# Medical Record Decoumentation Audit Tool

**Physician Name:** _____ **Office Name:** _____

**Office Address:** _____ **Office Phone:** _____

**Office Contact:** _____ **Office Fax:** _____

**Date of Onsite Audit:** _____ **Type of Audit:** _____

**Reviewer** _____

| #DIV/0! | **Charts Reviewed:** 0 | **Total Possible Points:** 0 | **Final Audit Score:** 0 | **Audit Rate:** #DIV/0! |
|---|---|---|---|---|

| | Standard | Member ID(s) | | | | | | | | | | Element Score | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Confidentiality of member information and records are protected through secure storage and limited access. | | | | | | | | | | | 0 | |
| 2 | Records are organized and easily retrieved at the time of each visit. | | | | | | | | | | | 0 | |
| 3 | Patient identification information on each written page or electronic file record | | | | | | | | | | | 0 | |
| 4 | Identity of provider rendering service and date of service | | | | | | | | | | | | |
| 5 | Medication List | | | | | | | | | | | 0 | |
| 6 | Allergies and adverse reactions are prominently documented in a uniform location in the medical record; If no known allergies, NKA or NKDA is documented. | | | | | | | | | | | 0 | |
| 7 | An immunization record is established for pediatric members or an appropriate history is made in chart for adults. | | | | | | | | | | | 0 | |
| 8 | Evidence that established clinical practice guidelines are followed, including preventive services, risk screening and EPSDT services as appropriate. | | | | | | | | | | | 0 | |
| 9 | Past medical history is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; For children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses. | | | | | | | | | | | 0 | |
| 10 | Physical, clinical findings and evaluation for each visit are clearly documented including appropriate treatment plan and follow-up schedule as indicated. | | | | | | | | | | | 0 | |
| 11 | Ancillary services and diagnostic tests ordered by practitioner. Abnormal lab and imaging study results have explicit notations in the record for follow up plans. | | | | | | | | | | | 0 | |
| 12 | All diagnostic and therapeutic service for which a member was referred are documented including follow up of outcomes and summaries of treatment rendered elsewhere. | | | | | | | | | | | 0 | |
| 13 | Health teaching and/or counseling is documented. | | | | | | | | | | | 0 | |
| 14 | For members ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried). | | | | | | | | | | | 0 | |
| 15 | Documentation of failure to keep an appointment or follow-up services. | | | | | | | | | | | 0 | |
| 16 | Evidence that an advance directive has been offered to adults 18 years of age and older. | | | | | | | | | | | 0 | |
| 17 | Physical health medical records documented as being sent to behavioral health provider, if applicable | | | | | | | | | | | 0 | |
| 18 | Documentation of preferred language, need for interpreter, and cultural preferences, if indicated | | | | | | | | | | | 0 | |

| **Record Totals:** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Total Met | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Not Met | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Needs Improvements | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Not Applicable | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |