KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

*MODUL 1*

# AHIMA CODE OF ETHICS

***MATA KULIAH : ENGLISH FOR MEDICAL RECORD***


PROGRAM STUDI DIPLOMA TIGA REKAM MEDIS DAN INFORMASI KESEHATAN
POLTEKKES KEMENKES YOGYAKARTA
KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

Bahasa Inggris 2 : Medical Record Jobs

Kode Mata Kuliah : RMIK202

Tanggal Mulai : 13 Januari 2022

**HANYA UNTUK PENGGUNAAN INTERNAL**

# Medical Record Jobs

Modul: 1


Niko Tesni Saputro, S.KM., M.P.H

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Yogyakarta, Indonesia

## Kata Pengantar

Laboratorium pendidikan adalah unit kerja pendidikan yang menyediakan fasilitas dan peralatan untuk kegiatan praktikum mahasiswa. Laboratorium pendidikan juga berfungsi sebagai fasilitas penunjang mahasiswa dalam mengembangkan keahlian dan menciptakan karya ilmiah. Kegiatan praktikum pada suatu mata kuliah, merupakan bagian yang tidak dapat dipisahkan dalam proses pencapaian keberhasilan mahasiswa dalam pengembangan keilmuan, kemampuan, dan penemuan. Karena itu perlu dibuat Modul Praktik Bahasa Inggris 2 dalam rangka mendukung hal tersebut.

Melalui modul praktik ini mahasiswa dapat memperoleh materi dan soal latihan tentang *English in Medical Record* , pada mata Bahasa Inggris 2. Dengan demikian diharapkan tidak ada mahasiswa yang terkendala dalam mengikuti praktik laboratorium.

Besar harapan kami, modul ini dapat bermanfaat dalam memperlancar proses kegiatan praktik mahasiswa. Serta kami menerima kritik dan saran jika terdapat hal-hal yang belum sempurna, agar modul ini dapat digunakan dengan baik di kalangan mahasiswa maupun kalangan instruktur praktik.

Yogyakarta, 13 Januari 2022

Tim Penyusun

# Daftar Isi

1. Pengantar

Mata Kuliah ini membahas tentang pekerjaan perekam medis, keamanan rekam medis, pemberian informasi, lembar persetujuan, fasilitas rehabilitasi, konsultasi dan konsolidasi, permintaan, kebutuhan, dan kewajiban dalam manajemen rekam medis. Mata kuliah ini menjadi salah satu mata kuliah wajib yang harus diikuti oleh setiap mahasiswa. Mata kuliah ini memberikan pengalaman belajar kepada mahasiswa yang mendukung untuk mencapai capaian pembelajaran khususnya dari aspek sikap, pengetahuan dan ketrampilan umum berdasarkan Standar Nasional Pendidikan Tinggi (Permendikbud Nomor 3 Tahun 2020)

Modul Praktik Bahasa Inggris 2, Program Studi Diploma Tiga Rekam Medis dan Informasi Kesehatan Semester Ganjil Tahun Akademik 2021/2022, disusun dengan tujuan untuk memberikan arahan serta acuan bagi mahasiswa dan instruktur praktik, dalam melaksanakan kegiatan praktikum selama Semester Genap di Prodi Diploma Tiga Rekam Medis dan Informasi Kesehatan Tahun Akademik 2021/2022. Modul praktik ini berisi tentang materi *Medical Record Jobs, Security of Medical Record, Relase of Information, Informed Consent, Rehabilitation Facilities, Consultation and Consolidation, Request Necessities Obligations.*

2. Capaian Pembelajaran

Peserta didik mampu memahami tentang *Medical Record Jobs, Security of Medical Record, Relase of Information, Informed Consent, Rehabilitation Facilities, Consultation and Consolidation, Request Necessities Obligations.*

3. Bahan Kajian

1. *Medical Record Jobs*
2. *Security of Medical Record*
3. *Relase of Information*
4. *Informed Consent*
5. *Rehabilitation Facilities*
6. *Consultation and Consolidation*
7. *Request Necessities Obligations.*

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1. Mampu memahami dan menjelaskan *Medical Record Jobs*
2. Mampu memahami dan menjelaskan *Security of Medical Record*
3. Mampu memahami dan menjelaskan *Relase of Information*
4. Mampu memahami dan menjelaskan *Informed Consent*
5. Mampu memahami dan menjelaskan *Rehabilitation Facilities*
6. Mampu memahami dan menjelaskan *Consultation and Consolidation*
7. Mampu memahami dan menjelaskan *Request Necessities Obligations*

5. Luaran

1. Peserta didik memiliki kompetensi dalam menjelaskan Medical Record Jobs
2. Peserta didik memiliki kompetensi dalam menjelaskan Security of Medical Record
3. Peserta didik memiliki kompetensi dalam menjelaskan Relase of Information
4. Peserta didik memiliki kompetensi dalam menjelaskan Informed Consent
5. Peserta didik memiliki kompetensi dalam menjelaskan Rehabilitation Facilities
6. Peserta didik memiliki kompetensi dalam menjelaskan Consultation and Consolidation
7. Peserta didik memiliki kompetensi dalam menjelaskan Request Necessities Obligations

6. Medical Record Jobs

a. Defenition

Medical record is a compilation of pertinent facts about a patient's life and health history, including past and present illnesses and treatments. Its written by the health professionals contributing to the patient's care.

*b. Jobs Description of Medical Record Officer*

Description job as medical record offiicer is responsible for managing patients' health records and history. Their main duties include helping conduct audits, gathering and filing patient information and processing discharge papers. example of activities as a medical record officer is to make sure that patient record get to the various departements around the hospital on time for things like clinic appoinments and admissions and when patients arrive at emergency. Do things like collecting and delivering files. Making sure the paperwork is in the right order and make sure the clinical trems can easily and quickly find current information.The officer Also send file to other health professionals whe asked so patient can be assured of on going medical care.

*c. Medical Record Purposes*

Medical Record really important comprehensive and accurate medical records empower healthcare professionals to treat patients to the best of their ability. Every single available detail is important because all accumulated information can contribute to diagnosis and treatment.

With the help of information technology, healthcare could become more cost-effective and facilitate improved patient outcomes.

- ✓ Safety can be increased
- ✓ Processes can be sped up
- ✓ Claims processing and reimbursement can be improved
- ✓ Effectiveness of therapies and treatments can be monitored and tracked
- ✓ With a growing amount of information, outcome predictions can be made
- ✓ From a legal point of few, liability is reduced as a result of increased oversight
- ✓ With IT, loss of information, errors and omissions can be significantly reduced
- ✓ Accurate documentation of initial assessments and progress improves quality assurance
- ✓ Methodical records of symptoms, diagnoses and treatments will greatly benefit the next healthcare professional involved and more importantly benefit the patient

7. Penugasan

a. Task 1

In this topic, you are going to learn about the jobs related to medical record technology. It becomes a part of health information management. So, what is health information management? Please, watch the video on the link and we are going discuss about the information you get from the video.

Link on Youtube

https://www.youtube.com/watch?time_continue=11&v=eZeG9Vlirfw&feature=emb_title

Students make a summary of the material from the video.

b. Task 2

Create mind mapping of the material from the video you have watched and present it to your friends in class.

