An Integrated Medical Record and Data System for Primary Care

Part 7: The Encounter Form: Problems and Prospects for a Universal Type

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The importance of an encounter form for recording ambulatory patient information is stressed. Certain problems surrounding appropriate definition of the minimum basic data set (MBDS) are discussed as is the potential development of a uniform encounter form which would cover diagnostic information as well as items necessary for insurance companies and internal practice management.

In a one-year period from May 1973 to April 1974 an estimated 645 million visits were made to physicians' offices.[1] To properly document this vast number of outpatient visits, current medical practice requires structured records which detail not only the medical content of each visit but also contain the information required for administrative purposes. Requisite data, at a minimum, identify the patient, detail services received, and indicate the expected source of payment. A single form may be devised to cover most facets of information required for effective management of an office-based practice. For convenience, the form under consideration in this communication is called an encounter form.

Design and content of an encounter form should reflect both the medical and administrative functions of the particular practice. Consideration should be given to details of services rendered, third-party billing needs, accountability to governmental and other agencies, and, if warranted, research.

Recently there has been increased pressure on the medical community for cost containment and accountability of quality of care. However, accurate data needed to assess the content, process, and outcome of medical care are generally lacking. To promote the collection and standardization of these data, the National Center for Health Statistics published two separate minimum basic data sets, "MBDS." One is designed for hospital use[2] and the other for ambulatory care records.[3] The latter has been subject to question[4] and is currently being reevaluated by a national task force.* An ambulatory MBDS which receives approval from the government will be an important determinant of format for encounter forms because these forms are ideal vehicles to record MBDS information.

Data Needs and Design

Generally, two types of data need to be abstracted from records of ambulatory patient encounters. The first is registration data which is collected initially and upgraded regularly. The second is encounter data which must be collected at each patient encounter. One MBDS that has been suggested is the following:[5]

Registration Data:

1. Person identification
2. Residence, including zip code
3. Date of birth
4. Sex
5. Marital status
6. Race

Encounter Data:

1. Facility identification
2. Provider identification
3. Person identification
4. Source(s) of payment
5. Date
6. Patient's purpose, reason, symptom, or complaint
7. Physician evaluation (diagnosis or determined problem)
8. Diagnostic, therapeutic, or management procedures
9. Disposition of patient

Additional determinants of encounter form design relate to the size, complexity, range of services, and financial support of the health-care facility. A solo physician practicing in a fee-for-service setting requires far less information to satisfy his/her administrative needs than does a government-funded neighborhood health-care center or a research-oriented group practice.

At a meeting of the directors of research of the New York State Family Medicine Training Programs, data items in addition to the MBDS listed above were identified as desirable for routine collection. Some of these are:

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*Technical Consultant Panel (TCP) on the Development of the Minimum Basic Data Set for Ambulatory Medical Care of the US National Committee of Health and Vital Statistics. Maurice Wood, MD, Chairman.

1. The patient identification number should identify the household, the patient's position in the household, eg, husband, wife, first child, etc, and status as an active or transient patient.
2. The facility identification should include the place of encounter, eg, office, hospital Emergency Room, home, etc.
3. A coded diagnosis. Members of the Committee suggested use of the *International Classification of Health Problems in Primary Care* (ICHPPC).[6] A checklist of the most frequent problems or diagnoses within that classification was considered desirable. Also, at least one written diagnosis for insurance purposes was recommended.
4. For procedures and financial charges, a coded list of procedures with itemized charges for each procedure performed was considered desirable. The New York Relative Value Scale was recommended as a guide to charges.
5. Authorization to release information.
6. The time scale. Recommended was the recording of time arrived, appointment time, and time departed.
7. Disposition. Needed was information such as discharge, return, referral, admission to hospital.
8. Outcome information. Outcome here refers to appointment kept, appointment broken, walk-in, or left without examination.
9. Precepting information. For training programs, desirable data would include whether or not precepting occurred and the type of precepting, eg, in-office observation, two-way mirror, or case presentation.
10. Provider signature. A signature would permit a copy of the encounter form to serve as an itemized bill.

