



**TriState Child Health Services**  
Practitioner Medical Record Review

Physician Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Practice Site: \_\_\_\_\_ PCP - Specialist \_\_\_\_\_

Review Date: \_\_\_\_\_ Review Person(s) \_\_\_\_\_ Credential – Re-Credential \_\_\_\_\_

*Note: This document is part of the quality assessment activities of TriState PHO and, as such, is a confidential document not subject to discovery pursuant to Ohio Revised Code Section 2305.25 and 2305.251. All Committees involved in the review of this document, as well as those individuals preparing and submitting information to such Committees, claim all the privileges and protection afforded by ORC 2305.25, 2305.251, and 2305.28 and any subsequent litigation.*

<b>Need to see documentation by each physician in practice (minimum of 5 records each)</b>	Yes = 1 No = 0	Yes = 1 No = 0	Yes = 1 No = 0	Yes = 1 No = 0	Yes = 1 No = 0	Balance
<b>Record Number</b>						
1. Each page in the record contains the patient's name or identification number						
2. Personal biographical data includes parent/guardian name, address, phone number, insurance						
3. All entries in the MR contain the author's identification. Author identification may be a handwritten signature, an initials-stamped signature, or a unique electronic identifier.						
4. All entries are dated						
5. Entries are legible by review person (Another/second reviewer for any judged illegible)						
6. Significant illnesses and medical conditions are indicated on a problem list.*						
7. Allergies and adverse reactions or NKA are prominently noted in the record.*						
8. Past medical history (for patients seen 3 or more times) is easily identified and includes serious accidents, operations, and illnesses. Children and adolescents (18 y.o. or younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.*						
9. For patients 14 years and older there is an appropriate notation concerning the use of tobacco, alcohol, and other substances						
10. The history and physical documents appropriate subjective and objective information pertinent to the patient's complaints. (Reason for visit, , current medications, pertinent symptoms and findings on exam)						
11. Laboratory and other studies are ordered, as appropriate						
12. Working diagnoses are consistent with findings *						
13. Treatment plans are documented and consistent with diagnoses (tests, prescribed medications, referrals) *						
14. Notation, when indicated, regarding follow-up care (call, visit, time specific)						
15. Patient/parent education documented if indicated at visit						
16. Unresolved problems from previous visit(s) are addressed in subsequent visits						
17. Neither over or under utilization of consultants is apparent						
18. If a consultation was requested, a note from the consultant is in the MR						
Total scores for this page						