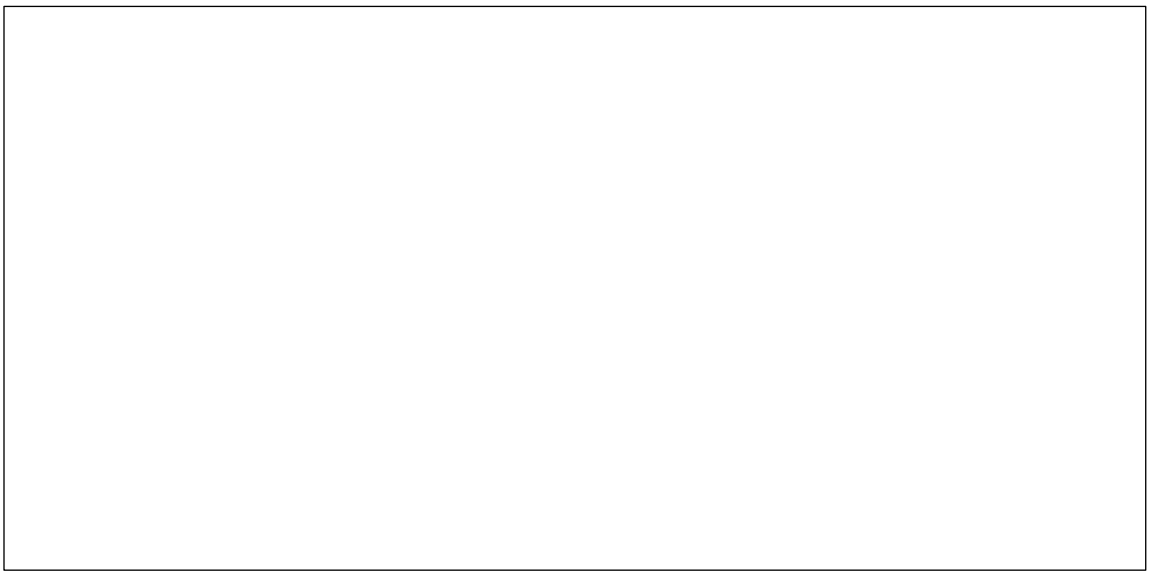
c. Task 3

Answer the following questions based on material in this modul and from the video you have watched.

1. What are the format of HIM?

2. Mention the 4 main focuses of HIM?

3. What are possible jobs in HIM?



4. How to be a professional HIM?

8. Referensi


1. Hancock, Mark, & McDonald, A. (2009). English Result Intermediate Student's Book. Oxford University Press
2. Hornby, A.S. Oxford Advanced Learners Dictionary, 8th edition. Oxford: Oxford University Press
3. Huffman, E.K., (1994). Health Information Management. Physician Record Company. Illynois.
4. Murphy, R. (2012). English Grammar in Use. London: Cambridge University Press
5. CDEDYourOnlineSchool.2017, 16 November. What is Health Information Manajement. Youtube.https://www.youtube.com/watch?time_continue=11&v=eZeG9Vlirfw&feature=emb_title

9. Lembar Catatan Pembelajaran

Nama :

NIM :

Kelas :

| No | Tanggal | Aktivitas | Catatan pengampuan | Tanda tangan pengampu |
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| 1 | | | | |
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| 5 | | | | |

Nilai Akhir: _____

Pengampu,

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

*MODUL 2*

# ROLES OF HIM PROFESSIONAL

***MATA KULIAH : ENGLISH FOR MEDICAL RECORD***


PROGRAM STUDI DIPLOMA TIGA REKAM MEDIS DAN INFORMASI KESEHATAN
POLTEKKES KEMENKES YOGYAKARTA
KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

Bahasa Inggris 2 : Medical Record Jobs

Kode Mata Kuliah : RMIK202

Tanggal Mulai : 20 Januari 2022

**HANYA UNTUK PENGGUNAAN INTERNAL**

# Medical Record Jobs

Modul: 2


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Program Studi Diploma Tiga Rekam Medis dan Informasi Kesehatan,
Politeknik Kesehatan Kemenkes Yogyakarta,
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Yogyakarta, 13 Januari 2022

Tim Penyusun

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6. Jobs in Medical Record

a. Health Information Technician
    1. Usually hold at least an associate's degree
    2. May work in a doctor's office, hospital or any other facility where patient records are kept.
    3. Medical records or health information technicians manage the data regarding a patient's history and also do checks for quality on such information, according to Career Overview. All kinds of health information might be included in the kinds of records handled, from patient intake information to diagnosis and treatment notes or test results.
    4. Good computer skills are a must, but it's also helpful for a health information technician to have some understanding of medical terminology.

b. Electronic Health Records (EHR) Professional
    1. Technicians and consultants helping with electronic health records (EHR).
    2. Well trained people to manage the software.
    3. Take general templates and customize them for specific needs, such as building a requested patient's history.
    4. The data may be on an larger scale such a health profiles for a certain demographic.
    5. Have a background in medicine already, perhaps as a medical assistant or nurse.
    6. Can be used in a consulting capacity.
    7. These are just a few of the medical record keeping jobs you can find in the current healthcare system. The list could also include such jobs as medical billing and coding.
    8. Care and accuracy in handling information and some familiarity with medical terminology and healthcare delivery are perhaps your biggest assets as you look into jobs available in medical records.

c. Medical Transcriptionist
    1. People who transcribe doctor's notes, usually recorded, onto a computer. These notes get added to patient medical files and ensure that the doctor has accurate and legible notes to refer to when needed.
    2. Fast, accurate typing and some familiarity with medical terminology Have an associate's degree (some), while others complete an approximately one-year program.
    3. Can sometimes work from home or as independent contractors.

d. Medical Biller and Coder
Medical Biller

The person ho handling the process of submitting health insurance claims on behalf of the patient to various health insurance payors for the purpose of acquiring payment for services rendered in a medical facility.

Medical Coder

The individuals responsible for translating physicians' reports into useful uniform medical codes. These professionals work behind the scenes in a variety of settings, ensuring all pertinent information is coded appropriately to ensure consistency and accuracy.

Authority of Medical Record Officer

a. Who is responsible for making entries in the medical record?

A medical record is generated at the point at which a patient gets admitted to a ward in a healthcare institution. Depending on the country and the institution, a new medical record may be created each time the patient is admitted, or the medical record may move from ward to ward or institution institution.

The first page of the medical record is called the Admission Form. Although several people may contribute to it, the admitting doctor of the health institution is the person mainly responsible for documenting the first page. The patient is admitted to the relevant ward with this partially completed medical record. Thereafter, the ward doctors (Intern Medical Officers, Senior House Officers, Registrars, Senior Registrars and Consultants) and nurses attached to this ward are responsible for documenting pertinent information about the patient until the separation of the patient from the ward either by discharge or death

b. Can I access someone else's medical records (health records)?

Health and care records are confidential so you can only access someone else's records if you're authorised to do so.

- ✓ To access someone else's health records, you must:
- ✓ be acting on their behalf with their consent, or
- ✓ have legal authority to make decisions on their behalf (power of attorney), or
- ✓ have another legal basis for acces

c. Applying for access to someone else's health records

A request for someone's health and care records should be made directly to the health and care organisation that provided the treatment, such as:

- ✓ GP surgery
- ✓ hospital
- ✓ optician
- ✓ dentist
- ✓ care home

You will need the patient or service user's written consent if you wish to access their record.

Where written consent is not possible, other arrangements will be necessary.

d. Refused request

A healthcare provider can refuse to supply some of your request if, for example:

- ✓ it is likely to cause serious harm to the physical or mental health of any individual
- ✓ the information you have asked for contains information that relates to another person

If your request is rejected, or you have a complaint about the process, you can complain to the healthcare provider

e. Patients unable to give consent

If a person does not have the mental capacity to manage their own affairs and you are their attorney, you will have the right to apply for access to their health and care records.