Sample Encounter Form

The encounter form currently in use in the Rochester Family Medicine Program is described. This program not only serves a large patient population but is also a teaching and research center. Thus, it may include data items not germaine to other types of practices but may serve as a guideline for developmental purposes. Included are data items from the suggested MBDS in addition to others identified as useful by family medicine training programs. Figure 1 illustrates the face side of the four-part NCR (no carbon required) Family Medicine Program encounter form. For convenience it has been divided into six sections which will be described separately.

Figure 1, Section 1 — Demographic Data

Such information as date of birth and address is included. This program's population is mobile and to assure accuracy, the address is collected at each visit. This section also contains billing and provider information. All health-care providers in the Family Medicine Program are assigned a three-digit code number for computer purposes.

Figure 1, Section 2 — Reason for Visit

A classification entitled "A Reason for Visit Classification for Ambulatory Care" has recently been published but not yet field tested.[7] The reason for visit described here is documented in anticipation of using that information in a study of patient behavior.

Figure 1, Section 3 — Services

Services are divided into types: services (100), laboratory (200), procedures (300), equipment (400), and x-rays (500), with spaces available to indicate charges and to add items not included in the standard list. Charges are entered by the secretary at the time of the visit and immediate payment is encouraged.

Figure 1, Section 4 — Disposition

This section serves to instruct the secretary about return visits or referral.

Figure 1, Section 5 — Diagnoses and Signature

A written diagnosis for insurance purposes and the signature of the provider add sufficient information and approval to permit a copy of the encounter form to serve as an itemized bill suitable for submission to insurance companies.

Figure 1, Section 6 — Additional Instructions

This section is generally used to request services from the nurses, such as dietary instructions or additional blood pressure readings.

Figure 2 — Diagnostic Information

The reverse side of the last sheet contains explicit medical information. Listed by section are 142 diagnostic titles from the 371 rubrics in the ICHPPC. Titles and code numbers are printed together with four possible episode types: N, O, R, F, for each problem. Details of episode type are given at the top of the page under Instructions (Figure 2). Other code numbers not among the printed list may be entered in the spaces in the lower left portion of the page. Space for data entry for special studies is reserved in the lower right portion of the page.

The diagnostic checklist is a relatively recent innovation in this practice. Concern was expressed that the relative convenience of the list would have the effect of limiting use of the other diagnostic titles. Providers might

(I)

Family Medicine Group
885 South Ave.
Rochester, N.Y. 14620

No. 32193

DATE: 7/21/77

NAME	FAMILY #	DOCTOR	CODE
Susan Price	01338-02	Gardner	313

ADDRESS	TOWN	ROOM #	ALSO TO SEE
436 Pinetree La.	Rochester	7	

ZIP	C.T.	D.O.B.	HEAD OF HOUSEHOLD	APPT. TIME	ARRIVAL	DEPART
14623	64	6-5-21	James Price	10:30		

INSURANCE CO.	NO.
GVMC	572436

☐ NO SHOW

☐ CONFIRMED ☐ BILL TO PT ☐ BILL TO INS. ☐ WORKMENS COMP. ☐ CANCELLED ☐ WALK IN

MOTOR VEHICLE ACCIDENT YES ☐ NO ☒ ☐ LEFT ☐ RESCHEDULED

(II) I'm tired and my back hurts

☐ DOCTOR INITIATED VISIT
☒ PATIENT INITIATED VISIT
☐ 3RD PARTY INITIATED VISIT

REASON FOR VISIT (IN PATIENT'S OWN WORDS)

(III)

