

Healthcare Skills Student Packet

Vocabulary • patient communication • role-ready scripts

Study guide for the care team

Medical administrative assistant • clinical medical assistant • EKG tech • patient care tech

What is a care provider?

Care provider is the universal term used in this packet for the trained professional who is providing or coordinating care. In different settings, that person may be a medical administrative assistant, clinical medical assistant, EKG technician, patient care technician, nurse, or another authorized healthcare professional.

Your role determines: what you may do, what you must report, and what you must document.

What is your role and setting?

Name: _____

Date: _____

Role title: _____

Setting: _____

Instructor or supervisor: _____

How to use this packet

- ☐ Study the vocabulary and word parts used in healthcare communication.
- ☐ Use the bed and environment reference as a review tool.
- ☐ Practice the universal script with your assigned role and setting.
- ☐ Always follow current orders, facility policy, training, and scope of practice.

Role Vocabulary I

Administrative and clinical medical assistant terms

Use the vocabulary that matches your assignment. The role title does not replace the need to follow state law, employer policy, supervision, training, and scope of practice.

Medical administrative assistant

Records, scheduling, patient flow, privacy, referrals, billing, and coding.

TERM / ABBREV.	MEANING / USE
EMR / EHR	Electronic medical record / electronic health record.
PHI / HIPAA	Protected health information / privacy and security requirements.
ROI	Release of information; authorization or process for sending records.
MRN / DOB	Medical record number / date of birth; approved identifiers help verify the patient.
PCP	Primary care provider.
CMS	Centers for Medicare & Medicaid Services.
ICD-10-CM	Diagnosis classification and coding system.
CPT	Procedure and professional service codes.
HCPCS	Codes for healthcare services, supplies, and equipment.
NPI	National Provider Identifier.
PA	Prior authorization; payer approval may be required.
Copay / deductible	Patient-cost terms; confirm plan-specific details.
Referral / eligibility	Connects a patient to another service / checks coverage status.
Encounter / superbill	Patient visit or service record / charge or code summary.

Clinical medical assistant

Intake, measurements, preparation, specimens, delegated procedures, and documentation.

TERM / ABBREV.	MEANING / USE
VS	Vital signs: BP, HR, RR, temperature, and SpO2 as assigned.
BP / HR / RR / SpO2	Blood pressure / heart rate / respiratory rate / oxygen saturation.
BMI	Body mass index; a screening measure from height and weight.
CC / HPI / ROS	Chief complaint / history of present illness / review of systems.
PMH / PSH / FH / SH	Past medical / past surgical / family / social history.
NKDA	No known drug allergies; confirm and document by policy.
SOAP	Subjective, objective, assessment, plan.
PPE	Personal protective equipment.
CLIA-waived	Test category with specific training, quality, and documentation requirements.
Aseptic technique	Steps used to reduce contamination and infection risk.
Venipuncture / capillary	Blood collection from a vein / skin puncture.
Specimen	Collected sample; label and handle according to policy.
MAR / Dx / Tx / Rx	Medication record / diagnosis / treatment / prescription or medication.
QA / QC	Quality assurance / quality control.

Scope reminder: Administrative staff route clinical questions. Clinical assistants confirm the order, delegation, equipment, competency, supervision, and documentation requirement before a clinical task.

Role Vocabulary II

EKG technician and patient care technician terms

These terms support patient preparation, accurate measurements, safe care, observation, and reporting. Perform only the duties authorized for your role and setting.

EKG technician

Patient preparation, electrodes, ECG acquisition, artifact reduction, equipment care, and routing.

