Health Care District of Palm Beach County Medical Record Review / Re-credentialing Worksheet

Provider:														
Date:														
Reviewer:			Click o	n slots t	o fill in I	Membe	r IDs Re	viewed	for this	Provide	er			
													Totals	
ltem	Each Medical Record must include the following, as appropriate:											YES's	NO's	N/A's
1	Separate for each patient											0	0	0
2	Content, format, and sequence are uniform in the medical record											0	0	0
3	Legible											0	0	0
4	Maintained in detail											0	0	0
5	Written in English											0	0	0
6	Name											0	0	0
7	Identification number i.e.medical record# or Medicaid# or Health Plan#											0	0	0
8	Date of Birth											0	0	0
9	Sex / gender											0	0	0
10	Primary language spoken											0	0	0
11	Identify Members needing communication/translation assistance in the delivery of health care services											0	0	о
12	Documentation of legal guardianship or responsible party if under eighteen (18) years old											0	0	о
13	Signed documentation of HIPAA notification, or documented reason why member did not sign											0	0	о
14	Documentation that written information regarding advanced directives was provided by the PCP office											0	0	0
15	Documentation that PCP office inquired if member has executed an advanced directive and a copy is maintained in the medical record (if executed)											0	0	o
16	Summary of significant surgical procedures, past and current diagnoses or problems											0	0	0
17	Current medications, including over the counter products along with any changes including the name and dosage when available											0	0	о
18	All records in the PCP office shall contain an immunization history											0	0	0
19	Information on smoking, alcohol and/or substance abuse for members 12 yrs old or greater											0	0	о
20	Date (and department, if departmentalized) of encounter											0	0	0
21	Record of ER care/ hospital discharge summaries with appropriate medical follow-up for PCP and specific speciality provider											0	0	0
22	Current medical history and initial physical exam, if applicable											0	0	0

23	Appropriate and timely referral for services, with evidence of communication between PCP and specialty providers, i.e. letters, copies of consults or progress notes copied to the referring provider.								
24	All services provided by providers. Such services include, but not necessarily be limited to, family planning, preventative services, STD treatment and health evaluation and wellness services.						0	0	0
25	All infants, children up to age five (5) and pregnant, breast-feeding and postpartum women will be referred to the Florida WIC program.						0	0	0
26	Documentation that all women of childbearing age are given HIV counseling and offered HIV testing. PCP, OB/GYN offices						о	о	о
27	Progress notes						0	0	0
28	Provider follow-up with member after a "missed appointment", "canceled appointment" or "no show".						о	о	о
29	Vital signs documented on all PCP encounters and/or specialist providers in which vital signs are in conjunction with the nature of the visit						о	о	o
30	Height and weight documented on all PCP encounters and/or specialist providers in which height and weight are in conjunction with the nature of the visit						0	0	0
31	Reports/Test results verified by provider						0	0	0
32	Appropriate and timely follow-up of findings of test/reports with results verified by the provider (14 days from date of test unless urgent)						о	o	0
33	Member is contacted as quickly as possible for follow-up regarding: significant problems, abnormal labs/radiological problems that have been indentified						0	0	0
34	Timely entry and sequencing of lab and radiology data in records (14 days from date of test)						о	о	0
35	Member clinical information is available to health care providers as needed anytime the office is open to members						o	o	0
36	All entries must be dated and include the name and profession of the provider rendering services (e.g., MD, DO, ARNP, PA, OD), including the signature or intials of the provider.						0	0	0
37	Indicate a chief complaint or purpose of visit						0	0	0
38	Allergies/untoward reactions to medications, and materials are documented at every patient encounter and recorded in a prominent and uniform location in the patient's records and updated whenever new allergies or sensitivities are idenfitied						0	0	0
39	Contain the objective findings of the practitioner						0	0	0
40	Contain the diagnosis / medical findings of the provider (consistent with claim)						0	о	0
41	Indicate labs, studies (X-rays, ECG) or testing ordered						0	0	0
42	Indicate the therapies administered and/or prescribed						0	0	0
43	Include the disposition, recommendations and instructions to the member						о	o	0
44	Discussion with patient concerning the necessity, appropriateness and risks of proposed surgery, as well as discussions of treatment alternatives, if applicable by specialist and/or PCP						0	0	0

	Indicate evidence of whether or not there was follow-up and outcome of									
	services							о	0	0
	Notation of diagnostic or therapeutic intervention as part of clinical research, if applicable							о	о	0
47	Proof that instruction has been given to the member regarding 24-hour call-in information, such as medications renewals, appointment cancellation, ER visits.							0	0	0
	The medical record is maintained in a physically safe and secure environment where confidentiality of its contents is maintained.							0	0	0
49	There is a person designated to supervise the collection, processing, maintenance, storage, timely retrieval and distribution of records, and maintenance of a predetermined, secured and organized record format.							0	o	0
	The medical record meets the requirement for retention of records, retirement of inactive records, timely entry of data in records, release of information contained in records.							0	0	0
51	Enrollees referral to appropriate provider was done within four weeks of the CHCUP examination for further assessment and treatment of conditions found during the CHCUP examination, if applicable.							0	0	0
	The referral appointment following CHCUP examination is scheduled for a date within 6 months of the initial CHCUP examination, if applicable.							0	0	0
53	Documentation as appropriate of signficant medical advice given to a member by telephone is entered in the medical record; is appropriately signed and initialed including medical advice provided by after hours telephone member information services or triage telephone services.							0	0	0
54	To ensure continuity of care, timely summaries or pertinent records are obtained from previous provider(s) or organization(s) and incorporated into the member's medical record (14 days from request unless urgent)							0	0	0
							Totals:	0	0	0