

Medical Record Review – Recording Sheet

Name of Doctor _____

Name of Practice Nurse _____

Instructions to doctors / practice nurses

Record each item and total those met, not met or partially met for 15 patient records
 Having performed the review of records, doctors and practice nurses will identify areas of omission or weaknesses in their record keeping and devise a plan for improvement.

Identify each patient reviewed with their NHI number	Patients NHI															Met	Part met	Not met	Not applicable
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
Patient records contain sufficient information to identify the patient and document: the reason(s) for a visit, relevant examination and assessment, management, progress and outcomes																			
<i>Core demographic data includes:</i>																			
Patients name																			
NHI number																			
Gender																			
Address																			
Date of birth																			
Contact phone no																			
Ethnicity																			
Registration status																			
contact in case of emergency (ICE)																			
Next of kin -where applicable																			
Primary language-where applicable																			
Whether or not an interpreter is needed																			
<i>Other demographic data:</i>																			
occupation history																			
Significant relationships																			
Hapu, iwi																			
Alternate names																			
<i>Medical records show:</i>																			
Clinically important drug reactions and other allergies (or the absence thereof)																			
Directives by patient																			
Problem lists are easily identifiable																			
disease coding																			
Past medical history																			
Disabilities of the patient																			

English proficiency limitations																				
Identifiable current and long-term medications(s)																				
Reasons for changes to medication																				
Clinical management decisions made outside consultations e.g. telephone calls																				
Consultation records:																				
Each entry is dated																				
The person making the entry is identifiable																				
The entry is understood by someone not regularly working at that practice (e.g. a locum)																				
Consultation records support continuity of care and record:																				
The reason for encounter																				
Examination findings																				
Investigations ordered																				
Diagnosis and assessment																				
Management/treatment plans																				
Health information given to patients, including notification of recalls, test results, referrals and other contacts																				
Medications, including: <i>drug name/dose/frequency/amount/time/volume</i>																				
Current and long term medications																				
Intermediate clinical outcomes																				
Brief interventions																				
Screening and preventative care initiatives recommended																				
A follow-up plan																				
End of life needs where applicable																				
Name of interpreter used if applicable																				

Risk factors are identified, including:													
Awareness alerts e.g. deaf, blindness, communication requirements, mental health issues													
Family history													
Current smoking status													
Smoking history of patients 15 and over													
Offer of smoking cessation where appropriate													
Alcohol/drug use													
Blood pressure													
Weight/height/BMI													
Immunisations													
Referral letters contain:													
Special considerations: interpreter needed, language, disability, transport													
Current problem													
Current medical warnings													
Long term medications													
The reason for referral													
Background information and history													
Key examination findings													
Current treatment													
Appropriate investigations and results													
Incoming information is filled or available electronically in the patient's medical records. This includes:													
Laboratory results													
Radiology results													
Other test results or health information e.g. MMSE													
Other health information													
Discharge and outpatients information													
Specialist letters													
Screening is up-to-date, including:													
Cervical smears													
Mammograms													
Cardiovascular risk assessment													
Diabetes screening													

Sample audit

Totals out of 15

An audit of 15 records				
	Met	PM	Not Met	N/A
Core demographic data includes:				
Patient name				
NHI number				
Gender				
Address				
Date of birth				
Contact phone no				
Ethnicity				
Registration status				
Contact in case of emergency (ICE)				
Next of kin –where applicable				
Primary language-where applicable				
Whether or not an interpreter is needed				
Other demographic data:				
Occupation history				
Significant relationships				
Hapu, iwi				
Alternate names				
Medical records show:				
Clinically important drug reactions and other allergies (<i>or the absence thereof</i>)				
Directives by patient				
Problem lists are easily identifiable				
Disease coding				
Past medical history				
Disabilities of the patient				
English proficiency limitations				
Identifiable current and long-term medications(s)				
Reasons for changes to medications				
Clinical management decisions made outside consultations e.g. telephone calls				
Consultation records:				
Each entry is dated				
The person making the entry is identifiable				
The entry can be understood by someone not regularly working at that practice (<i>e.g. a locum</i>)				
Consultation records support continuity of care and record:				
The reason for encounter				
Examination findings				
Investigations ordered				
Diagnosis and assessment				
Management/treatment plans				

Health information given to patients, including notification of recalls, test results, referrals and other contacts				
Medications, including: <i>drug name /dose/frequency/ amount/time/volume</i>				
Current long-term medications				
Intermediate clinical outcomes				
Brief interventions				
Screening and preventative care initiatives recommended				
A follow-up plan				
End of life needs where applicable				
Name of interpreter used if applicable				
<i>Risk factors are identified, including:</i>				
Awareness e.g. deaf, blind, communication requirements, mental health issues				
Family history				
Current smoking status				
Smoking history of patients 15 and over				
Offer of smoking cessation where appropriate				
Alcohol/drug use				
Blood pressure				
Weight/height/BMI				
Immunisations				
<i>Referral letters contain:</i>				
Special considerations: interpreter needed, language, disability, transport				
Current problem				
Long-term medications				
The reason for referral				
Background information and history				
Key examination findings				
Current treatment				
Appropriate investigations and results				
<i>Incoming information is filled or available electronically in the patient's medical records. This includes:</i>				
Laboratory results				
Radiology results				
Other test results or health information e.g. MMSE				
Other health information				
Discharge and outpatient information				
Specialist letters				
<i>Screening is up-to-date, including:</i>				
Cervical smears				
Mammograms				
Cardiovascular risk assessment				
Diabetes screening				

Report & Plan template

Record Review comments		
Core Demographic data		
Other demographic data		
Medical records show:		
Clinically important drug reactions and other allergies (or the absence thereof)		
Directives by patients		
Problem lists are easily identifiable		
Disease coding		
Past medical history		
Disabilities of the patient		
English proficiency limitations		
Identifiable current and long-term medication(s)		
Reasons for changes		
Clinical management decisions made outside consultation e.g. telephone calls		
Consultation records show:		
The entry is dated		
Person making the entry is identifiable		
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Medications, including: drug name/dose/ frequency/amount/time/ volume		
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Intermediate clinical outcomes		
Brief interventions		
Screening and preventative care initiatives recommended		
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End of life needs where applicable		
Name of interpreter used If applicable		
Risk factors are identified, including		
Awareness alerts e.g. deaf, blind, communication requirements, mental health issues		
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Smoking history of patients 15 and over		
Offer of smoking cessation where appropriate		
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Blood pressure		
Weight/height/BMI		
Immunisations		
Referral letters contain:		
Special considerations: Interpreter needed, language, disability, transport		
Current problem		
Current medical warnings		
Long-term medications		
The reason for referral		
Background information and history		

Key examination findings		
Current treatment		
Appropriate investigations and results		
Incoming information is filled or available electronically in the patient's medical records. This includes:		
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Other health information		
Discharge and outpatient information		
Specialist letter		
Screening is up-to-date, including.		
Cervical smears		
Mammograms		
Cardiovascular risk assessment		
Diabetes screening		

