Documentation Essentials
Using Documentation to Support & Defend Your Good Care

Risk Management Education
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DISCLAIMER  
The information contained in this document does not establish a standard of care. The information is for general informational purposes to aid in reducing professional liability exposure.  

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**Introduction**

Why is documentation so important? Medical record documentation is important for many reasons, including:

- To plan and coordinate the patient’s medical care,
- To communicate with other healthcare professionals,
- To support charges for services and ensure reimbursement,
- To document fulfillment of regulatory, accreditation, and licensure requirements, and
- For electronic health record users, to justify compliance with Meaningful Use criteria in order to receive federal incentive payments.

There is another very important reason to document...to prevent or defend allegations of medical malpractice, the focus of this educational program. A well-documented medical record may actually prevent a lawsuit from being filed if your documentation shows you rendered the standard of care. However, a poorly documented medical record can render an otherwise defensible case indefensible.

Consider the following example of an actual claim where poor documentation was a major stumbling block in the defense of the claim.

*The patient, a 50-year-old female, presented to the podiatric physician with complaints of a painful bunion. Surgery was scheduled for the following week and the podiatrist performed a modified McBride bunionectomy with metatarsal osteotomy and screw fixation.*

*Post-operatively, the patient had pain and swelling in her foot, and admitted to being on her feet and walking without crutches against the podiatrist’s advice.*

*The patient’s foot continued to be swollen and painful at one month post-op. X-rays showed some lipping on the metatarsal head which the podiatrist attributed to “too much use.” Additionally, the screw was backing out a little. The podiatrist then took the patient back to surgery for a screw removal and modification to the McBride bunionectomy.*

*Following the second surgery, the patient again insisted upon walking so the podiatrist dispensed a CAM walker. She returned to the podiatrist for four post-operative visits. At the final visit, the podiatrist noted the incision site was well coapted, swelling was decreased, and there was no warmth or erythema. The patient was instructed to continue using her CAM walker and return in one week. However, she did not return. Instead, she went to an orthopedic surgeon who diagnosed her with a “pin track infection.” She ultimately had a fusion of the first MP joint of the right foot. She also received lumbar epidural sympathetic blocks from a pain specialist.*

*The patient filed a lawsuit against the podiatrist alleging:*

- Failure to provide conservative treatment prior to performing the initial surgery.
- Incorrect performance of the modified McBride bunionectomy with metatarsal osteotomy and screw fixation.
- Failure to diagnose and treat an infection.
- Failure to refer to an infectious disease specialist.
Upon review of the podiatrist’s medical records by the defense, the following was noted:

- **Documentation of the patient’s initial visit indicates the “left” bunion was being treated. However, the patient listed her problem as a “right” bunion on her patient history form. Subsequent documentation also wrongly listed the problem on the “left” foot. The impression listed on the initial visit was “plantar fascitis and heel spur syndrome” which was clearly wrong. The podiatrist admitted to using template language and failing to “customize” it to the patient.**

- **The operative report also consisted of template language. It did correctly state the surgery was performed on the right, but it was impossible to tell exactly what was done.**

- **At a visit three weeks following the first surgery, the podiatrist “put patient on Keflex.” There was no mention of why antibiotics were needed. There was no copy of a prescription or any documentation that Keflex was dispensed. The podiatrist stated he gave her samples.**

- **Two visits later, the podiatrist prescribed Clindamycin. There was no reference to the prescription or of any clinical evidence to warrant the use of antibiotics or why he changed from Keflex to Clindamycin in the medical record. There was only a copy of the prescription.**

The podiatrist documented in the patient’s medical record, but the documentation contained erroneous, inconsistent, and useless information. He admitted to using template notes which he did not take the time to modify with patient-specific information. It was impossible to determine if the patient had an infection at the time of the second surgery. The podiatrist’s documentation did not state his rationale for placing the patient on antibiotics. It could have been for prophylaxis, but we will never know. If the patient had an infection, why did the podiatrist perform the second surgery? Again, there was no rationale documented and the podiatrist could not remember.

This claim was resolved through mediation.

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**The Medical Record**

A complete medical record should be maintained on all patients. This includes friends, associates, office staff, family members...EVERYONE to whom you provide podiatric services. Healthcare practitioners are legally required to keep medical records on each patient. Additionally, it is almost impossible to defend a claim without medical records.

The following claim illustrates the risk of not maintaining a complete medical record:

*The patient was the office manager for the podiatric physician at the time of the treatment. The podiatrist performed a neuroma excision. At three weeks post-op the patient presented with complications of medial deviation of the second toe. The podiatrist performed an in-office medial capsule release that same day. Two months later, he performed a total capsule release with pinning of the toe. Two weeks later the patient reported she was not tolerating the K-wire, so the podiatrist attempted to remove it. However, part of the K-wire broke off. The podiatrist determined that the remaining wire was entirely within the bone and let it remain in the foot.*

*The patient was later treated by another physician for cellulitis secondary to an abrasion over the second toe, hammertoe deformity, and pain on passive motion of the toe. He performed a surgical correction of the hammertoe and removal of the K-wire. During the surgery, the physician noted the patient had some arthritic degeneration at the MTP joint where the K-wire was located.*
The patient hired an attorney and filed a lawsuit against the original podiatric physician alleging:

- Improper performance of surgery causing a hammertoe, abrasion, and numbness.
- Failure to remove broken K-wire resulting in arthritis.

The discovery process yielded the following:

- The claim was reviewed by podiatry experts who determined the claim could be medically defensible. They felt the neuroma surgery was justified based upon the pathology report and the complications the patient suffered were known complications of the procedure. Additionally, they felt it was within the standard of care to leave the broken K-wire in place since x-rays taken by the podiatrist showed the K-wire was in the bone, rather than in the joint. The experts also felt the patient had progressive arthritis throughout her foot, which may have caused degenerative changes in the second toe, rather than the position of the K-wire.

- However, the podiatric physician kept minimal documentation in the patient’s medical record. The entire contents of the record consisted of:
  1. An ambulatory surgery center standard surgical consent form that was signed by the patient on the day of the initial surgery and the subsequent surgery. The consent forms contained basic consent language, but was not podiatric-specific and did not detail the risks and benefits of the procedure.
  2. Sketchy progress notes.
  3. Operative Reports from the initial and subsequent surgeries.
  4. Pathology Report from the initial surgery.
  5. Surgery Scheduling Checklist for the last surgery that listed the diagnosis, procedure, facility location and the type of anesthesia to be utilized.

The podiatric physician kept minimal documentation for this patient due to the casual nature of their employer-employee relationship. There was no documentation of a history or physical examination or of any conservative treatment rendered prior to surgery. There was no documentation of informed consent discussions (while the podiatrist utilized the hospital’s consent form, it was very generic and did not allow for specific documentation of the risks, benefits, and treatment alternatives) or of any patient instructions. The lack of documentation would make it very difficult to convince a jury the standard of care was rendered. This claim was resolved during mediation.

General Content

All medical records, paper or electronic, should be organized in a uniform and orderly manner. There are many ways to organize a paper medical record and likewise, there are many different electronic medical record systems. The important thing is to choose a system that works for you. Once the system is chosen, then all office staff who document in medical records should receive education and training on the system and be required to consistently utilize the system.

The following are general guidelines regarding medical record content:

- Basic patient demographics should be obtained at the initial visit and updated periodically. Such information includes:
  - Name;
  - Date of Birth;
  - Sex;
  - Phone numbers;
  - Address;
  - Emergency contacts;
  - Insurance information;
o Names of individuals to whom you may relate the patient’s health information;
o Pharmacy;
o The patient’s primary language; and
o The name & phone number of the patient’s primary care doctor.

• A patient information form should be completed by the patient or the patient’s representative at
the initial visit and updated periodically, to include:
o A listing of all medications the patient is currently taking, including prescriptions, over-the-counter
medications, & herbal supplements;
o Allergies;
o Psychosocial history;
o Family medical history;
o Patient’s medical history, including a listing of prior surgeries, hospitalizations with reason,
and dates; and
o A description of the patient’s current problem.