TERM / ABBREV.	MEANING / USE
ECG / EKG	Electrocardiogram; a recording of heart electrical activity.
12-lead ECG	Standard tracing using limb and precordial leads.
Electrode / lead	Electrode contacts skin; lead is an electrical view.
RA / LA / RL / LL	Right arm / left arm / right leg / left leg labels.
V1–V6	Precordial (chest) lead positions.
P / QRS / T	Atrial depolarization / ventricular depolarization / ventricular repolarization.
PR / QT / QTc	Intervals on the tracing; QTc is QT corrected for heart rate.
ST segment	Portion between ventricular depolarization and repolarization.
Artifact	Unwanted signal from movement, muscle tension, contact, interference, or equipment.
Baseline wander / AC	Common tracing distortions from movement, respiration, or electrical interference.
NSR / AFib	Normal sinus rhythm / atrial fibrillation; do not self-diagnose.
PVC / PAC	Premature ventricular / premature atrial contraction.
Brady / tachy	Slower-than-expected / faster-than-expected heart rate.
Skin preparation	Clean and dry contact sites; follow electrode and cable policy.

Patient care technician

Basic care, ADLs, mobility, measurements, comfort, safety, observation, and reporting.

TERM / ABBREV.	MEANING / USE
ADL	Activities of daily living: bathing, dressing, grooming, eating, toileting, mobility.
I&O	Intake and output; measure, record, and report by the care plan.
amb / OOB / BRP	Ambulate / out of bed / bathroom privileges.
ROM	Range of motion; active or assisted as directed.
Assist x1 / x2	One-person or two-person assistance; follow mobility level.
WBAT / NWB	Weight bearing as tolerated / non-weight-bearing.
Fall precautions	Safety measures identified by order, care plan, or policy.
Skin integrity	Protect skin, observe changes, reposition as directed, report concerns.
VS / TPR / SpO2	Vital signs / temperature, pulse, respirations / oxygen saturation.
SOB / NPO	Shortness of breath / nothing by mouth.
SBAR	Situation, background, assessment/observations, recommendation/request.
Call light	Patient alert or request system; keep within reach when used.
Transfer / gait belt	Move between surfaces / use only as trained and permitted.
Closed / open bed	Covers closed after discharge / linens folded back for use.
Occupied / surgical bed	Made with patient in bed / prepared for post-surgery return.

Role reminder: EKG technicians report symptoms and route tracings; authorized clinicians interpret. Patient care technicians follow the care plan and report changes; they do not diagnose or independently change the plan.

Healthcare Vocabulary

Common abbreviations: A through W

Use abbreviations only when they are approved by the program or facility. Meanings may vary by context; when in doubt, write the full term or ask the appropriate team member.

ABBREVIATION	MEANING
ac	Before meals
ADL	Activities of daily living
ad lib	As desired
amb	Ambulatory
bid	Twice a day
BM (bm)	Bowel movement
BP	Blood pressure
BRP	Bathroom privileges
c	With
CBR	Complete bed rest
c/o	Complains of
CPR	Cardiopulmonary resuscitation
CVA	Cerebrovascular accident; stroke
dc (d/c)	Discontinue
drsg	Dressing
Dx	Diagnosis
ECG (EKG)	Electrocardiogram
FF	Force fluids
HS (hs)	Hour of sleep
ht	Height
ICU	Intensive care unit
I&O	Intake and output
IV	Intravenous
NPO	Nothing by mouth
OOB	Out of bed

ABBREVIATION	MEANING
pc	After meals
po (per os)	By mouth
postop (post op)	Postoperative
prn	When necessary
Pt (pt)	Patient
PT	Physical therapy
q	Every
qd	Every day
qh	Every hour
q2h, q3h, q4h	Every 2 hours; every 3 hours; every 4 hours
qid	Four times a day
R	Rectal temperature
RLQ	Right lower quadrant
ROM	Range of motion
RUQ	Right upper quadrant
s	Without
SSE	Soap suds enema
stat	At once; immediately
tid	Three times a day
TPR	Temperature, pulse, and respiration
U/a (U/A, u/a)	Urinalysis
VS (vs)	Vital signs
WBC	White blood count
w/c	Wheelchair
wt	Weight

Care provider: the universal term used in this packet for the trained professional providing or coordinating care. The actual role may be a medical assistant, patient care technician, nurse, or another trained healthcare professional.