This would apply, for example, if you have a Lasting Power of Attorney with authority to manage their property and affairs

7. Penugasan

a. Task 1

Please watch the linked video. Write down the list of activities the officer does during his day as a medical record officer.

Link on Youtube

https://www.youtube.com/watch?time_continue=11&v=7kSb9SNii_g&feature=emb_title

List of activities the officer from the video

b. Task 2

In this section, you are going to have listening practice. Please listen the conversations carefully and do the quiz according to the conversations.

https://drive.google.com/file/d/1krI5mCnklLxAwBg831_FEZGRq5bWQRoK/view

Question 1-4

Complete the notes below

Students Name : Marten Hansen

1. Faculty of :
2. Address (number) :
3. Telephone :
4. Nationality :

Question 5-10

5. Why is Martin visiting the doctor?
    A. He feels sad
    B. He lacks friends
    C. He gets blue his eyes
    D. He feels interest of love
    E. He feels grateful of his friends

6. According to the doctor, what is the evidence of a psychiatric problem
    A. One feels difficult in making friends
    B. One thinks life is difficult
    C. One's daily is disrupted
    D. When feels lot of imagination
    E. When feels pleasure in usual activities

7. What causes Martin's depression?
    A. Family history of depression
    B. Become worrying change in life
    C. Abuse of alcohol
    D. Abuse of his friends
    E. Has lot of imagination

8. Antidepressant medications is not suggested by the doctor because ….
    A. Martin's depression is not serious
    B. Martin's have a history of illness
    C. Martin's does  not like medicine
    D. They have negative effects
    E. They are not effective

9. The purpose of psychotherapy is ….
    A. To make patients  always feels happy
    B. To help patients  in job
    C. To change the patients behavior
    D. To help patients cope with feeling more effective
    E. To make patients have insight into life

10. What does the doctor suggest Martin, except ….
    A. Do some physical exercises
    B. Consume antidepressant medications
    C. Find a hobby
    D. Come to the counseling
    E. Remember ask for help if the load is too heavy to handle

c. Task 3

Every students have to explain verbally in the class your point of view about your future as medical record officers. Please, prepare it well.

8. Referensi


1. Hancock, Mark, & McDonald, A. (2009). English Result Intermediate Student's Book. Oxford University Press
2. Hornby, A.S. Oxford Advanced Learners Dictionary, 8th edition. Oxford: Oxford University Press
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Nilai Akhir: _____

Pengampu,

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

*MODUL 3*

# WHAT IS CLINICAL DATA MANAGEMENT (CDM)?

***MATA KULIAH : ENGLISH FOR MEDICAL RECORD***


PROGRAM STUDI DIPLOMA TIGA REKAM MEDIS DAN INFORMASI KESEHATAN
POLTEKKES KEMENKES YOGYAKARTA
KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

Bahasa Inggris 2 : Security of Medical Records

Kode Mata Kuliah : RMIK202

Tanggal Mulai : 20 Januari 2022

**HANYA UNTUK PENGGUNAAN INTERNAL**

# Security of Medical Records

Modul: 3


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Program Studi Diploma Tiga Rekam Medis dan Informasi Kesehatan,
Politeknik Kesehatan Kemenkes Yogyakarta,
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Yogyakarta, 23 Januari 2022

Tim Penyusun

**Daftar Isi**

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5. Peserta didik memiliki kompetensi dalam menjelaskan *Rehabilitation Facilities*
6. Peserta didik memiliki kompetensi dalam menjelaskan *Consultation and Consolidation*
7. Peserta didik memiliki kompetensi dalam menjelaskan *Request Necessities Obligations*

6. Security of Medical Records

*a.* Aim of Security Medical Record*s*

Medical records are one of the data that can be used in proving malpractice cases in court. The medical record is also one of the documentation of the patient's condition and the contents of the medical record are medical secrets that must be kept confidential by every health worker.

Why are security and patient privacy important?

Medical information security can affect the quality of patient care and patient rights. It can also impact the work practices and legal responsibilities of health care professionals. Doctors can make the best decisions for your care if they can access all relevant information in your medical history. If the doctor cannot access the data, this can delay important medical decisions and potentially harm your medical care. Any protection methods must maintain medical record document privacy and confidentiality while still allowing authorized individuals to quickly and easily access it.

b. Security of medical record files in terms of physical aspects of the file

How is medical information kept secure and private?

Physical, technical, and administrative safeguards protect the privacy, security, and integrity of recorded patient information. At the same time, these safeguards allow appropriate access to health providers for patient care. Physical safeguards include:

1. ink, paper, folder, used shelf
2. Use of encrypted storage or devices
3. Restricting physical access to authorized personnel only
4. Preserving copies and conducting data backups
5. Maintaining emergency contingency protocols
6. Disposing outdated devices properly.

c. Security of medical record files in terms of non- physical aspects of the file
Security of medical record files in terms of non-physical medical record documents

Administrative safeguards include:

1. Requiring documentation of departmental security policies
2. Training staff about security policies
3. Conducting audit trails of all system logs by user identification and activity
4. Enforcing policies for storage and retention of electronic data and backup of all systems
5. Providing specific methods to report incidents and resolve security issues
6. Documenting accountability, sanctions, and disciplinary actions for any violation of policies and procedures.
7. unauthorized parties, natural disasters, dust, insects and other destructive pests.

Confidentiality of Medical Record Files

Patient privacy is your right to decide when, how, and to what extent others may access your health information. Patient privacy maintains confidentiality and only shares medical record document with those who need it to provide or improve medical care. If your medical record document is used for research purposes, researchers must obtain your informed consent. This may include using your medical information anonymously to conduct research.

Retention System and Destruction of Medical Records

What Makes Medical Record Retention and Destruction So Important?

Staying on top of medical record management is essential for protecting patients. This ensures their information remains safe through proper storage and destruction. However, there are also legal incentives for making medical record retention and destruction a priority.

According to the 2006 BPPRM, retention has the following meanings an activity to separate or transfer between recorded documents inactive medical with medical record documents that are still active in the room storage(filing). In addition, retention can also be interpreted asreducing the number of forms contained in the RM . file by sorting the use value of each form.

In accordance with the 2006 BPPRM, the destruction of medical records is the activity of eliminating/deleting/destroying physical medical record documents that have reached 5 years sincelast treatment at the hospital.

Retention or shrinkage of medical record documents is a activities to separate between medical record documents that are still active and inactive or inactive. The purpose is reduce the burden of storing medical record documents and prepare medical record use value assessment activities forthen enshrined or destroyed. Retention activities are carried out by storage officers (filing) periodically. And the documents that have been withheld must bestored in a separate room from active medical record documents by sorting according to the last date of treatment.

.