SERVICES (100)	CHARGES	LAB (200)	CHARGES	PROCEDURES (300)	CHARGES
101 ☐ NEW PT. OR COMPLEX		201 ☒ CBC 202 ☐ HCT		301 ☐ AUDIOMETRY 302 ☐ VISION	
102 ☒ ROUTINE		203 ☐ WBC 204 ☐ DIFF		303 ☐ DPT 304 ☐ OPV	
103 ☐ AFTER HRS. 104 ☐ HOME		204 ☒ SED. RATE		305 ☐ DT 306 ☐ TINE	
105 ☐ P.E. INITIAL 106 ☐ ANNUAL		205 ☒ U/A 206 ☐ URICULT		307 ☐ EAR IRRIGATION	
107 ☐ P.E. COLLEGE		207 ☐ CULTURE (SPECIFY)		308 ☐ EKG 309 ☐ IUD	
108 ☐ P.E. 6 - 16 YRS.		208 ☐ GRAM STRAIN		310 ☐ PROCTO 311 ☐ SIGMOID	
109 ☐ P.E. NEWBORN - 5 YRS.		209 ☐ WET MOUNT/KOH PREP		312 ☐ TONOMETRY 313 ☐ VITALOR	
110 ☐ COUNSELLING PER 1/2 HR.		210 ☐ GUAIAC		314 ☐ OTHER (SPECIFY):	
111 ☐ OB INITIAL 112 ☐ RECHECK		211 ☐ MONOSPOT 212 ☐ PREG. TEST			
113 ☐ WELL CHILD PKG 2 4 6 8 12 18 MOS.		213 ☐ OTHER (SPECFY):			
114 ☐ N.P. NEW PT. OR COMPLEX					
115 ☐ N.P. ROUTINE				EQUIPMENT (400)	
116 ☐ NURSE VISIT		214 ☐ OUTSIDE LABS (SPECIFY)		401 ☐ RENTAL BP CUFF	
117 ☐ SURGERY				402 ☐ SALE BP CUFF	
118 ☐ OTHER (SPECIFY):				403 ☐ RENTAL CRUTCHES	
				404 ☐ OTHER (SPECIFY):	
				X-RAYS (500)	
				501 ☐ CHEST	
				502 ☒ OTHER (SPECIFY): Spine	
LABS					
PROCEDURES					
TOTAL CHARGE					
☐ POSTED BILLED TO INS.		PAYMENT DUE UPON RECEIPT OF BILL		CASH (AMT.)	CHECK (AMT.)

(IV) DISPOSITION	(V) WRITTEN DIAGNOSIS FOR INSURANCE	(VI) ADDITIONAL INSTRUCTIONS
NEXT APPOINTMENT: 10 days	Lumbo-sacral strain,	1500 calorie/day
WITH (F.M. PROVIDER): Gardner	Depression, obesity	reduction diet
AMT. OF TIME NEEDED (CIRCLE): 15 (30) 45 60 MIN.		
CONSULTANT/HOSPITAL	SIGNATURE [signature]	
	BILLING	

Figure 1. Rochester Family Medicine Program Encounter Form

DIAGNOSTIC INFORMATION (E-BOOK)

INSTRUCTIONS:

1. Circle N, O, R or F for all conditions considered during each encounter.
   - N - New Diagnosis
   - R - Recheck
   - O - Old Diagnosis (not previously recorded)
   - F - Family History of
2. Use Additional Entries section to note other diagnoses not listed below, and obtain code numbers from ICHPPC booklet.

ICHPPC — COMMONLY USED DIAGNOSTIC CODES

Condition	Code	
INFECTIVE & PARASITIC DISEASES		
PRESUMED INFECT. INTEST. DIS.	009-	N O R F
DIARRHEA, CAUSE UNDETERMINED	0091	N O R F
STREP THROAT, SCARLET FEV.	034-	N O R F
INFECTIOUS MONONUCLEOSIS	075-	N O R F
VIRAL CONJUNCTIVITIS	078-	N O R F
WARTS, ALL SITES	0791	N O R F
GONORRHEA, ALL SITES	098-	N O R F
DERMATOPHYTOSIS & MYCOSIS	110-	N O R F
MONILIASIS, UROGENITAL, PROVEN	1121	N O R F
TRICH, UROGENITAL, PROVEN	131-	N O R F
ENDOCR, NUTRIT, METABOL DISEAS		
NONTOXIC GOITER & NODULE	240-	N O R F
HYPOTHYROIDISM	244-	N O R F
DIABETES MELLITUS	250-	N O R F
GOUT & HYPERURICEMIA	274-	N O R F
OBESITY	277- (circled)	N O R (circled) F
LIPID METABOLISM DISORDERS	272-	N O R F
BLOOD DISEASES		
MICROCYTIC & IRON DEF ANEMIA	280-	N O R F
MENTAL DISORDERS		
SCHIZOPHRENIA, ALL TYPES	295-	N O R F
AFFECTIVE PSYCHOSES	296-	N O R F
ANXIETY NEUROSIS	3000	N O R F
HYSTERIC & HYPOCHON NEUROSES	3001	N O R F
DEPRESSIVE NEUROSIS	3004 (circled)	N O R (circled) F
INSOMNIA & OTHER SLEEP DISORDERS	3064	N O R F
TENSION HEADACHE	3068	N O R F
TRANSIEN SITUAT DISTURB, ADJ REACT	307-	N O R F
BEHAVIOR DISORDERS NEC	308-	N O R F
ALCOHOL ABUSE	3031	N O R F
TOBACCO ABUSE	3049	N O R F
PERSONALITY & CHAR DISORDERS	301-	N O R F
NERV SYSTEM, SENSE ORGAN DISEAS		
EPILEPSY, ALL TYPES	345-	N O R F
MIGRAINE	346-	N O R F
CONJUNCTIVITIS & OPHTHALMIA	360-	N O R F
OTITIS EXTERNA	380-	N O R F
ACUTE OTITIS MEDIA	3810	N O R F
CHRONIC SEROUS & OTITIS MED	3811	N O R F
DEAFNESS, PARTIAL OR COMPLETE	386-	N O R F
WAX IN EAR	3871	N O R F
CIRCULATORY SYSTEM DISEASES		
ACUTE MI/SUBAC ISCHEMIA	410-	N O R F
CHRONIC ISCH HRT DIS/ANGINA	412-	N O R F
HEART FAILURE	4270	N O R F
ECTOPIC BEATS, ALL TYPES	4277	N O R F
MURMURS NEC/NYD/FUNCTIONAL	4278	N O R F
ELEVATED BLOOD PRESSURE NYD	4011	N O R F
HYPERTENSION, UNCOMPLICATED	401-	N O R F
HYPERTENSION INVOLVING TARGET ORGAN	400-.	N O R F
PHLEBITIS & THROMBOPHLEBITIS	451-	N O R F
VARICOSE VEINS OF LEGS	454-	N O R F
HEMORRHOIDS	455-	N O R F
RESPIRATORY SYSTEM DISEASES		
ACUTE URI	460-	N O R F
SINUSITIS, ACUTE & CHRONIC	461-	N O R F
RESPIRATORY CONT.		
ACUTE TONSILLITIS & QUINSY	463-	N O R F
LARYNGITIS & TRACHEITIS, ACUTE	464-	N O R F
BRONCHITIS & BRONCHIOLITIS, ACUTE	466-	N O R F
INFLUENZA	470-	N O R F
PNEUMONIA	486-	N O R F
BRONCHITIS, CHRONIC	491-	N O R F
EMPHYSEMA, BRONCHIECTASIS & COPD	492-	N O R F
ASTHMA	493-	N O R F
HAY FEVER	507-	N O R F
DIGESTIVE SYSTEM DISEASES		
TEETH & SUPPORT STRUCTURE DISEASES	520-	N O R F
DUOD ULCER W/WO COMPLICATIONS	532-	N O R F
GASTRITIS/INDIGESTION	536-	N O R F
INGUINAL HERNIA W/WO OBSTRUCT	550-	N O R F
HIATUS/DIAPHRAGMATIC HERNIA	551-	N O R F
IRRIT BOWEL SYNDR/INTEST DISOR NEC	564-	N O R F
CONSTIPATION	5640	N O R F
BLEEDING PER RECTUM NOS	5692	N O R F
GENITOURINARY SYSTEM DISEASES		
CYSTITIS & UTI NOS	595-	N O R F
URETHRITIS NOS, NEC, NONSPEC	597-	N O R F
