Medical Record Documentation Review

Type of Provider/Practitioner (circle): PCP/Specialist

Date of Review:______________

Reviewer:_____________________

Record Reviewed : Paper____ EMR____

Provider Name:_______________________________

Clinical Specialty: __________________

	Standard	Yes	No	NA	Comments
Section 1 **Complete for Adult PCP Only**					
1.	Documentation of smoking habits and history of alcohol or substance abuse				Patients 8 years old and older
2.	Immunization history addressed and documented				
3.	Mammography for women over 40 years of age offered				
4.	Cervical cancer screening/ Pap smear offered				
5.	Prostate exam for men over age of 50 offered				
6.	Cholesterol screening complete				For males >35 y.o., for women > 45 y.o.
7.	There is evidence preventive screening and services are offered in accordance with organization's practice guidelines.				
8.	Consultant summaries, lab, and/or diagnostic study results reflect PCP/provider review				
Section 2 **Complete for PCP and Adult Specialists**					
9.	Past medical history (for patients seen 3 or more times) easily identified				
10.	The H&P exam identifies appropriate information pertinent to the patient's presenting complaints.				
11.	Lab and other studies relate to symptoms or diagnosis				
12.	Working diagnosis consistent with findings				
13.	Treatment plan consistent with diagnosis (es)				
14.	Return visit or other follow up plan for each encounter				
15.	Previous problem follow up				
16.	Review of consultant referral patterns				(i.e. over/under utilization)
17.	Continuity/coordination of care between primary and specialists physicians				
18.	Current problem list in chart (if not problem list, current therapies are documented)				Problem list may include past procedures, chief complaint, allergies, medications, diagnosis
19.	Significant Illness and medical conditions are stated on the problem list (if not problem list, current therapies are documented)				

This document contains CONFIDENTIAL and

Medical Record Documentation Review

	Standard	Yes	No	NA	Comments
20.	Care appears medically appropriate- no evidence a patient is placed at inappropriate risk by a diagnostic or therapeutic problem.				i.e. diagnostic or therapeutic procedures
21.	HIV consent form present				Found under consent tab of record
22.	Consent for treatment form present				
23.	Allergies/absence of allergies & adverse reactions to medications prominently displayed				
24.	Documentation of follow-up for missed and cancelled appointments is present.				
25.	Significant advice given by telephone is recorded.				
Section 3	**Complete for OB/GYN Specialists Only**				
1.	Prenatal care in first trimester				
2.	Appropriate labs performed				(glucose, urine culture, rubella screening, etc)
Section 4	**Complete for Behavioral Care Specialists Only**				
1.	Smoking/ETOH/substance abuse habits noted.				
2	CD Referral documented if applicable				
3.	Patient strengths/weaknesses documented				
4.	Psychiatric Assessment Completed w/chief complaint, hx of mental illness, past tx, therapeutic interventions and responses, medication use, and relevant family information				
5.	Suicidal/homicidal ideation documented				
6.	Medical evaluation requested with SMI diagnosis				
7.	Patient education provided				Record documents preventive services, relapse services, and lifestyle changes
8.	Release of information documented if applicable				Examples: minors/patients receiving ECT

Totals: Yes _______ No ________ NA ________ Score: __________%

This document contains CONFIDENTIAL and PRIVILEGED information prepared for Quality and Peer Review Committees.