Texas Practitioner Clinical Medical Record Audit

Physician Name: _______________________ Office Manager: _______________________

Office Address: ____

Specialty: ______________ Date: ___________ Reviewer Name: __________________

Patient Name: __________________________ Chart/Member #: ________________

		Point Value	Y	N	Point Score
1	Is chart accessible?	4			
2	Do all pages contain patient ID (name/ID #)?	4			
3	Are there personal/biographical data?	3			
4	Is the provider identified on each entry?	4			
5	Are all entries dated?	4			
6	Is the record legible?	3			
7	**Are significant illnesses and medical conditions indicated on the problem list? ***	4			
8	**Are allergies and adverse reactions to medications prominently displayed or, if patient has no known allergies or history of adverse reaction, is this appropriately noted in the record? ***	4			
9	**Is there an appropriate past medical history in the record (for patients seen 3 or more times) which includes serious accidents, operations or illnesses, emergency care and discharge summaries? 18 and under should include prenatal care, birth, operations and childhood illnesses. ***	3			
10	Is there documentation of smoking habits and history of alcohol or substance abuse (age 14 and over)?	4			
11	Is there a pertinent history and physical exam?	4			
12	Are labs and other studies ordered, as appropriate, and reflect PCP review?	3			
13	**Are working diagnoses consistent with findings? ***	3			
14	**Do plans of action/treatments appear consistent with diagnosis (es)? ***	4			
15	Is there a date for a return visit or other follow-up plan for each encounter?	4			
16	Are problems from previous visits addressed?	3			
17	Is there evidence of appropriate use of consultants?	3			
18	Is there evidence of continuity and coordination of care between primary and specialists?	3			
19	Do consultant summaries, lab and imaging study results reflect PCP review?	3			

Provider Name: ________________________ Office Manager: ________________________

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		Point Value	**Y**	**N**	**Point Score**
20	**Does the care appear to be medically appropriate? (There is no evidence that patient was placed at inappropriate risk by diagnostic or therapeutic procedure.) ***	4			
21	Is there a completed immunization record (ages 13 and under)?	3			
22	Are preventive services appropriately used?	3			
23	Is an Advance Directive present on the chart (age 21 and older)?	2			
24	Was an Advance Directive offered (age 21 and older)?	1			
25	Does pediatric documentation include: (4 points total)				
	- Growth chart (1.5 pts.)	1.5			
	- Head circumference chart (1 pt.)	1			
	- Developmental milestones (1.5 pts.)	1.5			
26	Is there a list of current medications?	4			
27	If a mental health problem is noted, was a referral made or treatment performed by the PCP?	3			
28	If a substance abuse problem is noted, was a referral made or was treatment or education noted?	3			
29	Are referrals with results documented?	2			
30	Are copies of any emergency treatment and/or hospital admission (including discharge summaries and/or ancillary services) present in the chart?	1			
31	Are abnormal test results acknowledged?	1			
32	If smoking is noted, was patient advised to quit (age 14 and older)?	1			
33	Is there evidence of blood lead risk assessment (verbal assessment or blood lead test, ages six months to six years)?	1			
	TOTAL	100			

* These critical elements must be met, in addition to receiving an average score of 80 percent, to achieve an acceptable rating on the Clinical Medical Record Review.