Patient Record Review

Date of Office Review: _____

Office Reviewers: (1) _____

(2) _____

Doctor Reviewed: _____

Doctor present for Review? **Yes_____** **No_____**

Clinic: _____

List, by name and Saskatchewan Health ID number, the patient files reviewed.

1. _____ ID_____
2. _____ ID_____
3. _____ ID_____
4. _____ ID_____
5. _____ ID_____
6. _____ ID_____
7. _____ ID_____
8. _____ ID_____
9. _____ ID_____
10. _____ ID_____

If required, list the additional files reviewed. Reason: _____

_____

_____

11. _____ ID_____
12. _____ ID_____
13. _____ ID_____
14. _____ ID_____
15. _____ ID_____

Initial Visit / New Condition

Items in BOLD are mandatory components of patient record.

Items in regular type are highly recommended but remain optional.

Part A. History

	File #	1	2	3	4	5	6	7	8	9	10
1. Patient data recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Chief complaint recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Duration of symptoms recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Adequate description of symptoms?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Related or associated symptoms?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Aggravating or relieving factors?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Previous care/Chiro/MD/Physio etc?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Previous diagnostic tests/records?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Systems review / medical history?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Family / social history?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. Subjective outcome measure tools used? i.e. NDI, Oswestry, VAS, etc.		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

****Assessors please note that if the doctor being assessed did NOT do the initial intake, please choose another file – if needed please have them pull a new patient file.**

_____

_____

_____

_____

Part B. Examination Findings (on Initial Visit or New Condition)

	File #	1	2	3	4	5	6	7	8	9	10
1. Observations recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
a. Postural analysis		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
b. Height		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
c. Weight		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Palpation / percussion recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Range of motion recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Orthopedic tests recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Chiropractic tests recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Neurological tests recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Positive and negative tests recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Validated outcome tools used? i.e. goniometer, dynamometer, algometer, etc.		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Part C. X-rays / Other reports If Applicable

	File #	1	2	3	4	5	6	7	8	9	10
Does history indicate X-rays,											
CT Scan, or MRI taken?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Diagnostic imaging reports in file?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Lab reports, other test results in file?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Part D. Working / Provisional Diagnosis

	File #	1	2	3	4	5	6	7	8	9	10
1. A working diagnosis is recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. A differential diagnosis is recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

****Assessors please note that a code is no longer sufficient - please indicate if it is a code**

Comments:

Part E. Treatment Plan

	File #	1	2	3	4	5	6	7	8	9	10
1. A treatment plan is recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
a. Type of Treatment		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
b. Frequency		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
c. Duration		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

****Assessors please note that this is on the initial only – this does not include the proposed subsequent treatment on the daily SOAP notes**

Comments:

Part F. Consent Form

	File #	1	2	3	4	5	6	7	8	9	10
1. Signed consent form?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

a. Updated CCPA Form? ☐ **Yes** ☐ **No**

b. When does the patient sign Consent Form? _____

**** The CCPA recommends that patients sign the consent form after the Report of Findings.**

****Assessors please look for deficiencies (missing date, witness signature – and indicate)**

Comments:

Daily Chart Management

Items in BOLD are mandatory components of patient record.

Items in regular type are highly recommended.

	File #	1	2	3	4	5	6	7	8	9	10
1. Patient identification present on each page?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Date of treatment / consultation recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. S.O.A.P. format or equivalent used?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Patient response to treatment recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. General health advice / exercise recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Proposed subsequent treatment plan?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Are contraindications to treatment and life-threatening allergies clearly documented?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. If more then 1 doctor treats patient, is each doctor identifiable on treatment record?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Are periodic assessments performed?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Are there signs of record alteration? i.e. white out, cover up, etc.		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. Overall is it possible to determine when, why & how many treatments pt received?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. Is it clearly documented when patient referred for second opinion / treatment?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13. If present, are letters to other health professionals **a**ppropriate and professional?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. If present, are telephone consults with patients and third parties appropriately recorded?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15. Are late, missed or changed appointments documented?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Positive Findings to share with colleagues

Examples: case history forms, patient questionnaires, file management system, treatment recording systems, outcome measurement tools, educational material, etc.

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

Clinical Records Summary

In General, after reviewing the files would you agree with the following statements?

	Yes	No	Comments
1. Chart documentation organized?	□	□	_____
2. Records are legible?	□	□	_____
3. Key available for abbreviations?	□	□	_____
4. Patient information clearly identified?	□	□	_____
5. Patient name, ID recorded on each page?	□	□	_____
6. Date of each visit/consultation recorded?	□	□	_____
7. Informed consent form completed?	□	□	_____
8. Questions when, what, why and by whom generally answered by the patient record?	□	□	_____
9. Patient records, including financial records stored.	□	□	_____

Office Reviewer Summary

Based on the review of the physical facility and clinical records you just completed, please rate your overall assessment below.

PASS

☐ **Commendable** Consistently meets the standards of good record keeping. Physical facility in good repair. No concerns identified.

☐ **Acceptable** Occasional deficiencies (less than 30% of the files reviewed) in standards of good record keeping were observed and are listed.

Physical facility deficiencies were noted that may pose risk to patient but are not deemed as serious.

FAIL

☐ **Not Acceptable** More than 30% of the files reviewed had major deficiencies noted. A review of the standards of acceptable record keeping is required including a follow-up within 6 -12 months.

☐ **Physical facilities** pose an immediate risk to patient safety. Immediate action is required to remedy the problem. Follow-up within one month is recommended.

Deficiencies requiring attention: (if more detail required, please list on a separate sheet)

1. _____

2. _____

3. _____

4. _____

5. _____

Office Reviewer: _____ **Name**

_____ **Signature** ____/____/____ **Date**
day month year

Office Reviewer: _____ **Name**

_____ **Signature** ____/____/____ **Date**
day month year