7. Penugasan

a. Task 1

Please watch the linked video. Write down the resume of the material from the video

Link on Youtube

https://www.youtube.com/watch?v=yvV-f0hFowA&t=7s

https://www.youtube.com/watch?v=wWMlGKvsn3M&t=2s

Resume of the material

b. Task 2
   Please watch the linked video

Link on Youtube :

https://youtu.be/i71Q5x_T0Dw

Create mind mapping of the material from the video you have watched .

c. Task 3

For this topic, you are going have team work for having presentation in front of the class with the conditions:

1. One group consist of 3 persons: PPt writer, presenter, moderator
2. All the group have to write an essay about Security of Medical Records consists of 3-paragraphs.
3. Make PPt referring to the essay of 5-10 slides
4. Each group wil present their PPt in front of the class

8. Referensi


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7. RSRSrecords.2014, 24 Maret. How to Scan Your Patient Medical Records in 10 Steps.. Youtube. https://youtu.be/i71Q5x_T0Dw

9. Lembar Catatan Pembelajaran

Nama :

NIM :

Kelas :

| No | Tanggal | Aktivitas | Catatan pengampuan | Tanda tangan pengampu |
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Nilai Akhir: _____

Pengampu,

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

*MODUL 4*

# DATA MANAGEMENT IN CLINICAL RESEARGH : AN OVERVIEW

***MATA KULIAH : ENGLISH FOR MEDICAL RECORD***


PROGRAM STUDI DIPLOMA TIGA REKAM MEDIS DAN INFORMASI KESEHATAN
POLTEKKES KEMENKES YOGYAKARTA
KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

Bahasa Inggris 2 : Release of Information

Kode Mata Kuliah : RMIK202

Tanggal Mulai : 03 Februari 2022

**HANYA UNTUK PENGGUNAAN INTERNAL**

# Release of Information

Modul: 4


Niko Tesni Saputro, S.KM., M.P.H

Sefi Nurhadianti, S.S., M.P

Program Studi Diploma Tiga Rekam Medis dan Informasi Kesehatan,
Politeknik Kesehatan Kemenkes Yogyakarta,
Yogyakarta, Indonesia

## Kata Pengantar

Laboratorium pendidikan adalah unit kerja pendidikan yang menyediakan fasilitas dan peralatan untuk kegiatan praktikum mahasiswa. Laboratorium pendidikan juga berfungsi sebagai fasilitas penunjang mahasiswa dalam mengembangkan keahlian dan menciptakan karya ilmiah. Kegiatan praktikum pada suatu mata kuliah, merupakan bagian yang tidak dapat dipisahkan dalam proses pencapaian keberhasilan mahasiswa dalam pengembangan keilmuan, kemampuan, dan penemuan. Karena itu perlu dibuat Modul Praktik Bahasa Inggris 2 dalam rangka mendukung hal tersebut.

Melalui modul praktik ini mahasiswa dapat memperoleh materi dan soal latihan tentang *English in Medical Record* , pada mata Bahasa Inggris 2. Dengan demikian diharapkan tidak ada mahasiswa yang terkendala dalam mengikuti praktik laboratorium.

Besar harapan kami, modul ini dapat bermanfaat dalam memperlancar proses kegiatan praktik mahasiswa. Serta kami menerima kritik dan saran jika terdapat hal-hal yang belum sempurna, agar modul ini dapat digunakan dengan baik di kalangan mahasiswa maupun kalangan instruktur praktik.

Yogyakarta, 23 Januari 2022

Tim Penyusun

# Daftar Isi

1. Pengantar

Mata Kuliah ini membahas tentang pekerjaan perekam medis, keamanan rekam medis, pemberian informasi, lembar persetujuan, fasilitas rehabilitasi, konsultasi dan konsolidasi, permintaan, kebutuhan, dan kewajiban dalam manajemen rekam medis. Mata kuliah ini menjadi salah satu mata kuliah wajib yang harus diikuti oleh setiap mahasiswa. Mata kuliah ini memberikan pengalaman belajar kepada mahasiswa yang mendukung untuk mencapai capaian pembelajaran khususnya dari aspek sikap, pengetahuan dan ketrampilan umum berdasarkan Standar Nasional Pendidikan Tinggi (Permendikbud Nomor 3 Tahun 2020)

Modul Praktik Bahasa Inggris 2, Program Studi Diploma Tiga Rekam Medis dan Informasi Kesehatan Semester Ganjil Tahun Akademik 2021/2022, disusun dengan tujuan untuk memberikan arahan serta acuan bagi mahasiswa dan instruktur praktik, dalam melaksanakan kegiatan praktikum selama Semester Genap di Prodi Diploma Tiga Rekam Medis dan Informasi Kesehatan Tahun Akademik 2021/2022. Modul praktik ini berisi tentang materi *Medical Record Jobs, Security of Medical Record, Relase of Information, Informed Consent, Rehabilitation Facilities, Consultation and Consolidation, Request Necessities Obligations.*

2. Capaian Pembelajaran

Peserta didik mampu memahami tentang *Medical Record Jobs, Security of Medical Record, Relase of Information, Informed Consent, Rehabilitation Facilities, Consultation and Consolidation, Request Necessities Obligations.*

3. Bahan Kajian

1. *Medical Record Jobs*
2. *Security of Medical Record*
3. *Relase of Information*
4. *Informed Consent*
5. *Rehabilitation Facilities*
6. *Consultation and Consolidation*
7. *Request Necessities Obligations.*

4. Tujuan Pembelajaran

Peserta didik mampu memahami tentang pekerjaan perekam medis, keamanan rekam medis, pemberian informasi, lembar persetujuan, fasilitas rehabilitasi, konsultasi dan konsolidasi, permintaan, kebutuhan, dan kewajiban dalam manajemen rekam medis.

1. Mampu memahami dan menjelaskan *Medical Record Jobs*
2. Mampu memahami dan menjelaskan *Security of Medical Record*
3. Mampu memahami dan menjelaskan *Relase of Information*
4. Mampu memahami dan menjelaskan *Informed Consent*
5. Mampu memahami dan menjelaskan *Rehabilitation Facilities*
6. Mampu memahami dan menjelaskan *Consultation and Consolidation*
7. Mampu memahami dan menjelaskan *Request Necessities Obligations*

5. Luaran

1. Peserta didik memiliki kompetensi dalam menjelaskan *Medical Record Jobs*
2. Peserta didik memiliki kompetensi dalam menjelaskan *Security of Medical Record*
3. Peserta didik memiliki kompetensi dalam menjelaskan *Relase of Information*
4. Peserta didik memiliki kompetensi dalam menjelaskan *Informed Consent*
5. Peserta didik memiliki kompetensi dalam menjelaskan *Rehabilitation Facilities*
6. Peserta didik memiliki kompetensi dalam menjelaskan *Consultation and Consolidation*
7. Peserta didik memiliki kompetensi dalam menjelaskan *Request Necessities Obligations*

6. Release of Information

a. What is Release of Information?

Release of information (ROI) is the process of providing access to protected health information (PHI) to an individual or entity authorized to receive or review it. *PHI* is a term derived from a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), that refers to health information about a specific patient. Authorization to release this information typically is provided by the patient to whom it pertains or that patient's legal representative. However, the staff working in a healthcare organization's ROI area may be responsible for monitoring and controlling access to PHI by others within the organization as well as by those who have a right to access PHI without patient authorization.

The ROI function previously was known as the correspondence or copy desk because staff members received letters requesting copies of patient records. However, today, patients and other authorized individuals obtain copies of medical information in a variety of ways, including directly through a patient portal, electronically stored on a USB drive, and electronically written to a DVD.

Fifty years ago, what has come to be known as the health information management (HIM) department was called the medical records department, and the only mail it received was requests from insurers, attorneys, patients, and physicians for copies of medical records or professional journals and books. Fax machines were a rarity in both the medical records department and administration in those days. Today, the HIM department still receives conventional mail that includes requests for patient information along with glossy advertisements and the occasional professional journal that hasn't converted to an online format. But today's requests for information also come via fax, email, and for some organizations, through a secured portal for information other than what the patient can access directly on the organization's health information portal. The requestors now include an array of third-party payers, researchers, quality improvement organizations, governmental and other external auditors, and, of course, attorneys, patients, and physicians.

