



Medical Record Review Tool

Responses: Met (M), Needs Improvement (NI), Not Met (NM), Not Applicable (NA)
Physician/Clinic Site Review Tool

CLINIC SITE &/OR PHYSICIAN NAME:			SURVEYOR:								DATE:		Total Points:		#DIV/0!
STANDARD #	POINTS POSSIBLE	STANDARD DESCRIPTOIN	MEMBER #1	MEMBER #2	MEMBER #3	MEMBER #4	MEMBER #5	MEMBER #6	MEMBER #7	MEMBER #8	MEMBER #9	MEMBER #10	TOTAL POINTS	TOTAL POSSIBLE	% / STANDARD
1	1	Each and every page in the record contains the patient's name or ID number.											0	0	#DIV/0!
2	1	Personal/biographical data includes address, employer, home and work telephone numbers, and marital status as well as assessment of cultural and/or linguistic needs such as deaf/blind, etc.											0	0	#DIV/0!
3	1	All entries in the medical record contain author identification.											0	0	#DIV/0!
4	1	All entries are dated.											0	0	#DIV/0!
5	1	The record is legible to someone other than the writer and in ink/electronic.											0	0	#DIV/0!
6	4	Significant illnesses and medical conditions are indicated on a Problem List.											0	0	#DIV/0!
7	4	Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.											0	0	#DIV/0!
8	4	Medication List includes instructions to member regarding dosage, initial date of prescription, and number of refills.											0	0	#DIV/0!

9	4	Past medical history (for patients seen three or more times) are easily identified and include serious accidents, operations, and illnesses. For children and adolescents (18 yrs. Or younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.											0	0	#DIV/0!
10	1	For patients 11 years and over, there are appropriate notations concerning use of cigarettes, alcohol, and substance abuse (for patients seen three or more times).											0	0	#DIV/0!
11	1	The history and physical exam records appropriate subjective and objective information for presenting complaints.											0	0	#DIV/0!
12	1	Laboratory and other studies are ordered, as appropriate.											0	0	#DIV/0!
13	4	Working diagnoses are consistent with findings.											0	0	#DIV/0!
14	4	Treatment plans are consistent with diagnoses.											0	0	#DIV/0!
15	1	Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN.											0	0	#DIV/0!
16	1	Unresolved problems from previous office visits are addressed in subsequent visits.											0	0	#DIV/0!
17	1	No evidence of under and over utilization of consultants (evidence of appropriate use of consultants).											0	0	#DIV/0!
18	2	If a consultation is requested, there is a note from the consultant in the record.											0	0	#DIV/0!
19	1	Consultation, lab and imaging reports filed in the chart are initialed by the practitioner who ordered them to signify review. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.											0	0	#DIV/0!
20	4	No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure (does the care appear to be medically appropriate?).											0	0	#DIV/0!
21	1	An immunization record has been initiated for children, or an appropriate history has been made in the medical record for adults.											0	0	#DIV/0!
22	4	Evidence that preventive screening and services are offered in accordance with the Plan's practice guidelines.											0	0	#DIV/0!
23	4	Evidence of an Advance Directive for patients over 18 years of age. (Medicaid or Medicare only)											0	0	#DIV/0!
24	4	Records are stored in a secure manner that allows easy retrieval by authorized personnel only.											0	0	#DIV/0!
25	4	Record format is organized and consistent.											0	0	#DIV/0!
		SCORE:											0	0	#DIV/0!