Role reminder: your title does not automatically authorize every task. Work within your education, training, authorization, supervision, and scope of practice.

Healthcare Vocabulary

Word parts, prefixes, suffixes, and anatomy roots

A prefix appears at the beginning of a word. A suffix appears at the end. A combining form usually connects a root to a suffix. Break an unfamiliar term into parts, then confirm its meaning in context.

WORD PART	MEANING
hyper-	excessive
-dynia	pain
endo-	within
a- / an-	without
anti- / contra-	against or opposed to
ab-	away from
ad-	to, toward, or near
circum- / peri-	around
hemi- / semi-	half
hypo-	below or deficient
macro-	large or long
micro-	small
mono- / uni-	one
poly- / multi-	many
brady-	slow

WORD PART	MEANING
tachy-	fast
post-	after or behind
dys-	painful, difficult, or faulty
eu-	good or normal
-algia / -dynia	pain
-rrhea	discharge
-oma	tumor
-osis	condition or increase
-gram	record
cyan/o	blue
erythr/o	red
leuk/o	white
melan/o	black
hydro/o	water
py/o	pus

WORD PART	MEANING
gastr/o	stomach
hem/o / hemat/o	blood
oste/o	bone
ur/o / urin/o	urine
aden/o	gland
arthr/o	joint
cephal/o	head
col/o / colon/o	colon
derm/o / dermat/o / cutane/o	skin
cyt/o	cell
hist/o	tissue
my/o / muscul/o	muscle
nas/o / rhin/o	nose
nephro / ren/o	kidney
neur/o	nerve
or/o	mouth
pneum/o / pneumon/o	air or lung
abdomin/o / lapar/o	abdomen
acr/o	extremity or topmost
carcin/o	cancer
necr/o	death
onc/o	tumor or mass
path/o	disease
phag/o	eat or swallow

Combine a root and a suffix

Example: gastr/o + -itis = gastritis. The root tells the body part or system; the suffix helps describe the condition or procedure.

Study check: Choose one word part above, write a healthcare term that uses it, and explain the term in your own words.

Healthcare Vocabulary

Clinical language and documentation terms

TERM	MEANING
CC	Chief complaint
c/o	Complains of
Dx	Diagnosis
Hx	History
PERRLA	Pupils equal, round, and reactive to light and accommodation
PH, PMH	Past history; past medical history
R/O	Rule out
WNL	Within normal limits
acute	Sharp; intense, often severe symptoms with a short course
chronic	A condition that develops slowly and persists over time
benign	Mild or noncancerous
malignant	Harmful or cancerous
diagnosis	Determination of a disease based on evaluation of symptoms, signs, and test findings
febrile	Relating to a fever
localized	Limited to a definite area or part
systemic	Relating to the whole body rather than only a part
malaise	A feeling of uneasiness or discomfort; often an early indication of illness

TERM	MEANING
prognosis	Prediction of the likely outcome of a disease based on health status and the usual course of the disease
prophylaxis	A process or measure that prevents disease
sign	Objective evidence of disease that can be seen or verified by an examiner
symptom	Subjective evidence of disease perceived by the patient
post-op / postop	Postoperative; after surgery
pre-op / preop	Preoperative; before surgery
BRP	Bathroom privileges
DC or D/C	Discharge; discontinue
ETOH	Ethyl alcohol
SOB	Shortness of breath
Tx	Treatment or traction
ID	Intradermal injection; within the skin
IM	Intramuscular injection; within the muscle
IV	Intravenous injection; within the vein
ad lib.	Ad libitum; as desired
amt	Amount
NPO	Non per os; nothing by mouth

Documentation practice

Write one patient-friendly observation: “The patient states...” or “I observed/measured...”

Universal Care Provider Script

Quick-use five-step script for office, clinic, hospital, or inpatient practice.

Practice rule: Read the “Say” lines aloud and complete every “Do” action in order. Replace the brackets with your actual role, assignment, and setting. The evaluator may pause you at any step.

Practice script: prepare, enter, and begin

1 PREPARE

Say: “I reviewed the order or care plan for [task]. I have the correct supplies and will work within my role and supervision.”

Do: Confirm patient, order/care plan, purpose, scope, supervision, documentation, clean/working supplies, packaging and expiration when applicable. Perform hand hygiene before touching the patient, supplies, or an aseptic site.

2 ENTER + PRIVACY

Say: “Hello, my name is [name], and I am a [role]. May I come in?”

Do: Knock, announce yourself, wait when possible, close the door or curtain, use a drape, and expose only the area needed. State the task you are assigned to perform or assist with.

3 IDENTIFY + EXPLAIN

Say: “Please tell me your [identifier 1] and [identifier 2]. I am going to [task] because [purpose]. You may feel/notice [expectation]. What questions do you have?”

Do: Match two approved identifiers to the order or record; never use the room number as an identifier. Explain the purpose, steps, expected sensations or patient actions, and approximate time.

4 CONSENT + START

Say: “I want to make sure I explained this clearly. May I begin? Please tell me if you need to pause.”

Do: Follow the setting's consent process. Confirm understanding. If the patient is unsure, asks questions, or refuses, pause and notify the appropriate team member. Before an aseptic task, perform hand hygiene again and apply PPE when indicated.

Stop and ask for help: The patient is unstable, the order/identity/equipment/consent does not match, or the task is outside your training, authorization, supervision, or scope.

Universal Care Provider Script

Role and setting adaptations, handoff language, and a practice check.

3. Perform the skill safely

- ☐ **Clean/aseptic practice:** Perform hand hygiene again immediately before an aseptic task. Apply PPE when exposure to blood, body fluids, mucous membranes, non-intact skin, or contaminated items is anticipated.
- ☐ **Explain as you go:** Tell the patient what you are doing, maintain privacy, use safe technique, and encourage the patient to report pain, dizziness, breathing difficulty, or the need to pause.
- ☐ **Stay within scope:** Perform only the assigned task for which you are trained, authorized, and supervised. Do not diagnose, interpret results, or promise an outcome.
- ☐ **Observe and respond:** Watch the patient, equipment, specimen, and environment. Stop and get help for an unexpected response, unsafe condition, or change in status.

4. Finish the encounter

- ☐ **Check the patient:** Ask about comfort, symptoms, questions, and immediate needs. Return the patient and environment to a safe condition.
- ☐ **Clean up:** Dispose of waste and sharps correctly. Clean, disinfect, or reprocess equipment according to policy. Remove PPE correctly when used.
- ☐ **Perform hand hygiene after care:** Clean hands after touching the patient or immediate environment, after body-fluid exposure risk, and immediately after glove removal. Wash with soap and water when visibly soiled.
- ☐ **Leave safely:** Place the call light or needed items within reach when used in the setting, explain the next step, and protect privacy as you leave.

5. Report and document

- ☐ **Report:** Communicate abnormal findings, symptoms, refusals, incidents, specimen problems, equipment problems, and changes in condition to the designated team member promptly.
- ☐ **Document or hand off:** Record the date/time, skill or service, relevant findings or measurements, patient response, teaching, consent/refusal, notifications, and result/specimen routing as required. Use objective language.

Use SBAR for a concise handoff

S — Situation: "I am calling about [patient / visit] because..." **B — Background:** "The relevant order, history, or context is..." **A — Assessment / observations:** "I observed / measured..." **R — Recommendation / request:** "I need you to review / assess / clarify..."

Student checkoff notes

Role: _____

Setting: _____

Skill: _____

Evaluator: _____