This decentralization of ROI has both advantages and disadvantages. One advantage is that many departments share the work, so it might not be necessary to add employees strictly for ROI. Another advantage is that each department becomes "expert" with respect to the components of its records and can address the contents of its records to comply with a request.

However, the disadvantages are several:

- If a request for copies of patient records asks for "any and all documents" pertaining to the patient, then first the request must be validated for reasonable purpose for "any and all documents." If confirmed, then someone must copy the request and distribute it to all departments that may have records on the patient or one department must serve as the clearinghouse that gathers the records necessary to respond to the request.

Organizations using one or more electronic health records (EHR) are finding it easier to centralize the ROI because a single department may be given the access rights to electronic documentation generated by many staff members residing in many departments and available on several EHRs.

- When ROI remains decentralized, staff in each department/location must be fully educated with respect to federal and state laws and regulations that apply to ROI and to any ROI policies implemented by the facility. Maintaining a thorough and current understanding of regulations and their nuances can be challenging, but this ensures that all departments involved in ROI remain up to date and have the technology available to provide requestors the necessary information in the necessary format.
- Later chapters address an aspect of HIPAA known as "accounting of disclosures." This process results in a list of all disclosures of PHI to third parties that were not specifically authorized by the patient. Collecting this information can be difficult when multiple departments or individuals throughout the organization disclose information. It is further complicated by the use of HIEs.

b. New Format

Releasing PHI doesn't always involve paper copies of a patient's records. For example, the constant chase to have films returned and the high cost of preparing duplicate films encouraged radiology departments to implement electronic radiology imaging systems. Many radiology departments have started using picture archiving and communication systems (PACS) to eliminate the need to create radiologic films and the inherent storage requirements associated with them. PACS-equipped radiology departments often provide CDs containing requested images. Requestors are finding that asking for paper copies only means that they will now need to store the paper. So now they are requesting the copies be written to CDs, DVDs, or similar media that can easily be copied to their document repositories and eliminate the bulk of paper.

Release of PHI isn't limited to paper copies and high-density media. A variety of other media environments serve this function, as well. For example, the cardiology imaging department might create and release copies of videos, and the pathology department might release slides containing treated slices of specimen. Some PHI is contained in tracing and monitoring systems such as fetal monitors, pulmonary monitoring devices, anesthesia systems, and cardiology tests.

With the intense focus on patient privacy and patients' access to their health information, managing ROI has never been more challenging than it is today

c. Who Requests Access to Health Information?

Health information demands are numerous. The variety of requestors includes but is not limited to:

- Other caregivers who serve the patient in the same or alternate settings
- Payers
- Payer agents who audit charges against documentation, review claims for excess payment recovery, or assess the necessity of services
- Governmental agencies such as the U.S. Department of Health and Human Services, the Occupational Safety and Health Administration, the U.S. Food and Drug Administration, quality improvement organizations, state departments of health, and others that use the information to further their purposes
- Researchers who collect data to obtain more information about established disease conditions such as cancer or to treat conditions more effectively
- Operational teams that gauge the performance of healthcare providers and organizations by identifying pathways to provide more efficient care
- Insurers that want to evaluate the health of applicants
- Attorneys who want to determine the extent of injuries
- Patients who want to monitor their health or take information to a specialist or other physician
- Family members who need the information to obtain additional care or reimbursement for the care provided to a relative

## Figure 1.1 | Uses and Disclosures of PHI for Treatment, Payment, and Healthcare Operations

**Title:** Uses and Disclosures of PHI for Treatment, Payment, and Healthcare Operations

**Policy:** PHI for which this organization is responsible may be used and disclosed for treatment, payment, and healthcare operations (TPO) only in accordance with HIPAA and other laws and regulations, and with our privacy notice.

**Purpose:** To protect patient privacy and ensure regulatory compliance, this policy outlines the requirements that must be followed when using or disclosing PHI for purposes of TPO.

**Scope:** This policy applies to PHI in any form that is being used or disclosed for the purposes of TPO. It applies to our workforce, affiliates, agents, and business associates.

**GENERAL RULES:**

1. Except where prohibited by state or federal laws, we may use and disclose PHI for treatment, payment, and our own healthcare operations without permission from an individual who is the subject of the PHI.
2. We may disclose PHI for the healthcare operations of another covered entity (CE) provided that the receiving CE has or had a relationship with the patient who is the subject of the PHI, the PHI pertains to that relationship, and the disclosure is for a purpose listed below:
    - Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing healthcare costs; protocol development; case management and care coordination; contacting of healthcare providers and patients with information about treatment alternatives; and related functions that do not include treatment
    - Reviewing the competence or qualifications of healthcare professionals; evaluating practitioner and provider performance; reviewing health plan performance; conducting training programs in which students, trainees, or practitioners in areas of healthcare learn under supervision to practice or improve their skills as healthcare providers; training of nonhealthcare professionals; and accreditation, certification, licensing, or credentialing activities
    - For the purpose of healthcare fraud and abuse detection or compliance
3. Uses and disclosures of PHI must be consistent with our privacy notice.
4. The minimum necessary standard applies to uses and disclosures of PHI except for treatment purposes.

**Figure 1.1 | Uses and Disclosures of PHI for Treatment, Payment, and Healthcare Operations (cont.)**

5. State and/or federal laws define specially protected categories of information that require more stringent protection than afforded by HIPAA. A valid authorization form, signed by the individual or legal representative, is required prior to any disclosures of the following:

    a. HIV test results

    b. Alcohol and drug abuse records (42 *CFR* Part 2)

    c. Genetic screening test results

    d. Confidential communications of psychotherapy notes contained in medical records of treatment by a psychiatrist, social worker, psychologist (or graduate of or student enrolled in a doctoral degree program and working under the supervision of a licensed psychologist), or licensed mental health nurse clinical specialist

    e. Other professional services of a licensed psychologist

    f. Social work counseling/therapy

    g. Domestic violence victims counseling

    h. Sexual assault counseling

    i. Psychotherapy notes documenting therapy sessions and kept by a mental health professional outside of a patient's medical record

Figure 1.1 presents a sample policy on the uses of PHI for treatment, payment, and healthcare operations.

## Figure 1.2 | ABC Provider Health Information Exchange

**ABC Provider Health Information Exchange (HIE) Opt-Out**

Name: _____

Date of Birth: _____/_____/_____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

I hereby acknowledge and agree as follows:

1. I WISH to **OPT-OUT of the ABC Provider HIE**. I understand that by making this selection, **NONE** of my healthcare providers will be able to access my health information maintained anywhere on the ABC Provider HIE, even in cases of a medical emergency;
2. I UNDERSTAND that my providers who originally generated information about me **will continue to have access** to my information, but only in the medical record that *they* created for me or by obtaining it via previously established methods;
3. I UNDERSTAND that this **HIE Opt-Out** will NOT allow ABC Provider to make my health information available to other connected HIEs with whom ABC Provider participates, even in cases of a medical emergency;
4. I UNDERSTAND that this **HIE Opt-Out** does NOT cover or effect my opting out of any other HIE. I UNDERSTAND that if I wish to opt out of another HIE, I am responsible for approaching my provider participating in such other HIE(s) about how I can do that;
5. My **HIE Opt-Out** selection will remain in effect unless I change it in writing;
6. I UNDERSTAND that once this **HIE Opt-Out** goes into effect, I can change my mind **only by** submitting a **Cancellation of Prior ABC Provider HIE Opt-Out** form;
7. I have had an opportunity to have all my questions about this **HIE Opt-Out** and any others answered;
8. Any information that is disclosed before I submit this **HIE Opt-Out** cannot be taken back and will remain with my provider, who may have accessed such information before this **HIE Opt-Out** went into effect; and
9. This request can take up to two business days to take effect.