• An thorough initial history and physical should be performed and documented. (See page 11)
• Progress notes for subsequent visits should be documented in a consistent format, such as SOAP
(Subjective, Objective, Assessment, and Plan) notes. (See page 20)
• Two patient identifiers such as the patient’s name and date of birth or medical record number should be placed
on each page or computer screen of the medical record.
• Current allergy information should be displayed in an easily accessible, prominent location. If the patient does
not have any known allergies, document the absence of allergies (e.g., NKA or No Known Allergies) to confirm
that the allergy status was assessed. Make sure allergy information is verified and recorded at each patient
contact, including telephone discussions for medication refills.
• Maintain a problem list that contains current information pertaining to chronic, acute, or significant conditions.
A problem is any identifiable factor that may have a significant influence on a patient’s health or quality of life.
A problem could be a proven diagnosis (e.g., osteomyelitis), a physiological entity or syndrome (e.g., peripheral
vascular disease), a symptom (e.g., heel pain), a physical abnormality (e.g., bunion), an abnormal lab value
(e.g., elevated blood glucose), a risk factor (e.g., smoking), an operation (e.g., hammertoe repair), or a
psychological or social problem (e.g., unable to care for self). The list should identify the date of occurrence or
discovery and the date of resolution, if known.
• Maintain a medication list to serve as a ready reference of the patient’s medication and renewal history. The list
should reflect the drug, dose, date prescribed, and date discontinued.
• Additionally, the following documentation should be maintained in the patient’s record:
o Phone calls or electronic communication to, from or concerning the patient regarding clinical matters;
o Pertinent discussions with the patient and/or family members;
o Instances of patient non-compliance, including “no shows” and cancellations;
o Laboratory, imaging or other diagnostic reports with evidence of the requesting doctor’s review of the
reports and communication of the results to the patient;
o Consultation requests and reports with evidence of the requesting doctor’s review of the reports;
o Informed consent forms;
o Operative reports;
o Copies of pertinent hospital or other healthcare provider records;
o Any written or electronic correspondence to, from, or concerning the patient; and
o Patient authorizations (e.g., authorization to treat, medical records release, etc.).
General Principles of Documentation for Paper and Electronic Records

Medical record documentation should accurately reflect the care and treatment provided to a patient, and that the standard of care was rendered. Eight general principles of documentation that apply to both paper and electronic records are discussed below.

Objective
Documentation should be free from conjecture or speculation. By documenting things you saw (e.g., bleeding, deformities, wounds) heard (e.g., the patient’s statements, moaning), felt (e.g., skin temperature, motion at a fracture site), or smelled (e.g., malodorous drainage, alcohol on the patient’s breath), the patient’s medical record will be specific and objective.

Document objective signs and symptoms, physical examination findings, and the patient’s response to treatment. Use quotation marks when quoting the patient. It is important to avoid using your personal opinions or labeling the patient in the medical record.

An example of a patient label is, “Patient is a drug seeker.” A more objective entry would be, “Patient requests another prescription for Vicoden for complaints of foot pain. His subjective complaints of pain are not supported by my objective examination findings.”

Specific
Medical record documentation should be specific and factual. If a patient brings a lawsuit against you, many times you will not be able to remember specific events. You will have to rely on your documentation to support that you rendered the standard of care. If your documentation is not specific, your defense will be hampered. Avoid generalizations, vague statements, or speculation in your documentation.

An example of a vague statement is, “Patient is doing well.” A more specific statement would be, “Patient reports an improvement in postoperative foot pain. She is back at work full time. She is no longer taking narcotic pain medication. She states, ‘I have mild foot pain at the end of the day which is relieved by Tylenol.’”

Complete
The patient’s medical record should contain a complete story from the patient’s initial visit to the last visit. Anyone reading the patient’s medical record should be able to immediately understand exactly:

- The care and treatment you rendered to the patient;
- Your decision-making process for the care and treatment you provided, including the reason for any deviation from standard treatment;
- The patient’s progress, or lack of progress, with treatment; and
- The outcome of your treatment.

If your treatment “story” is complete, it will assist concurrent or subsequent caregivers in providing care and treatment to the patient. It will also play a huge part in a patient’s decision to bring a lawsuit or, if a lawsuit is filed, in your defense. It is much easier to prove the standard of care was met if your documentation supports your treatment decisions such as the need for surgery, your decision for a particular type of surgical procedure, or the rationale for your decision to deviate from your original plan of care.

Accurate
It is of major importance that the content of patients’ medical records be accurate. Inaccuracies, discrepancies, or inconsistencies in the medical record, such as documentation of an ulcer on the right foot when the ulcer was on the left foot, can lead to adverse events. They can also cause a jury to question the credibility of the entire record.

Check your entries into the medical record immediately after documentation to make sure they accurately reflect the patient’s condition, your assessment, treatment provided, orders, patient instructions, etc. Additionally, make sure you have documented in the correct patient’s medical record. All pages of the medical record, both paper and electronic, should be labeled with at least two patient identifiers, such as the patient’s name and medical record number.
The following case illustrates the difficulties of defending a claim in which the medical record was incomplete and contained multiple discrepancies.

A 56-year-old nurse presented to the podiatric physician with complaints of a painful, ulcerated IPK on the left foot. She was noted to be a diabetic. The podiatrist diagnosed contracted digits, hammertoes, and IPK under the second and third metatarsals. He debrided the ulcer, then applied a dressing.

Several weeks later after no improvement, the podiatrist performed capsulotomies of toes 2-4 and arthroplasties of toes 2-5 of the left foot. The patient developed a postoperative MRSA infection and was referred to an infectious disease specialist. The infectious disease specialist immediately admitted the patient to the hospital and asked for a vascular consultation. The vascular surgeon determined that the leg could not be saved and a below-the-knee amputation was performed.

The patient sued the podiatric physician alleging negligence and lack of informed consent.

The discovery process yielded the following:

- The podiatrist utilized “canned notes” to document the patient’s care and treatment. This documentation contained multiple inconsistencies, especially with the patient’s postoperative course and treatment. For example, although it was documented that the patient had no infection, a culture and sensitivity was obtained.
- Photographs of the patient’s foot, taken postoperatively by the podiatrist, showed a frankly infected foot with evidence of severe peripheral vascular disease and gangrenous toes. However, the notes did not reflect any of these problems.
- There was no documentation of a preoperative history and physical, and no mention of vascular status, control of diabetes, or medical clearance.

The lack of documentation and inconsistencies noted in the patient’s medical record aided to render this case indefensible. This case was resolved during mediation.

**Concurrent**

Document in the patient’s medical record as soon as possible after an event or observation is made when your memory of the event or observation is fresh and your documentation is more likely to be accurate. Documentation that is made at or near the time of the event or observation is more likely to be perceived as credible by a jury.

Any necessary late entries or addendums to the medical record should be clearly noted as such with the date and time the entry was made and the date and time for which the entry refers.

**Chronological**

Regardless of the format you use, paper or electronic, the medical record should reflect the continuous chronology of the patient’s care. If electronic medical records are utilized, it is important for caregivers documenting in the record to be able to view episode-based information. It is also important for the system to have the capability to print the patient’s medical record in chronological order.

Each entry in the medical record should include the date and time of the entry and the signature or other authentication of the person making the entry. Entries into the medical record should never be pre- or post-dated. Do not skip lines or leave blank spaces in paper records. If an electronic medical record system is utilized, the system should have the capability to automatically apply the date and time of each entry.

**Clinically Relevant**

Documentation in the patient’s medical record should only pertain to the direct care and treatment of the patient. Avoid documentation of “fluff,” information that is not associated with the reason for the patient’s visit or plan of treatment. For example, documentation that the patient is “well developed, well nourished and with good attention to hygiene and body habitus” and “oriented to person, place, and time” in every progress note when there is no history that the patient ever had a problem with hygiene or cognition.
A medical record that contains a large volume of information that does not relate to the specific patient or the patient’s complaints may prove less effective than a simple record which is clinically relevant and accurately describes the patient’s condition.

**Special Concerns Regarding Checklists & Forms**

It is important that all fields of checklists and forms be completed in paper or electronic documentation. If a particular field is not applicable to the patient, then identify the field as not applicable (N/A) to denote the field was considered and not ignored.

**Special Concerns Regarding Jousting**

Emotional feelings or statements that blame, accuse, or compromise other caregivers, the patient, or the patient’s family, have no place in the medical record. Jousting (arguing, complaining, belittling, criticizing, or blaming others) only serves to inflame the patient and is the driving force behind many lawsuits against other healthcare professionals and the doctor who made the disparaging remarks. The following actual claim illustrates the risk of jousting.

_The patient, a 47-year-old avid runner, initially consulted with an orthopedist because of a one-month history of left foot pain. The orthopedist diagnosed extensor tendonitis, dorsal osteophytes of the talus, and osteoarthritis. He treated the patient with a steroid injection, physical therapy, and anti-inflammatory medication._

_Three days later the patient noticed a red circle on his left foot about an inch and one-half below the injection site. The patient called the orthopedist to report the condition and was told that the inflammation was normal and was instructed to apply cortisone cream to the area. The patient did so for a period of several weeks. However, six weeks later, he noticed that the red area was swollen and moved when he touched it. The patient cancelled his follow-up appointment with the orthopedist and scheduled an appointment with the podiatric physician._

_The patient was evaluated by the podiatrist a week later. The podiatrist felt the patient had a ruptured tendon. He told the patient the rupture was probably caused by the orthopedist’s injection and documented his opinion in the patient’s medical record._

_The podiatrist ordered an MRI which he interpreted to show a complete rupture of the extensor hallucis longus tendon. The podiatrist recommended surgical repair of the tendon. The patient requested a second opinion which he obtained the following day from another podiatrist. The podiatrist who provided the second opinion concurred with the original podiatrist’s diagnosis and treatment plan._

_Three weeks later, the original podiatrist repaired the tendon utilizing freeze-dried tendon allograft along with transfer of the extensor hallucis brevis and casted the patient. The patient returned to the podiatrist for a number of post-operative visits over the next three months._

_The recovery involved some swelling and pain with some limitation in the range of motion in the graft area. By the last office visit, the patient had continued pain and loss of movement in his toe. However, it had improved to the point where the patient was gradually returning to normal weight bearing activities, including running._

_The patient obtained the services of an attorney and filed a lawsuit against the orthopedist AND the podiatrist. Allegations against the podiatrist included failure to perform the appropriate procedure._

_The discovery process yielded the following:_

- _The patient testified during his deposition that the podiatric physician questioned him about who gave him the injection and asked the patient if he was going to sue the orthopedist. The podiatrist purportedly told the patient that he should sue since he believed the injection ruptured the tendon. The patient further testified that he had no complaints against the podiatrist, but his attorney advised him to sue all the treating doctors._
• The plaintiff’s expert only had one complaint against the podiatrist. He felt that the podiatrist should have first attempted an end-to-end repair of the tendon. If that was unsuccessful, the podiatrist should have transferred one of the extensor tendons to the great toe to assist with dorsiflexion. He testified that the use of an allograft was contraindicated and would only result in extensive scar tissue formation and loss of mobility and function of the great toe.

The defense team felt this case had a high likelihood of a defense verdict and decided to take the case to trial. The trial was held two and one half years after the lawsuit was filed. The jury reached a unanimous verdict for the defense within 12 minutes. While no money was paid to the patient, $54,000 was incurred in defense costs, and the podiatrist had to deal with the stress associated with a lawsuit for over two years.

When talking to a patient who is questioning care by another doctor, or when you question the care by another doctor, it is best to tell the patient and document the FACTS only. Facts include physical examination findings, the patient’s current condition/diagnosis, and the plan for continued care, etc.

Legible

All contents of the medical record, including scanned or faxed documents, must be legible so that essential patient information can be accurately and clearly communicated to healthcare professionals involved in the care and treatment of the patient. Not only can illegible or unclear documentation put the patient at risk for medical errors, it may cause a jury to view you in a negative light. During a trial, it is not uncommon for a plaintiff’s attorney to hand the defendant physician a copy of the patient’s medical record and ask the physician to read a selection. It can be extremely detrimental to the defense of the case if the physician cannot read his/her own writing or a scanned document or determine the meaning of the note.

Special Concerns Regarding Abbreviations

The use of abbreviations can also make a medical record unclear. Abbreviations should be avoided as one person’s abbreviation might mean something totally different to another reader. Abbreviations are especially problematic in writing prescriptions or medication orders. There have been many documented adverse events, and subsequent claims, involving medication errors as a result of illegible abbreviations.

If abbreviations are used, a standard abbreviation list should be developed and utilized by everyone documenting in patient records so the meaning of an abbreviation is clear to everyone. Additionally, a list of abbreviations that are NOT to be used should be developed and enforced. (For additional information regarding medication abbreviations, see page 47.)

Authorship and Authentication

Physician office policies and procedures should specify who may document in patient medical records based on the staff member’s licensure, certification, or professional experience. Anyone documenting in the medical record should be trained and competent in fundamental documentation practices and legal documentation standards.

Each entry into the medical record should be noted with the date and time of the entry and authenticated by the author. Authors are responsible for the completeness and accuracy of their entries in a medical record. Once the record has been authenticated, the document should be considered locked from any editing. Any additions or corrections should be applied through an addendum or amendment (see page 52).

