative and quantitative analysis of patient files.
5	The student gets medical data, analyzes the data.
6	Keeps the data and provides it in case of need.
7	Applies the legal provisions related to the data.

Programme Outcomes (Medical Documentation and Secretarial Practices)

1	Write and pronounce medical terms correctly.
2	Collect data of medical statistics and report the results periodically after analyzing them scientifically.
3	Learn basic structure of human body and important system diseases.
4	Know principles and rules of medical secretaryship. Protect patients? rights and privacy.
5	Use Turkish and body language in a correct and effective way.
6	Run internal and external correspondence of the foundation, keep the files of the documents after classification, organize them and archive in line with filing techniques.
7	Establish verbal and written communication inside the foundation and out of foundation.
8	Make the coding procedure of diseases and health problems according to existing international classification systems.
9	Run the counseling services for patients and their relatives.
10	Solve the problems that are encountered in work life quickly and effectively.
11	Use the necessary equipment for professional practices such as computer and office devices effectively.
12	Improve professional knowledge and skills continuously.
13	Executes any patient registration-documentation processes
14	Makes archiving operations
15	Prepares medical documents
16	Knows Turkish history and Atatürk's revolutions.
17	Adapt to team work in application areas.
18	Knows and defines diseases.
19	Have general information about the world and biological formations.
20	English speaking writer

Contribution of Learning Outcomes to Programme Outcomes 1:Very Low, 2:Low, 3:Medium, 4:High, 5:Very High

	L1	L2	L3	L4	L5	L6	L7
P1	1	1	1	1	1	1	1
P2	4	4	4	4	4	4	4
P3	4	4	4	4	4	4	4
P4	5	5	5	5	5	5	5
P5	4	4	4	4	4	4	4
P6	4	4	4	4	4	4	4
P7	4	4	4	4	4	4	4
P8	5	5	5	5	5	5	5
P9	4	4	4	4	4	4	4
P10	5	5	5	5	5	5	5
P11	3	3	3	3	3	3	3
P12	5	5	5	5	5	5	5
P13	5	5	5	5	5	5	5
P14	5	5	5	5	5	5	5



P15	5	5	5	5	5	5	5
P17	5	5	5	5	5	5	5
P18	3	3	3	3	3	3	3

