MHS Health Wisconsin Medical Record Documentation Tool

CLINIC SITE: _____ **SURVEYOR:** _____ **DATE:** _____ **Total Points:** 0 **Total %** 0.00%

STANDARD #	POINTS POSSIBLE	PATIENT NAME										TOTAL POINTS	TOTAL POSSIBLE	% / STANDARD
1	1	Each and every page in the record contains the patient's name or ID number.										0	0	0.00%
2	1	Personal/biographical data includes address, employer, home and work telephone numbers, and martial status.										0	0	0.00%
3	1	All entries in the medical record contain author identification.										0	0	0.00%
4	1	All entries are dated.										0	0	0.00%
5	1	The record is legible to someone other than the writer.										0	0	0.00%
6	4	Significant illnesses and medical conditions are indicated on a problem list.										0	0	0.00%
7	4	Any allergies (medication, food &/or tactile) 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. Medication information list includes instructions to member regarding dosage, initial date of prescription, and number of refills.										0	0	0.00%
8	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	0.00%
9	1	For patients 13 years and over, there are appropriate notations concerning use of cigarettes, alcohol, and substance abuse (for patients seen three or more times).										0	0	0.00%
10	1	The history and physical exam records appropriate subjective and objective information for presenting complaints; clinical findings and evaluations are documented for each visit. Clinical Focus: Diabetes, Hypertension Behavioral Health Focus: ADD, AMM										0	0	0.00%
11	1	Laboratory and other studies are ordered, as appropriate.										0	0	0.00%
12	4	Working diagnoses are consistent with findings.										0	0	0.00%

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13	4	Treatment plans are consistent with diagnoses.										0	0	0.00%
14	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	0.00%
15	1	Unresolved problems from previous office visits are addressed in subsequent visits.										0	0	0.00%
16	1	No evidence of under and over utilization of consultants (evidence of appropriate use of consultants).										0	0	0.00%
17	2	If a consultation is requested, there is a note from the consultant in the record.										0	0	0.00%
18	1	Consultation, lab and imaging/diagnostic reports, ancillary and therapeutic reports are filed in the chart and 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	0.00%
19	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	0.00%
20	1	An immunization record has been initiated for children, or an appropriate history has been made in the medical record for adults.										0	0	0.00%
21	4	Evidence that preventive screening and services are offered in accordance with the plan's clinical practice guidelines (Lead Poisoning, Diabetes, Emotional and Behavioral Problems) 2020 Preventive Measure Focus AWC, LSC, BCS, FUM										0	0	0.00%
22	4	Records are stored securely with access limited to authorized personnel, and easily retrievable upon request. All member information is confidential.										0	0	0.00%
23	4	Record format is organized and consistent.										0	0	0.00%
24	4	Evidence of an Advance Directive for patients over 18 years of age.										0	0	0.00%
		SCORE:										0	0	0.00%