**Figure 1.2 | ABC Provider Health Information Exchange (cont.)**

**For your protection, ABC Provider HIE requires that you verify your identity in order to process this request. Upon receipt, our HIE Opt-Out Liaison will contact you at the telephone number you provided.**

Signature: _____ Date: _____

If Legal Rep, State Authority: _____

Completed and signed ABC Provider Opt-Out form can be returned to Registration/Reception Desk; faxed to (555)555-5555; or mailed to:

**ABC Provider Health Information Exchange**
**123 Main Street**
**Anytown, US 12345**

HIE, system interoperability, and the expansion of EHRs have helped ease the process of providing information to requestors. As more documents become available online, staff members working in the ROI function will be able to accommodate requests on a timelier basis and with less effort than searching for paper documents. Few healthcare organizations have a fully electronic health record, but even those that do not now often scan their remaining paper at the time of discharge, thus allowing the ROI staff to print, save, and access those documents on alternative media without leaving their desks

d. Typical Steps in the ROI Process

1. Receive request to access or obtain copies of a patient's record
2. Confirm that the organization treated this patient and that records are available .
3. Log the request
4. Validate that the appropriate party (typically the patient or patient's representative) authorized the request
5. Validate that the request contains all necessary elements
6. Reject an invalid request and log the invalid request out
7. Determine the location(s) of or applications storing the requested components of the record
8. Search for and retrieve the components
9. Review the record for the specific documents requested
10. Review the record for specific documentation that is to be excluded
11. Prepare the copies in the mode requested or make arrangements for review of the record by the requestor
12. Count the pages copied and calculate fees, if any
13. Invoice or prebill the requestor for copies or review time
14. Collect payment and mail/provide copies
15. Log the completed request

e. Who Should Manage ROI?

The healthcare provider is the legal owner of patient records that it creates. With this single exception, the record is the property of the provider—not the patient. Patients, however, do have the right to the information contained in the record. As the owner, theprovider is responsible for deciding who may use the information, for what purpose, when and how the information in the record may be released, and what should be released. A myriad of laws and policies govern the provider's decision matrix for these items. However, the onus of the proper management of the disclosure is that of the legal owner of the patient record and/or the business associate that the owner engaged to perform the disclosure function for the owner. Rapidly emerging automation of PHI capture and storage to ensure longitudinal access to PHI for patient care is a hallmark of today's healthcare environment. Electronic medical and health records are replacing paper records in physician offices and ambulatory settings to facilitate PHI collection and access, as well as to gain the economies and legibility these systems offer. Additionally, HITECH also expanded the protections of PHI, defined criteria that providers must achieve and demonstrate that they are using EHRs in a meaningful way, imposed additional sanctions on those business associates using and/or processing PHI, expanded the exchange of health information, and detailed the actions required when an unauthorized disclosure occurs. While not all providers have adopted EHRs.

7. Penugasan

a. Task 1

Here are three forms of information published. You can find out what are the main general information between those templates and the differences.

https://drive.google.com/drive/folders/127xuqKYCvCTKT10we5hnNRNC4Bhq9CM?usp=sharing

b. Task 2

Here is a short video about the release of information. Please, watch the video and write the important topic of it and make an open discussion whether all of you have the same point of view or not.

Link on Youtube

https://www.youtube.com/watch?v=8jrm9LYqpAY

8. Referensi


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6. BACTES Imaging Solutions. 2014, 11 November. Understanding the Release of Information Process. Youtube. https://www.youtube.com/watch?v=8jrm9LYqpAY

9. Lembar Catatan Pembelajaran

Nama :

NIM :

Kelas :

| No | Tanggal | Aktivitas | Catatan pengampuan | Tanda tangan pengampu |
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Nilai Akhir: _____

Pengampu,

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

*MODUL 5*

# E-HEALTH

***MATA KULIAH : ENGLISH FOR MEDICAL RECORD***


PROGRAM STUDI DIPLOMA TIGA REKAM MEDIS DAN INFORMASI KESEHATAN
POLTEKKES KEMENKES YOGYAKARTA
KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

Bahasa Inggris 2 : Informed Consent

Kode Mata Kuliah : RMIK202

Tanggal Mulai : 17 Februari 2022

**HANYA UNTUK PENGGUNAAN INTERNAL**

# Informed Consent

Modul: 5


Niko Tesni Saputro, S.KM., M.P.H

Sefi Nurhadianti, S.S., M.P

Program Studi Diploma Tiga Rekam Medis dan Informasi Kesehatan,
Politeknik Kesehatan Kemenkes Yogyakarta,
Yogyakarta, Indonesia

## Kata Pengantar

Laboratorium pendidikan adalah unit kerja pendidikan yang menyediakan fasilitas dan peralatan untuk kegiatan praktikum mahasiswa. Laboratorium pendidikan juga berfungsi sebagai fasilitas penunjang mahasiswa dalam mengembangkan keahlian dan menciptakan karya ilmiah. Kegiatan praktikum pada suatu mata kuliah, merupakan bagian yang tidak dapat dipisahkan dalam proses pencapaian keberhasilan mahasiswa dalam pengembangan keilmuan, kemampuan, dan penemuan. Karena itu perlu dibuat Modul Praktik Bahasa Inggris 2 dalam rangka mendukung hal tersebut.

Melalui modul praktik ini mahasiswa dapat memperoleh materi dan soal latihan tentang *English in Medical Record* , pada mata Bahasa Inggris 2. Dengan demikian diharapkan tidak ada mahasiswa yang terkendala dalam mengikuti praktik laboratorium.

Besar harapan kami, modul ini dapat bermanfaat dalam memperlancar proses kegiatan praktik mahasiswa. Serta kami menerima kritik dan saran jika terdapat hal-hal yang belum sempurna, agar modul ini dapat digunakan dengan baik di kalangan mahasiswa maupun kalangan instruktur praktik.

