

# Guidelines for Medical Record Documentation



Consistent, current and complete documentation in the medical record is an essential component of quality patient care. The following 21 elements reflect a set of commonly accepted standards for medical record documentation. An organization may use these elements to develop standards for medical record documentation.

NCQA considers 6 of the 21 elements as core components to medical record documentation. Core elements are indicated by an asterisk (\*).

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## Commonly Accepted Standards for Medical Record Documentation

1. Each page in the record contains the patient's name or ID number.
2. Personal biographical data include the address, employer, home and work telephone numbers and marital status.
3. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
4. All entries are dated.
5. The record is legible to someone other than the writer.
- \*6. Significant illnesses and medical conditions are indicated on the problem list.
- \*7. 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.
- \*8. 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 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
9. For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, query substance abuse history).
10. The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
11. Laboratory and other studies are ordered, as appropriate.
- \*12. Working diagnoses are consistent with findings.
- \*13. Treatment plans are consistent with diagnoses.
14. Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed.
15. Unresolved problems from previous office visits are addressed in subsequent visits.

16. There is review for under - or overutilization of consultants.

17. If a consultation is requested, there a note from the consultant in the record.

18. 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 also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of followup plans.

\*19. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.

20. An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults).

21. There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines.