

Medical Record Standards



Johns Hopkins HealthCare has established standards for primary care medical record documentation.

Practice Name: _____ Date of Birth: _____

Reviewer: _____ Review Date: _____

Medical Record Security	YES	NO
Is there a process in place which provides patient confidentiality and medical record security?		
Are medical records easily retrievable at the time of patient encounter and for administrative purpose?		
Do only authorized personnel have access to records?		
Do staff receive periodic training in member information confidentiality?		

Medical Record Documentation						
Patient Name:						
	YES	NO	N/A	YES	NO	N/A
Do all pages contain patient name or identification number?						
Is there one patient in each chart?						
Does the medical record include gender and date of birth?						
Is there author identification on each entry?						
Are all the entries dated?						
Is the file in chronological order, by date?						
Is the record legible to someone other than the writer?						
Are medical records organized, permitting effective patient care and quality review?						
Are all documents in the medical record securely attached in chart?						
Is there a completed problem list, which states significant illness and medical conditions?						
Are allergies and adverse reactions to medications, or the lack of them (NKA) prominently displayed?						
Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 and younger) past medical history relates to prenatal care, birth, operations and childhood illnesses.						
For patients 12 and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, there is evidence of substance abuse query).						

The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints						
Encounter forms or notes have a notation regarding follow-up, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed						
Unresolved problems from previous office visits are addressed in subsequent visits						

Patient Name:						
	YES	NO	N/A	YES	NO	N/A
If a consultation is requested, a note from the consult is in the record.						
Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is representation of review by the ordering practitioner.						
Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.						
An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults)						
There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines.						
Total:						

Review Standard

- Office 1-2 practitioners = 3 charts total
- 3-4 practitioners = 5 charts total
- ≥ 5 practitioners = 10 charts total

YES _____

NO _____

TOTAL (Y+N) _____

SCORE = # YES ÷ TOTAL _____%