Yogyakarta, 23 Januari 2022

Tim Penyusun

**Daftar Isi**

1. Pengantar

Mata Kuliah ini membahas tentang pekerjaan perekam medis, keamanan rekam medis, pemberian informasi, lembar persetujuan, fasilitas rehabilitasi, konsultasi dan konsolidasi, permintaan, kebutuhan, dan kewajiban dalam manajemen rekam medis. Mata kuliah ini menjadi salah satu mata kuliah wajib yang harus diikuti oleh setiap mahasiswa. Mata kuliah ini memberikan pengalaman belajar kepada mahasiswa yang mendukung untuk mencapai capaian pembelajaran khususnya dari aspek sikap, pengetahuan dan ketrampilan umum berdasarkan Standar Nasional Pendidikan Tinggi (Permendikbud Nomor 3 Tahun 2020)

Modul Praktik Bahasa Inggris 2, Program Studi Diploma Tiga Rekam Medis dan Informasi Kesehatan Semester Ganjil Tahun Akademik 2021/2022, disusun dengan tujuan untuk memberikan arahan serta acuan bagi mahasiswa dan instruktur praktik, dalam melaksanakan kegiatan praktikum selama Semester Genap di Prodi Diploma Tiga Rekam Medis dan Informasi Kesehatan Tahun Akademik 2021/2022. Modul praktik ini berisi tentang materi *Medical Record Jobs, Security of Medical Record, Relase of Information, Informed Consent, Rehabilitation Facilities, Consultation and Consolidation, Request Necessities Obligations.*

2. Capaian Pembelajaran

Peserta didik mampu memahami tentang *Medical Record Jobs, Security of Medical Record, Relase of Information, Informed Consent, Rehabilitation Facilities, Consultation and Consolidation, Request Necessities Obligations.*

3. Bahan Kajian

1. *Medical Record Jobs*
2. *Security of Medical Record*
3. *Relase of Information*
4. *Informed Consent*
5. *Rehabilitation Facilities*
6. *Consultation and Consolidation*
7. *Request Necessities Obligations.*

4. Tujuan Pembelajaran

Peserta didik mampu memahami tentang pekerjaan perekam medis, keamanan rekam medis, pemberian informasi, lembar persetujuan, fasilitas rehabilitasi, konsultasi dan konsolidasi, permintaan, kebutuhan, dan kewajiban dalam manajemen rekam medis.

1. Mampu memahami dan menjelaskan *Medical Record Jobs*
2. Mampu memahami dan menjelaskan *Security of Medical Record*
3. Mampu memahami dan menjelaskan *Relase of Information*
4. Mampu memahami dan menjelaskan *Informed Consent*
5. Mampu memahami dan menjelaskan *Rehabilitation Facilities*
6. Mampu memahami dan menjelaskan *Consultation and Consolidation*
7. Mampu memahami dan menjelaskan *Request Necessities Obligations*

5. Luaran

*1.* Peserta didik memiliki kompetensi dalam menjelaskan *Medical Record Jobs*
*2.* Peserta didik memiliki kompetensi dalam menjelaskan *Security of Medical Record*
*3.* Peserta didik memiliki kompetensi dalam menjelaskan *Relase of Information*
*4.* Peserta didik memiliki kompetensi dalam menjelaskan *Informed Consent*
*5.* Peserta didik memiliki kompetensi dalam menjelaskan *Rehabilitation Facilities*
*6.* Peserta didik memiliki kompetensi dalam menjelaskan *Consultation and Consolidation*
*7.* Peserta didik memiliki kompetensi dalam menjelaskan *Request Necessities Obligations*

6. Informed Consent

a. What is Informed Consent?

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

Informed consent is a process of communication between you and your health care provider that often leads to agreement or permission for care, treatment, or services. Evey patient has the right to get information and ask questions before procedures and treatments. If adult patients are mentally able to make their own decisions, medical care cannot begin unless they give informed consent.

Informed consent is based on the moral and legal premise of patient autonomy: You as the patient have the right to make decisions about your own health and medical conditions.

The informed consent process makes sure that your health care provider has given you information about your condition along with testing and treatment options before you decide what to do.

This information can include:

- The name of your condition
- The name of the procedure or treatment that the health care provider recommends
- Risks and benefits of the treatment or procedure
- Risks and benefits of other options, including not getting the treatment or procedure

Signing informed consent means:

- You have received all the information about your treatment options from your health care provider.
- You understand the information and you have had a chance to ask questions.
- You use this information to decide if you want to receive the recommended treatment option(s) that have been explained to you. Sometimes, you may choose to receive only part of the recommended care. Talk to your health care provider about your options.
- If you agree to receive all or some of the treatment options, you give your consent (agree) by signing a consent form. The completed and signed form is a legal document that lets your doctor go ahead with the treatment plan.

Under certain circumstances, there are exceptions to the informed consent rule. The most common exceptions are these:

1. An emergency in which medical care is needed immediately to prevent serious or irreversible harm
2. Incompetence in which someone is unable to give permission (or to refuse permission) for testing or treatment

b. Proceess of Informed Consent

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

1. Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
2. Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
   - The diagnosis (when known)
   - The nature and purpose of recommended interventions
   - The burdens, risks, and expected benefits of all options, including forgoing treatment
3. Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

c. Why do I have to sign a consent form?

The main purpose of the informed consent process is to protect the patient. A consent form is a legal document that ensures an ongoing communication process between you and your health care provider. It implies that your health care provider has given you information about your condition and treatment options and that you have used this information to choose the option that you feel is right for you.

The way in which your treatment options must be given to you (for example, verbally or in writing) may be listed in your state's laws. Your health care provider works with you to figure out the best way to give you the information you need. The provider may choose to use methods other than a verbal discussion or a written document, such as videos, interactive computer modules, audio files or other methods to help you understand the information better. Be sure you understand all the information given, even if it means going over it many times or asking your provider to explain it in different ways.

d. Can I change my mind after I've signed the consent?

Yes, you can change your mind at any time, even if you have already started treatment. Let your health care provider know of your wishes.

e. What if I don't want the treatment being offered?

You have the right to refuse any and all treatment options. You may also choose other treatment options that have been presented to you by your health care provider, even if they are not as well proven as the one your health care provider recommends. You may also refuse part of the treatment options, without refusing all care.

For example, you may choose to refuse surgery, but still wish to be treated for pain. In this case, it may be up to you to find another health care provider or facility to treat you with such an approach if your health care provider is not comfortable with it.

If you have decided to refuse treatment or diagnostic tests, your health care provider may tell you about the risks or likely outcomes of this choice, so you can make an informed refusal (meaning, you understand what could happen to your health by refusing the recommended treatment but you still don't want the treatment). In this case, you might be asked to sign a form to state that you received this information and that you still chose not to be treated.

f. What is shared decision-making?

Shared decision-making is actually part of the informed consent process and allows patients to play an active role in making decisions that affect their health. In shared decision-making, the health care provider and patient work together to choose tests, procedures, and treatments, and then to develop a plan of care. As described by the informed consent process, the provider gives the patient information about their condition and the pros and cons of all the treatment options. The patient then has a chance to ask questions and read more about the options. The patient also tells the health care provider what their preferences, personal values, opinions and such are about their condition and treatment options. The health care provider should always respect the patient's preferences and goals, and use them to help guide the patient's treatment

recommendations. This type of decision-making is especially helpful when there is no single "best" treatment option.

g. What if I want the doctor to make the decisions about my care?

Treatment cannot be given without your consent, Unless care and treatment are needed in an emergency and you are unable to give consent. However, you have the right to refuse information and treatment. Or, in advance, you can assign a person to make decisions for you through an advance directive or other legal document. You can also ask for minimal information and trust your health care provider to make decisions for you. At the same time, informed consent laws do not allow a health care provider to keep a diagnosis from the patient, even at the family's request.

h. What Are the 4 Principles of Informed Consent?

There are 4 principles of informed consent:

1. You must have the capacity (or ability) to make the decision.
2. The medical provider must disclose information on the treatment, test, or procedure in question, including the expected benefits and risks, and the likelihood (or probability) that the benefits and risks will occur.
3. You must comprehend the relevant information.
4. You must voluntarily grant consent, without coercion or duress.

i. How to Write a Medical Consent Form?

1. **Name the parties - the person who agrees to a medical procedure or treatment and the medical facility** . If you know who will perform surgery or, for instance, the patient has decided they want to be operated on by a specific physician, you need to state their name as well. In case the patient is a child, a minor Medical Consent Form must contain the name of the person who authorized the treatment.

2. **Describe the nature of consent - for example, the patient will provide a blood sample for laboratory tests** . Indicate the date of the procedure and list the recommendations given by the doctor to their patient.

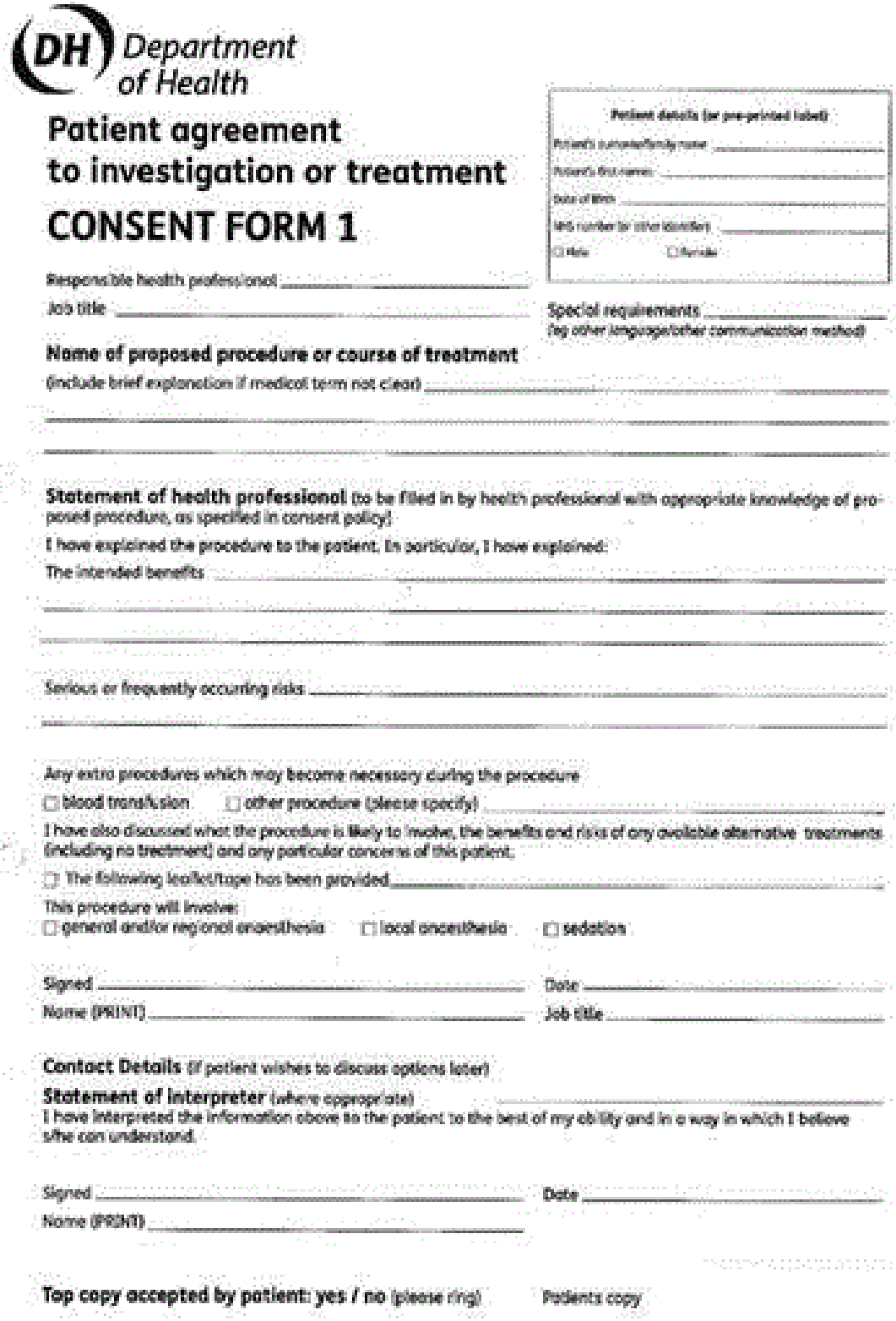
3. **Include information about the patient's diagnosis, benefits of the treatment, and steps that have already been taken to treat the individual** . Of course, if the consent is given for the first medical evaluation of the patient and the physician knows there will not be any harm to the patient's health, you can skip this part - instead, confirm the patient's agreement to be examined by a specific doctor

4. **Disclose any risks, side effects, and alternative choices to the procedure or operation in question** . If the patient takes medication and has any allergies or underlying conditions, they must inform the physician prior to the procedure - any restrictions or warnings have to be put in writing.

5. **Include the patient's contact information - in case anything goes wrong, it will be easier to find people who must be notified about the patient's condition** . Note that it is necessary to authorize the medical provider to disclose sensitive information about the patient's health to people named in the form as well as add their contact details.

6. **Sign the document** . The patient's signature demonstrates their intention to accept clinical evaluation and treatment and understanding of all the treatment options offered by the healthcare provider. While a Medical Consent Form for adults only requires the signature of the individual who will be treated, a child Medical Consent Form must be reviewed and signed by their parent or legal guardian

**Form of Informed Consent**



Department of Health

# Patient agreement to investigation or treatment

## CONSENT FORM 1

Patient details (or pre-printed label)

Patient's surname/family name

Patient's first names

Date of birth

NHS number (or other identifier)

Male Female

Responsible health professional

Job title

Special requirements
(eg other language/other communication method)

**Name of proposed procedure or course of treatment**
(include brief explanation if medical term not clear)

**Statement of health professional** (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits

Serious or frequently occurring risks

Any extra procedures which may become necessary during the procedure

☐ blood transfusion ☐ other procedure (please specify)

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

☐ The following leaflet/tape has been provided

This procedure will involve:

☐ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

Signed Date

Name (PRINT) Job title

**Contact Details** (if patient wishes to discuss options later)

**Statement of interpreter** (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed Date

Name (PRINT)

**Top copy accepted by patient: yes / no** (please ring) Patients copy

# Medical Consent Form

I, _____, am a [Parent/Legal Guardian] of _____, born on _____, do hereby consent to the following medical care while said individual is under the care of _____ of _____, City of _____, State of _____:

- ❑ X-ray examination;
- ❑ Anesthetic;
- ❑ Medical, surgical or dental diagnosis or treatment;
- ❑ Hospital care;
- ❑ Other: _____.

| _____ | _____ | _____ |
|---|---|---|
| Hospital Insurance (if applicable) | Policy Number (if applicable) | Insurance Company (if applicable) |

The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered. Should it be necessary for the undersigned to return home, the undersigned shall assume all transportation costs.

This authorization is effective from _____, to _____.

| _____ | _____ |
|---|---|
| Name of Parent/Legal Guardian | Witness Name |
| _____ | _____ |
| Signature of Parent/Legal Guardian | Witness Signature |
| _____ | _____ |
| Date | Date |

7. Penugasan

a. Task 1
Please watch the linked video. Write down the resume of the material from the video

Link on Youtube

https://youtu.be/mJ2GgOjatCA

Resume of the material

b. Task 2

Please look for examples of form patient informed consent and make one group consist of 2 persons please do the simulation of informed consent.

Example

Link on Youtube :

https://youtu.be/QBZoWjn-XMs

8. Referensi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9. Lembar Catatan Pembelajaran

Nama :

NIM :

Kelas :

| No | Tanggal | Aktivitas | Catatan pengampuan | Tanda tangan pengampu |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

Nilai Akhir: _____

Pengampu,