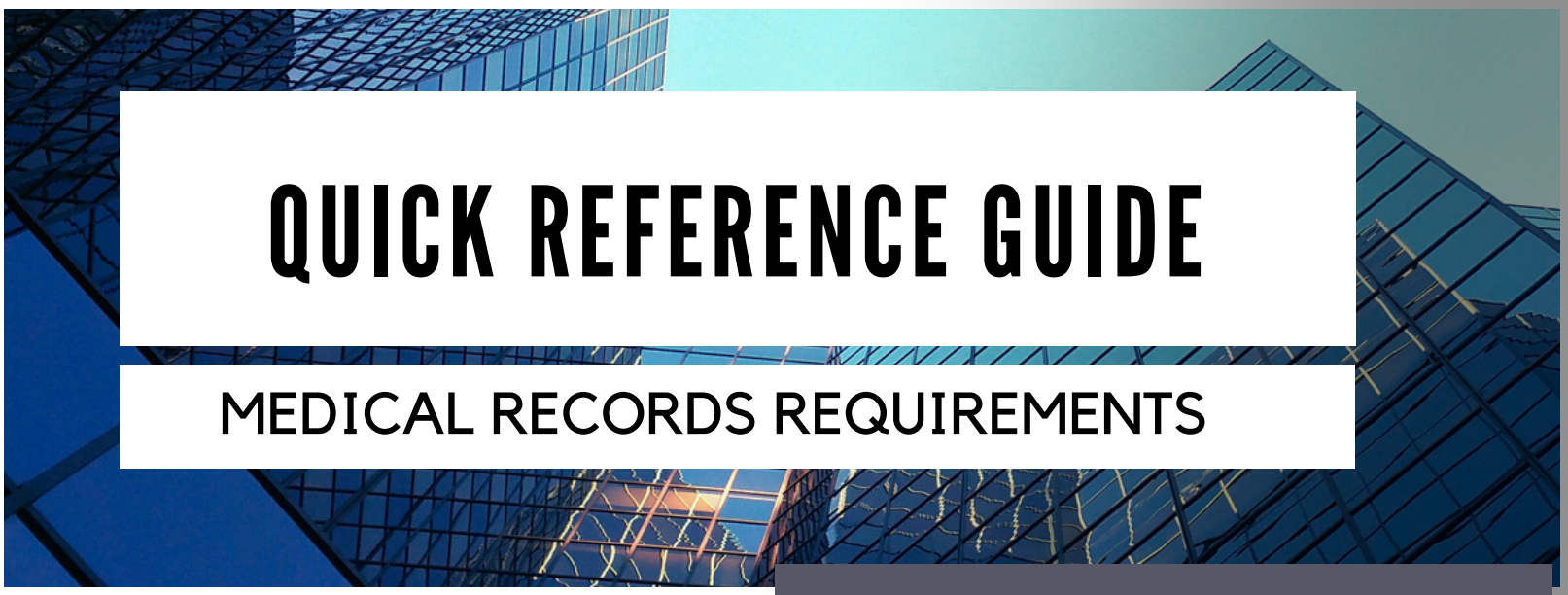
BPW
HEALTHCARE CONSULTING



QUICK REFERENCE GUIDE

MEDICAL RECORDS REQUIREMENTS

MEDICAL RECORD ENTRIES

Entries must be complete and legible with the identity of the patient and DOS for the entry

When a modification is made, the following apply

- Clearly identify any addendums
- Clearly identify the date and author of correction or addendum
- Clearly identify all original data, DO NOT DELETE

When correcting a paper medical record, single strike through is used so the original content is visible. Author must sign and date the revision or add.

When correcting an EHR, delayed entry needs to be identified and separate from the original content.

ACRONYMS

Acronyms are allowed in the medical record as long as they are common and used industry wide. Review Joint Commission acceptable and dangerous acronyms Do Not Use List Fact Sheet | The Joint Commission

MEDICAL HISTORY

A patient's medical history is required so healthcare providers can make assessments and identify risk prevention.

Can include-surgical history, OB history and outcomes, risks

Can include medications and allergies, immunizations

Can include family history, social history, medical directives

MEDICAL RECORD REQUIREMENTS

Admission report	Consent to treat form	Attestation statement	Medical history	Physician's orders
Physical examination	Progress Notes	Path reports	Rad reports	Consults
Anesthesia	Op reports	Vitals/Nurse Notes	Medications	Physical Therapy
	Special reports	Discharge		

National Patient Safety Goals | The Joint Commission

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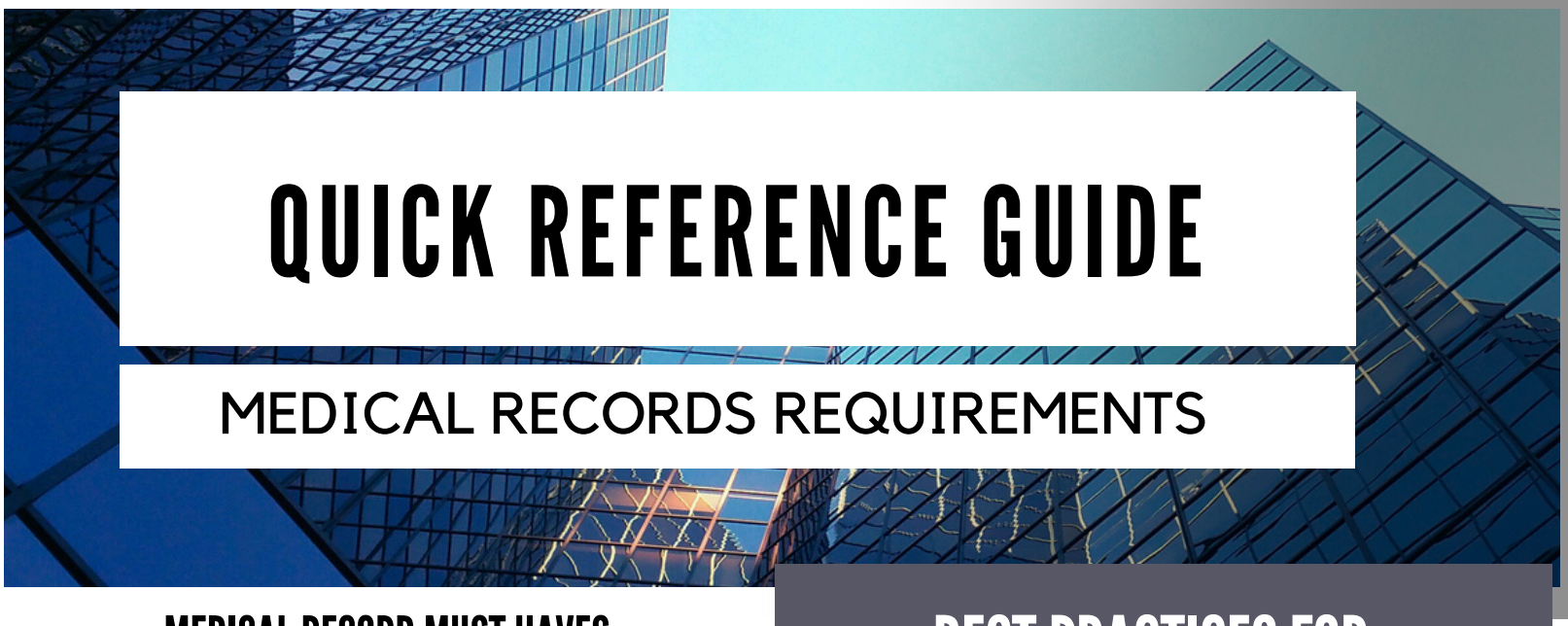
HEALTHCARE CONSULTING



QUICK REFERENCE GUIDE

MEDICAL RECORDS REQUIREMENTS

MEDICAL RECORD MUST HAVES

1. DATE AND TIME
2. SIGNATURE: FULL SIGNATURE IS BEST PRACTICE; ELECTRONIC SIGNATURE IS ALSO SUFFICIENT
3. A SYSTEM FOR THE PROVIDER TO VERIFY ENTRY IS VERIFIED AND ACCURATE

BEST PRACTICES FOR SIGNATURES

Program Memorandum (cms.gov)

MEDICAL RECORD COMPONENTS

Governed by the individual states; state law pre-empts federal regulations. Files must be accurate, complete and readily acceptable.

- Chief Complaint: Why the patient is presenting for services
- History: How the patient describes the symptoms
- Physical Exam: Performed by the provider, series of assessments, observations which are focused around the symptoms
- Assessment: Provider makes a determination and creates a plan to resolve the symptoms

SOAP

S: Subjective; patient provides information about symptoms and what have they done to relieve the symptoms

O: Objective; indicates the physical exam findings of the provider

A: Assessment, where the provider assessments of the patient's condition and renders a working DX or signs and symptoms if the DX is not definitive

P: Plan, provider's plan is documented in direct relation to the assessment. Definitive DX is established. If a DX is not reached, documentation should reflect tests that are ordered