

Chart Audit Worksheet – Surgical Specialists

**25 charts chosen randomly by the practice visitors from the day-sheets from
3 separate half-days within the previous month**

- A minimum of 15 randomly chosen charts must be reviewed.
- Other charts may be specifically selected to review certain patient- or disease-types.

A. Organization of the Charts

Before starting the audit, choose 3 charts to review immediately with the physician’s help.

“Please show me how to find each of the following in the chart.”

Using these 3 charts, complete the scale to the right.	<i>Present in <u>ALL</u> three files?</i>
(a) Are the records legible?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) Can the physician identify, by any means (e.g. handwriting, stamp, signature, etc), who has made the entries on the files?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) Is a patient’s name, date of birth and address and/or phone number identified in each chart?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Using these same 3 charts above, please complete the scale to the right.	<i>Present in <u>AT LEAST ONE</u> of the three files?</i>
(d) Allergies and drug reactions	Yes <input type="checkbox"/> No <input type="checkbox"/>
(e) Current medications	Yes <input type="checkbox"/> No <input type="checkbox"/>
(f) Past medical history	Yes <input type="checkbox"/> No <input type="checkbox"/>
(g) Laboratory and x-ray results	Yes <input type="checkbox"/> No <input type="checkbox"/>
(h) Occupational history	Yes <input type="checkbox"/> No <input type="checkbox"/>
(i) Are operative reports or the identity of the surgical facility on the chart?	Yes <input type="checkbox"/> No <input type="checkbox"/>

B. Evidence of Care Provided

Starting with the most recent visit and going back up to one year if necessary, please record the number of charts meeting each of the following criteria.

	Presence in the Files			Comments (Mandatory for "No")
	Yes	No	N/A	
a) For referred patients, is referral information present?				
b) Do the recorded history and physical findings support the problem or diagnosis?				
c) Are problems or diagnoses recorded in the chart?				
d) Do x-rays and laboratory tests support the problem or diagnosis?				
e) Are abnormal findings or results properly followed-up?				
f) Are the names, dosages and quantities of prescribed medications recorded?				
g) Are non-operative treatments and other interventions recorded and appropriate?				
h) Is a copy of the consultation letter/report present?				

