MIZORAM PUBLIC SERVICE COMMISSION

TECHNICAL COMPETITIVE EXAMINATIONS FOR RECRUITMENT TO
MEDICAL RECORD TECHNICIAN
UNDER MIZORAM INSTITUTE OF MEDICAL EDUCATION AND RESEARCH (MIMER) - 2018

TECHNICAL PAPER – I

Time Allowed : 2 hours Full Marks : 150

Attempt all questions.

All questions carry equal marks of 2 each.

1. "Medical Record as a clear concise and accurate history of patients life and illness from medical point of view" is defined by

(a) Mrs. Edna K. Huffman (b) Dr. T. Thomas

(c) Dr. Malcom T. Mac Eachern (d) Mrs. J. Hughman

2. "Medical Record as a store house of knowledge concerning the patients care" by

(a) Dr. Robert Chapman (b) Dr. Malcom T. Mac Eachern

(c) Mrs. Edna K. Huffman (d) Mr. Mc Powell

3. The most common medical Records are called

(a) Medical Record House (b) Librarian for Medical Record

(c) Source Oriented Record (d) Store House

4. The medical record should be completed in all respect. It should contain

(a) Good information (b) Sufficient data

(c) Complete document (d) Accurate data

5. The medical record should be adequate means, it should contain the patients

(a) Doctors note (b) Progress note

(c) Investigation (d) Document

6. Characteristics of medical record is/are

(a) Complete (b) Adequate

(c) Accurate (d) All of these

7. To be accurate, the medical record must be subjected to Quantitative Analysis by carrying out :

(a) Daily Census (b) Deficiency Check

(c) Hospital Statistics (d) Analysis

8. Need for medical record Department can be explained with the help of

(a) Essential Services (b) Record Keeping

(c) In-patient and out-patient Registration (d) All of these

9. The medical record provides a means of communication between the physician and other

(a) Para-Medical Staff (b) Patients Party

(c) Health Care Professional (d) His Colleague

10. The medical record is used for evaluating the care given in a Hospital by medical staff as a :-
(a) Document (b) Key Tool
(c) Study (d) Thesis

11. The medical record serve as a basis for an individual patient's care
(a) Caring (b) Planning
(c) Treatment (d) Investigation

12. The medical record furnish course of the patient's illness and treatment during each hospital admission for treatment visit
(a) Hospital data (b) Documentary evidence
(c) Investigation form (d) Information

13. The medical record serve as a basis of analysis, study and evaluation of the quality of care rendered to the
(a) Doctors (b) Patients
(c) Nurses (d) None of these

14. The medical record assist legal interest of the patient, hospital and physician in
(a) Producing (b) Protecting
(c) Introducing (d) Legalizing

15. The medical record provides for use in research and education as
(a) Document (b) Clinical data
(c) Patients file (d) Doctors note

16. The medical records also provide____ to the third payer
(a) Information (b) Enquiry
(c) Investigation (d) Evidence

17. Information acquired in a doctor-patient relationship which is generally considered to be confidential or priviledged communication is contained by :-
(a) Hospital (b) Central Admitting Office
(c) Medical Record (d) All of these

18. Uses of medical record is
(a) Personal document (b) Continuity
(c) Communication (d) None of these

19. The doctor can practice scientific medicine on the basis of :-
(a) Hospital data (b) Medical Record
(c) Information Service (d) Enquiry Service

20. For the doctors, when his services are challenged in the court of law, the medical record is very useful as it provides :-
(a) The patients record (b) Hospital data
(c) Medico legal safeguard (d) Medical information

21. Functions of medical records is/are
(a) Development of Hospital Statistics (b) Assistance to Medical Staff
(c) Advisory Services (d) All of these

22. The major section of medical record is/are
(a) Identification of Sociological Section (b) Medical Section
(c) Nurses Section (d) All of these

23. In the Medical Record Department, the record is assembled in a particular arrangement adopted by the
(a) Medical Superintendent (b) Medical Record Officer
(c) Matron (d) All heads of Department

24. The Medical Audit Committee consists of
(a) 10 members (b) 4 members
(c) 6 members (d) 5 members

25. Function of the Medical Audit Committee is
(a) Controls Routine of Patients (b) Assist Medical Record Committee
(c) Release of Information (d) None of these

26. A good Medical Record provides its utility to the
(a) Patient (b) Hospital
(c) Research (d) All of these

27. The value of Medical Record to the patient is/are
(a) Continuity (b) Follow-up
(c) Communication (d) All of these

28. The value of Medical Record to the doctors is/are
(a) Scientific Medicine (b) Continuity
(c) Publication (d) All of these

29. The value of Medical Record to the hospital is/are
(a) Yardstick (b) Hospital Statistics
(c) Planning (d) All of these

30. A physician cannot practice without complete and carefully written Medical Record
(a) Good Medicine (b) Scientific Medicine
(c) Admission Procedure (d) Discharge Summary

31. Information from Medical Record is helpful to the physician's subsequent
(a) Admission (b) Hospitalisation
(c) Treatment (d) Discharge

32. The post-graduate student use Medical Record for publication and preparing
(a) Notes (b) Thesis
(c) Desertation (d) Treatment

33. A place where the record of a patient are stored, maintained and retrieved is :-
(a) Store House of Hospital (b) Medical Record Department
(c) Central Vaccine Depot (d) Forensic Department

34. The inpatient Medical Record is prepared in the
(a) Medical Superintendent Office (b) Matron Office
(c) Central Admitting Office (d) Emergency Department

35. Patient's are admitted in the hospital through
(a) Out-patient Department (b) Central Admitting Office
(c) Emergency Department (d) Operation Theater

36. Function of Central Admitting Office is/are
(a) Enquiry Services (b) Scheduling of Patient
(c) Release of Information (d) All of these

37. The Central Admitting Office works in three shifts from (8 hourly) or four shifts (6 hourly) and
(a) Daily duties (b) Round the clock
(c) Routine duties (c) Midnight duties

38. The Central Admitting Office works only in 2 (two) shifts from 8 a.m to 2 p.m and 2 p.m to 8 p.m, and
(a) Daily duties (b) Whole day duties
(c) Day time only (d) Day care duties

39. In U.K, the Central Admitting Office is called
(a) Registration Office (b) Documentation Office
(c) Information Office (d) Filing Office

40. The Central Admitting Office controls the routing of the :-
(a) Doctors (b) Nurses
(c) Patient (d) Para-Medical

41. In a hospital, the Central Admitting Office may be treated as the
(a) Main (b) Chief
(c) Heart (d) Central

42. The Central Admitting Office is the first place of Medical Record Department of :-
(a) Enquiry (b) Planning
(c) Information (d) Publication

43. The Central Admitting Office is the place of public relation because it performs :-
(a) Registration (b) Reception
(c) Information (d) Documentation

44. Hospitals are free to follow their own format for
(a) Registration (b) Medical Record form
(c) Investigation form (d) None of these

45. For the users, the language of the caption should be
(a) Understandable (b) Readable
(c) Easy to fill out (d) All of these

46. The name of the hospital and the title of the sheet should be printed at the
(a) Bottom (b) Head
(c) Top (d) Middle

47. The quantitative analysis is done for the discharged inpatient Medical record to get the record computed through
(a) Hospital data (b) Deficiency Check Slip
(c) Phonograms of messages (d) Information centre

48. Progress notes begin with an admission note, continue with subsequent notes during hospitalisation and conclude with a

(a) Discharge Summary (b) Final notes on discharge or death
(c) Follow up notes (d) None of these

49. A short form of Medical Record is acceptable in treatment and diagnostic cases of a minor nature which required less than

(a) 24 hours Hospitalisation (b) 12 hours Hospitalisation
(c) 48 hours Hospitalisation (d) 60 hours Hospitalisation

50. Special consent for specific medical or surgical treatment are required as under :-

(a) Authorisation for Medical / Surgical treatment (b) Release of Information
(c) Release against Medical Advice (LAMA) (d) All of these

51. Who is responsible for designing Medical Record form ?

(a) Medical Record Committee (b) Hospital form Committee
(c) Medical Audit Committee (d) Scientific Committee

52. Who should be an active member of any forms Committee ?

(a) MRO / Administrator (b) Physician / MRO
(c) Surgeon / Administrator (d) Physician / Administrator

53. Forms which are necessary in majority of records regardless of the type of case is :-

(a) Important forms (b) Basic forms
(c) Necessary forms (d) Investigation forms

54. Specific Medical Record forms designed for a particular Department is called

(a) Specific forms (b) Particular forms
(c) Special forms (d) Necessary forms

55. Admission & Discharge / Summary record or face sheet / Social history record are called

(a) Special form (b) Important document
(c) Top or first form (d) Priority form

56. Most hospitals prefer to use carefully designed and printed forms because it is

(a) Easy to fill out (b) Reduce writing time
(c) Charts less bulky (d) All of these

57. The completion of Medical record is also a part of

(a) Deficiency check (b) Quantitative analysis
(c) Hospital Statistics (d) None of these

58. The Medical Record Department also provides advisory services to the Medical Staff for their

(a) Studies (b) Research work
(c) Thesis (d) Notes

59. Outsiders or unauthorised persons should not be allowed to access the medical record,by means of the firm control system of

(a) Hospital (b) Statistics
(c) Medical record (d) Central Admitting Office

60. The Medical record Department can perform any other assignment given by the

(a) Head of Department (b) Physician
(c) Other Health Professional (d) Head of the Institution

61. To prevent the misfiles of the record, the following points should be followed :
(a) One person responsible (b) File at once
(c) Do not access outsiders (d) All of these

62. The Medical Record is retained and preserved for the purpose of
(a) Patient care (b) Medico legal
(c) Research and education (d) All of these

63. A method of preservation of Medical Record is
(a) Photocopying (b) Storing in the computer
(c) Microfilming (d) Registering

64. The method of destruction of Medical Record is
(a) Destroy by - Burning - Burying (b) Destroy by - Recycling - Give away
(c) Destroy by - Burning - Recycling (d) None of these

65. To meet the medico-legal requirements, the in-patient should be preserved for
(a) 10 years (b) 5 years
(c) 15 years (d) 8 years

66. The medico-legal Register should be preserved for
(a) 5 years (b) 10 years
(c) 15 years (d) 20 years

67. The Medical Record Committee consists of
(a) 6 members (b) 4 members
(c) 3 members (d) 5 members

68. The Medical record Committee is organised to develop
(a) MR forms (b) MR policies
(c) MR legal policies (d) All of these

69. Duties of Hospital form committee is
(a) Review of new forms (b) Destruction of forms
(c) Designing forms (d) Assist Medical Record Committee

70. The methods of numbering system is/are
(a) Serial Numbering System (b) Unit Numbering System
(c) Serial-Unit Numbering System (d) All of these

71. How will you know that the data in a particular monthly or quarterly report is accurate
(a) The reported data matches with the data recorded in the respective register or tallies
(b) The reported data represents the actual number of cases served
(c) The reported represents with the daily patients census
(d) All of these

72. What is HMIS ?
(a) Collects data for performance monitoring from service delivery and administrative records
(b) Provides signals that can be reviewed frequently to monitor programme implementation
(c) Used for decision making
(d) All of these

73. Information management includes

(a) Data collection
(b) Data processing
(c) Data analysis
(d) All of these

74. HMIS reform is required

(a) To improve quality
(b) To reduce data burden
(c) To integrate data channel
(d) None of these

75. Quality HMIS information means that the information is

(a) Complete
(b) Relevant
(c) Reliable
(d) All of these

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