Medical Record Keeping Summary

September, 2022

Purpose of Medical Record Keeping

- A **concise document** of all data directly relevant to the patient condition
- A **source of communication** to all subsequent providers or other healthcare team members
- Provides insight into your **ability to identify the crucial information** in both history and physical exam and to **utilize that information** to develop a logical approach to the management of the patient
- A **medical legal document**

Visit Note

Cumulative Patient Profile Captures Health Context

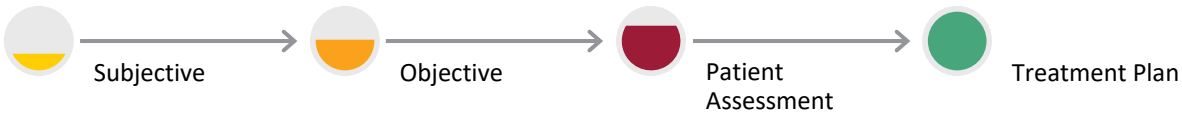
Current and Past Medical Conditions

Medication Lists

Tracking

Visit Note

The visit note consists out of **subjective**, **objective**, **assessment**, and **treatment plan**.



Subjective

The history section includes the **patient's own words**

History of present illness - Why have they booked the appointment?

- Patients' symptoms and their perception of their illness
- Chronological narrative of patient's complaints
- Systematic exploration of each symptom
    - "OLDCHARTS"
        - Onset
        - Location
        - Duration
        - Character
        - Alleviating or aggravating factors
        - Radiation
        - Temporal pattern
        - Symptoms associated
- Information obtained from other sources (always identify source if not the patient)
- Pertinent past medical history
- Pertinent review of system
- Relevant medications

Objective

- Vitals; observation of patient (even if not examined); focused physical exam; relevant lab tests or diagnostic imaging
- Consider using validated instruments and documenting here- PHQ9, GAD 7, Framingham, CHADS 2, etc.

Assessment

Integrates the subjective and objective elements – this represents your impression and interpretation

Problem List

A numerical list of problems identified.

- All listed problems need to be supported by findings in subjective and objective areas above. Include important positives & negatives that inform the differential diagnosis & identify most likely diagnoses
- Try to take the assessment of the major problem to the highest level of diagnosis that you can, for example, “low back sprain caused by radiculitis involving left 5th LS nerve root.”
- Provide at least 2 differential diagnoses for the major new problem identified in your note
- For **follow-up visits-** assessment includes an evaluation of how the patient is progressing toward established treatment goals and may include future plans
- Document consent for sensitive exams and offer of chaperone

Plan

Your plan for the patient based on the problems you’ve identified-what to do, when to return and why, and if appropriate, any preventative care that may be required

- Develop a diagnostic and treatment plan for each differential diagnosis.
- Includes tests, procedures, other laboratory studies, consultations, etc.
- A rational for their inclusion in the plan
- Document patient education, pharmacotherapy if any, other therapeutic procedures.
    - Document discussions of new medication or procedures including side effects, complications, & potential outcomes.
    - Include handouts or websites suggested
- Plans for follow-up (next scheduled visit, etc.) or presentations that may trigger an earlier visit.

NOTE: any interaction about the patient should be captured in the record- calls to specialists, follow up phone calls to patients; requests to staff to organize some aspect of care; staff attempts at contacting patient (see tracking below)

Cumulative Patient Profile Captures Health Context

Factors that influence the patient's life – who is this patient?

- Social history: lifestyle (exercise, smoking, alcohol, drugs), occupation, hobbies
- Family history
- Current & past medical conditions
- Up-to-date Medication list
- Allergies & Immunizations
- May include Prevention; Living will/ GOC

Current and Past Medical Conditions

- Update at periodic health care visits or add new diagnoses as they show up in consultation letters or in laboratory/imaging reports
- Be as thorough as possible- if available include relevant details about history
- Examples:
  - Date, Myocardial Infarction; vessels involved; intervention
  - Date, Colonoscopy, findings, next due
  - Date, Quit smoking, 25 pack-years

Medication List

- Update each time the list is opened to refill a medication
- Include medications prescribed by you; by other physicians; over the counter medications
- Update after a hospitalization or a change in medications by consultant
- If your EMR allows it- record why a medication was stopped

Tracking

- Expected to track patient referrals to specialists or other healthcare team members
- Most tracking can be managed by staff if appropriate timeline is established
- Track critical lab and diagnostic imaging results
    - Set an appropriate time for investigations to be completed (example; mammogram to be completed in next three months) and have staff check at that time. If not completed, patient should be reminded and reminders or attempts to contact the patient should be documented in the chart
- Track future follow-ups that are time specific
    - For example, if a colonoscopy report comes back with a suggestion for a repeat in 4 years or a repeat ultrasound is requested for one year - that needs to be tracked