For any method of authentication other than by written signature (including authentication of electronic medical records or scanned entries), you should consult federal and state laws and regulations regarding acceptable authentication of entries.
There are several ways to authenticate an entry, including:

- **Written Signature** - The majority of entries into paper medical records should be authenticated by a signature. The signature should include the author’s name and professional designation or title.

- **Countersignature** - A countersignature indicates a professional review and/or approval of an action taken by another practitioner. A countersignature may be required by state licensing or certification statutes related to professional scope of practice. The entries of individuals who are required to practice under the direct supervision of another professional should only be countersigned by the individual who has authority to evaluate the entry. Professionals who countersign an entry should review the entry prior to countersigning to assure it is correct. Once countersigned, the entry is legally adopted by the professional as his/her own entry.

- **Initials** - Should a practice choose to use initials in any part of the medical record for authentication, there should be a corresponding full identification of the initials on the same form or on a signature legend. A signature legend is used to identify the author and full signature when initials are used to authenticate entries and is kept on file in the office. Initials are commonly used to authenticate entries such as flow sheets, but should not be used for narrative notes or assessments or where a signature is required by law.

- **Electronic Signature** - An electronic signature is a generic term for the various ways that an electronic record can be signed, such as a digitized image of a signature, a biometric identifier, a PIN or a digital signature.

- **Digitized Signature** - A digitized signature is an electronic representation of a handwritten signature. The image of a handwritten signature may be created and saved using various methods, such as using a signature pad, scanning a signature or digital photography.

- **Biometric Signature** - A biometric signature is the use of biological data, such as fingerprints, handprints, retinal scans and pen strokes to authenticate an individual.

- **Digital Signature** - A digital signature is a cryptographic signature (a digital key) that authenticates the user, provides nonrepudiation and ensures message integrity.

If multiple people document at different times on a particular form, there should be a mechanism in place to determine who completed each part of the form. This can be accomplished by including a signature area at the end of the form for staff to sign and date noting the section of the form completed, or by each person documenting on the form initialing the section completed. Electronic records should also have a mechanism to determine who completed information on a particular document if more than one person makes an entry on the document.

Any clinical information supplied by another person to the author of an entry should be clearly attributed to the source. For example, if you call the patient’s primary care provider to find out the results of patient’s last HbA1c test, document:

> June 1, 2015/2:30 p.m. – Phone call to Dr. John Doe to obtain pt’s latest HbA1c results. Dr. Doe stated the test was performed on May 20, 2015 and the result was 7.8%. – John Smith, DPM.

If documentation of patient care is entered for another provider, the entry should include the name of the person who entered the information and the date of the entry. Then the entry should be authenticated and dated by the actual provider of care. For example, a patient calls the office with a problem and talks with your nurse. The nurse relays the message to you, you give patient instructions, and the nurse relays the message to the patient. The nurse would document:

> August 24, 2015/9:00 a.m. – Received phone call from patient. She stated her surgical incision site is red and swollen. She first noted the symptoms two days ago. I relayed information to Dr. Smith who gave verbal instructions for the patient to come to the office today to be seen. I provided her with Dr. Smith’s instructions and gave her an appointment for 1:00 p.m. today. – Barbara Bellione, RN
The doctor should then countersign and date the entry as soon as possible.

All transcriptions should be reviewed, signed, and dated with the date of the review by the dictating doctor to assure accuracy of the information that was dictated. Transcriptions should contain the date the patient was seen, the date of dictation, and the date of transcription.

Lab, diagnostic test, consultation reports, etc. should likewise be signed and dated by the prescribing doctor to indicate the doctor reviewed the report and the date of the review.

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**History and Physical**

An initial history and physical should be performed and documented at the intital visit prior to the intitation of treatment.

The patient should complete a medical, social and family history and information pertaining to the current problem for which he/she is seeking podiatric care. Below is a sample Patient Information Form that can be utilized for this purpose. One the patient completes the form you should review the form with the patient and provide evidence of your review, such as placing your initials and date of review on the form or documenting that you reviewed the medical, social and family history with the patient in the patient's medical record.

---

**SAMPLE FORM**

**PATIENT INFORMATION FORM**

(Please Print)

Date: ____ /____ /____

Patient Name: _______________ _______________ ______ Date of Birth: ____ /____ /____ Age: ____ Sex:  M  F

Last First MI

Home Address: ______________________________________ City/State: _________________ Zip: ______________

Home Phone #: (____) ____-_____ May We Leave A Message?   Yes   No

Work Phone #: (____) ____-_____ May We Leave A Message?   Yes   No

Cell Phone #: (____) ____-_____ May We Leave A Message?   Yes   No

E-Mail: ________________________ May We Leave A Message?   Yes   No

Primary Language: _______________________

Do you have a legal guardian or healthcare power of attorney?   Yes   No

If yes, name: ___________________________________ Relationship: __________________ Phone #: (____) ____-_____ 

Emergency Contact: ____________________________ Relationship: __________________ Phone #: (____) ____-_____ 

Primary Care Doctor: ____________________________ Phone #: (____) ____-_____ 

Pharmacy: ____________________________ Location: __________________ Phone #: (____) ____-_____ 

Is there a family member or other person you would like for us to share your medical information?

_____ Yes    Name: ____________________________

_____ No

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Continued on next page ▶
Who is responsible for payment? _________________________________ Relationship to Patient? __________________________
Address: ______________________ City/State: _________________ Zip: ______________ Phone #: (____) ____-_____
Who referred you to us? __________________________________________

**Insurance Information**

Primary Insurance Company Name: _______________________________________________________________________
Address: ______________________ City/State: _________________ Zip: ______________ Phone #: (____) ____-_____
Insured Name: __________________________ Date of Birth: _______________ Employer: ___________________________
Contract #: ___________________________________________ Group #: _________________________________________

Secondary Insurance Company Name: _______________________________________________________________________
Address: ______________________ City/State: _________________ Zip: ______________ Phone #: (____) ____-_____
Insured Name: __________________________ Date of Birth: _______________ Employer: ___________________________
Contract #: ___________________________________________ Group #: _________________________________________

Please list all medications you are currently taking (include prescriptions, over-the-counter meds and herbal supplements):

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>How often do you take?</th>
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</tr>
</tbody>
</table>

Please list all prior surgeries:

<table>
<thead>
<tr>
<th>Type of Surgery</th>
<th>Date</th>
<th>Type of Surgery</th>
<th>Date</th>
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</tbody>
</table>

Please list all prior hospitalizations (other than for surgery):

<table>
<thead>
<tr>
<th>Reason for Hospitalization</th>
<th>Date</th>
<th>Reason for Hospitalization</th>
<th>Date</th>
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<tbody>
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</tbody>
</table>
Social History
Marital Status: □ Single □ Married □ Partnered □ Separated □ Divorced □ Widowed
Use of Alcohol: □ Occassionally □ Never □ No longer use □ History of alcohol abuse
Use of Tobacco: □ Never □ Quit How long ago? ______ □ Current Smoker Packs a day ___ for _____ years.
Use of Recreational Drugs: □ Never □ Quit How long ago? _____ □ History of alcohol abuse
□ Current Use-Type(s) __________________________ □ Never □ Occassional
□ Moderate □ Daily
Employer: ______________________________________________ Occupation:__________________________________________
How much are you on your feet at work? □ 10% □ 25% □ 50% □ 75% □ 100%
Do others depend on you for their care? □ Children-Age(s) _________________ □ Pet(s)-What kind? _______________
□ Elderly or disabled family member □ Other __________________________
Exercise: □ Never □ Rarely □ Occassionally □ Weekly □ Several times a week □ Daily
Types of exercise:________________________________________________________________________________________

Family History
Do you have a family history of: □ Diabetes □ Cancer □ Heart disease □ High blood pressure
□ Stroke □ Coronary artery disease □ Thyroid disease □ Rehumatoid arthritis
□ Other __________________________________________________________________________________________

