absolute total care
Healthy Connections

Medical Record Documentation Standards

	Standard Descriptions All medical records, at a minimum, must contain the following items.
1	Patient name, identification number, age, date of birth, sex, places of residence, employment, and responsible party (member, parent, or guardian)
2	Services provided through the managed care organization (MCO), date of service, service site, and name of service provider
3	Medical history, diagnoses, prescribed treatment and/or therapy, and drug(s) administered or dispensed
4	The medical record shall commence on the date of the first patient examination made through, or by the MCO
5	Referrals and results of specialist referrals
6	Documentation of emergency and/or after-hours encounters and follow up
7	Signed and dated consent forms
8	For pediatric records (under 19 years of age) record of immunization status
9	Documentation of advance directives (for pediatric records, if completed) and executed advance directive maintained in medical record
	Each visit must include the following items.
10	Date
11	Purpose of visit
12	Diagnosis or medical impression
13	Objective finding
14	Assessment of patient's findings
15	Plan of treatment, diagnostic tests, therapies, and other prescribed regimens
16	Medications prescribed
17	Health education provided
18	Signature and title or initials of the provider rendering the service (if more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials)
19	Medication allergies
20	Legible and organized documentation