PROSTATITIS & SEMINAL VESICULITIS	601-	N O R F
CHRONIC CYSTIC BREAST DISEASE	610-	N O R F
PELVIC INFLAMMATORY DISEASE	612-	N O R F
CERVICITIS & CERVICAL EROSION	620-	N O R F
VAGINITIS NOS	6221	N O R F
MENOPAUSAL SYMPTOMS	627-	N O R F
ABSENT, SCANTY, RARE MENSTRUATION	6260	N O R F
EXCESSIVE MENSTRUATION	6262	N O R F
PAINFUL MENSTRUATION	6263	N O R F
PREMENSTRUAL TENSION	6268	N O R F
SKIN, SUBCUTANEOUS TISSU DISEAS		
BOIL & CELLULITIS EXCL FINGR & TOE	680-	N O R F
IMPETIGO	684-	N O R F
SEBORRHOEIC DERMATITIS	690-	N O R F
ECZEMA & ALLERGIC DERMATITIS	691-	N O R F
CONTACT & OTHER DERMATITIS NEC	692-	N O R F
DIAPER RASH	6929	N O R F
PRURITIS & RELATED CONDITIONS	698-	N O R F
SEBACEOUS CYST	7062	N O R F
INGROWN TOENAIL & NAIL DISEASE NEC	703-	N O R F
URTICARIA, ALLERGIC EDEMA, ANGIOEDEMA	708-	N O R F
MUSCULOSKELET, CONNECTIV TISSU DISEASE		
RHEUMATOID ARTHRIT & ALLIED CONDITN	712-	N O R F
OSTEOARTHRITIS & ALLIED COND	713-	N O R F
SHOULDER SYNDROMES	717-	N O R F
OTHER BURSITIS & SYNOVITIS	731-	N O R F
MUSCLE PAIN/MYALGIA	7179	N O R F
MUSCULOSKELET CONT.		
LOW BACK PAIN WO RADIATING SYMPTOMS	7289	N O R F
SIGN, SYMPTOM, ILL DEFINED COND		
DIZZINESS & GIDDINESS	7805	N O R F
HEADACHE	791-	N O R F
CHEST PAIN	7820	N O R F
EDEMA	7826	N O R F
ENLARGED LYMPH NODES, NOT INFECTED	7827	N O R F
COUGH	7833	N O R F
PLEURITIC PAIN	7837	N O R F
NAUSEA/VOMITING	7841	N O R F
ABDOMINAL PAIN	7855	N O R F
URINARY SYSTEM OR MICTURITION PAIN	7860	N O R F
FREQUENCY OF URINATION	7864	N O R F
PAIN IN LIMB	787-	N O R F
PAIN IN JOINT	7873	N O R F
FEVER OF UNDETERMINED CAUSE	7888	N O R F
RASH & OTHER NONSPECIFIC SKIN ERUPT	7882	N O R F
WEIGHTLOSS	7884	N O R F
MALAISE, FATIQUE, TIREDNESS	7901	N O R F
ABNORMAL URINE TEST FINDING	789-	N O R F
INJURIES & ADVERSE EFFECTS		
FRACTURE RADIUS/ULNA	813-	N O R F
FRACT (META)CARPAL & TARSAL	814-	N O R F
FRACTURE PHALANGS FOOT/HAND	816-	N O R F
SPRAIN/STRAIN WRIST, HAND, FINGERS	842-	N O R F
SPRAIN/STRAIN KNEE & LOWER LEG	844-	N O R F
SPRAIN/STRAIN ANKLE	8450	N O R F
SPRAIN/STRAIN NECK	8470	N O R F
CONCUSSION & INTRACRANIAL INJ	850-	N O R F
LACERAT/OPEN WOUND/ TRAUM AMPUTATN	889-	N O R F
INSECT BITES & STINGS	910-	N O R F
ABRASION, SCRATCH, BLISTER	918-	N O R F
BRUISE, CONTUSION, CRUSHING	929-	N O R F
BURNS & SCALDS, ALL DEGREES	949-	N O R F
FOREIGN BODY IN TISSUES	888-	N O R F
SUPPLEMENTARY CLASSIFICATION		
MEDICAL EXAM, NO DIS DETECTED	y00-	N O R F
PROPHYLACTIC IMMUNIZATION	y02-	N O R F
OBSERV/CARE PT ON HI RISK MED	y16-	N O R F
OBSERV/CARE OTHER HI RISK PAT	y17-	N O R F
ORAL CONTRACEPTIVES	y41-	N O R F
INTRAUTERINE DEVICES	y42-	N O R F
OTHER CONTRACEPTIVE METHODS	y43-	N O R F
GEN CONTRACEPTIVE GUIDANCE	y44-	N O R F
DIAGNOSING PREGNANCY	y60-	N O R F
PRENATAL CARE	y61-	N O R F
POSTNATAL CARE	y62-	N O R F
ADVICE & HEALTH INSTRUCTION	y71-	N O R F
MARITAL PROBLEM	y84-	N O R F
PARENT & CHILD PROBLEM	y85-	N O R F
FAMILY DISRUPTION W/WO DIVORCE	y87-	N O R F

ADDITIONAL ENTRIES:

Entry	Code	
L-S strain	8478	N (circled) O R F
		N O R F
		N O R F
		N O R F

ABBREVIATIONS

&	and, and/or
/	and/or
EXCL	excluding
NEC	not elsewhere classified
NOS	not otherwise specified, unspecified
NYD	not yet diagnosed
WO	without
W/WO	with or without
DIS	disease

FOR SPECIAL STUDIES

Figure 2. Rochester Family Medicine Program Encounter Form, Reverse Side

tend to "squeeze" an inappropriate diagnosis into one of the listed titles. However, data indicate that this has not occurred. For the year 1975-1976, 86 percent of problems coded were among the 142 titles subsequently chosen for the checklist. After the introduction of the checklist only 81 percent of titles were among those from the list. An additional benefit of the checklist is the time saved by providers for the recording of diagnoses within that list.

Distribution of the Encounter Form

The top half page (Section 1 - Figure 1) is retained by the secretary for control purposes. The first full page (color - blue) is sent to the billing office; the second full page (color - white) is given to the patient at the conclusion of the visit; and the last page (color - yellow) is used by keypunch operators for computer entry. For systems with computer billing capability, demographic, diagnostic, and procedure data can all be entered from the last page of the encounter form.

Use of the Encounter Form

A well-designed encounter form can facilitate several functions in an office-based practice. These include collection of information for:

1. Billing

Billing personnel require sufficient information for submission of bills to any of several sources for reimbursement. In some cases, a copy of the encounter form can serve as an itemized bill to be given to the patient at the conclusion of the office visit.

2. Communication between team members

Physicians can use the encounter form to make requests for laboratory procedures, dietary instructions, and return visits. In a multiple-provider office, written messages to laboratory technicians, nurses, and secretaries are often more efficient and accurate than are verbal communications.

3. Reports to governmental and other official agencies

Several ambulatory care centers derive all or part of their funding from governmental sources. Information for required periodic reports can be abstracted more easily from encounter forms than from medical records.

4. Health services research

Data entry to either manual or computer files can be made directly from the encounter form. Linkage between demographic information, morbidity data, and services rendered is thereby enhanced.

The Universal Health Insurance Form

A recent collaborative effort has resulted in development of a universal health insurance claim form. This form was designed as a joint effort by the American Medical Association, Bureau of Health Insurance of the US Department of Health, Education, and Welfare, California Medical Association, Health Insurance Council, Medical Group Management Association, National Association of Blue Shield Plans, Office of Secretary of Defense, Health and Environment (CHAMPUS), and others. Although this insurance form does not contain many of the items included on the illustrated encounter form, standardization of claim-related information has been long needed. A logical outgrowth of development of the uniform insurance form would be a uniform encounter form.

The Universal Encounter Form

A universal encounter form which would include items needed for insurance purposes (in addition to reason for visit, disposition, additional instruction, special purpose blanks, and extensive diagnostic information) would be desirable. Knowledge, technology, and suitable classifications are available at this time to accomplish development of a universal encounter form. Lacking are agreement on a minimum basic data set and a logistic design to obtain a consensus of opinion from all concerned parties.

References

1. National Health Survey. The National Ambulatory Medical Care Survey: 1973 Summary, Publication HRA 76-1772, US Department of Health, Education, and Welfare, Health Resources Administration. National Center for Health Statistics, Rockville, Maryland, 1975
2. National Center for Health Statistics: Uniform Hospital Abstract: Minimum basic data set. Vital and Health Statistics Publication (HSM) 73-1451, US Department of Health, Education, and Welfare, series 4, no. 14, 1973
3. National Center for Health Statistics: Ambulatory Medical Care Records: Uniform minimum basic data set. Vital and Health Statistics Publication (HRA) 75-1453, US Department of Health, Education, and Welfare, series 4, no. 16, 1974
4. Froom J: Minimum basic data set. NY State J Med 76:1541, 1976
5. Murnagham JH: Ambulatory medical care data. Report of the conference on ambulatory medical care records: Introduction. Med Care (suppl 2) 11:1, 1973
6. Classification Committee of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians: International Classification of Health Problems in Primary Care. Chicago, American Hospital Association, 1975, p 119
7. Schneider D, Appleton L: Reason for Visit Classification. Chicago, American Medical Record Association, 1976