

## Medical Record Documentation Standards

---

The medical record contains valuable information about the patient's health status and facilitates communication, continuity and coordination of care, and promotes efficiency and effectiveness of treatment.

All practitioners must establish a process and meet the following criteria for medical record documentation:

1. All pages of the medical record must contain the patient's name and/or ID number.
2. Demographic information must include: Name, gender, date of birth, address and telephone number.
3. All entries must be dated and include an author identifier (handwritten signature, an initialed stamped signature, or a unique electronic identifier).
4. A problem list must include medical and/or behavioral health conditions.
5. The past medical history must include serious accidents, surgeries and illnesses.
6. Documentation must include relevant subjective information and objective clinical findings and evaluation pertinent to the patient's presenting problem and/or complaint.
7. All medication allergies and adverse reactions must be prominently documented in the medical record. If there are no known allergies (NKA), this must be noted as well.
8. A system must be utilized in the medical record to provide information on prescribed medications, and include dose and date of both initial and refill prescriptions.
9. An immunization record must be utilized to track up-to-date and/or overdue immunizations, or an appropriate history or member refused/declined must be documented.
10. The following documentation must be in a prominent part of the medical record of a member  $\geq 65$  years of age:
  - Documentation of advance directives
  - Documentation of whether or not a member has executed an advance directive
11. When applicable, encounter forms or progress notes must include a notation for follow-up care, phone calls, or visits. The specific time is noted in weeks, months, or as needed.
12. If a consultation is requested, documentation from the consultation must be in the medical record.
13. There must be documentation that preventive screenings and services are offered.
14. There must be documentation that all referrals for diagnostic and therapeutic services (home health, nursing reports, hospital discharge reports, PT reports) are noted.