Your Medical History
Allergies:
□ Medications __________________________________________________________
□ Anesthesia ____________________ □ Foods __________________________________
□ Tape □ Latex □ Shellfish □ Iodine □ Other ________________________________
□ None Known
Have you ever had any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acid Reflux</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Anemia</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Asthma</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Back trouble</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Bladder infections</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Abnormal bleeding</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Blood clots</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Bronchitis/emphysema</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Cancer</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Diabetes: Type 1 or Type 2 (circle)</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Fibromyalgia</td>
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<tr>
<td>Gout</td>
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<tr>
<td>Heart attack</td>
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<td>Heart disease/failure</td>
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<tr>
<td>Hepatitis</td>
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<tr>
<td>HIV+/AIDS</td>
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<tr>
<td>High blood pressure</td>
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<tr>
<td>Kidney disease</td>
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<tr>
<td>Liver disease</td>
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<tr>
<td>Low blood pressure</td>
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<tr>
<td>Migraine headaches</td>
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<tr>
<td>Mitral valve prolapse</td>
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<tr>
<td>Neuropathy</td>
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<tr>
<td>Open sores</td>
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<tr>
<td>Pneumonia</td>
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<tr>
<td>Polio</td>
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<td></td>
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<tr>
<td>Rheumatic fever</td>
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<tr>
<td>Sickle cell disease</td>
<td></td>
<td></td>
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<tr>
<td>Skin disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep apnea</td>
<td></td>
<td></td>
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<tr>
<td>Stomach ulcers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
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<tr>
<td>Thyroid disease</td>
<td></td>
<td></td>
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<tr>
<td>Tuberculosis</td>
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</tr>
</tbody>
</table>

Other conditions:

Current Problem
What specific problem brings you to our office today? __________________________________________________________
__________________________________________________________________________________________________________

Continued on next page ▷
Where is the pain/problem located? Mark on the pictures below:

<table>
<thead>
<tr>
<th>Left Foot</th>
<th>Right Foot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top of Foot</td>
<td>Top of Foot</td>
</tr>
<tr>
<td>Bottom of Foot</td>
<td>Bottom of Foot</td>
</tr>
<tr>
<td>Inside of Foot</td>
<td>Outside of Foot</td>
</tr>
<tr>
<td>Outside of Foot</td>
<td>Inside of Foot</td>
</tr>
</tbody>
</table>

How long ago did this problem first start? ____________ days / weeks / months / years

Did your pain or problem:  
☐ Begin all of a sudden  
☐ Gradually develop over time

How would you describe your pain?  
☐ No pain  
☐ Sharp  
☐ Dull  
☐ Aching  
☐ Burning  
☐ Radiating  
☐ Itching  
☐ Stabbing  
☐ Other ____________________________

How would you rate your pain on a scale form 1 to 10? (Please circle)  
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain possible)

Since the time your pain or problem began, has it:  
☐ Stayed the same  
☐ Become worse  
☐ Improved

What makes your pain or problem feel worse?  
☐ Walking  
☐ Standing  
☐ Daily activities  
☐ Resting  
☐ Dress shoes  
☐ High heels  
☐ Flat shoes  
☐ Any closed toe shoe  
☐ Running  
☐ Other ____________________________

What makes your pain or problem feel better? ____________________________

What treatments have you had for this problem? ____________________________

How has this problem affected your lifestyle or ability to work? ____________________________

Was this problem caused by an injury?  
☐ Yes (Describe) ____________________________  
☐ No

☐ If yes, was it a work-related injury?

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

______________________________________________  ______________________________________________
Print name of patient, parent or guardian  Signature of doctor

______________________________________________  ______________________________________________
If other than patient, relationship to that patient  Date

______________________________________________  ____________________________
Signature  Date
Once you have reviewed the patient information form with the patient, then you should perform and document your history and physical examination. The history and physical documentation should include:

- A review of systems;
- The chief complaint and a chronological description of the development of the patient's present problem from onset to present;
- Lower extremity examination and current clinical condition;
- Objective findings;
- The patient's expectations and goals for treatment;
- Who was present in the treatment room with the patient, if applicable (i.e., spouse/family member/friend);
- The presence or absence of functional limitations;
- Your diagnosis or impression;
- The treatment plan, including diagnostic and radiologic tests and results;
- Treatment administered and anticipated frequency and duration of treatment;
- Treatment results, including complications;
- Your prognosis;
- Any medication or therapy ordered and copies of the prescriptions and/or referrals given to the patient;
- Whether or not any special procedures are anticipated;
- Education provided; and
- Instructions for follow-up.

A sample template for dictating or documenting your history and physical is provided on the following page. This template can also be incorporated into your electronic medical record system.
New Patient/Consultation Form
Patient information, Medical History and Lower Extremity Examination

| Date: ______________________ |
| Patient Name: ________________________________    _________________________________    _________________________ |
| Last First Middle |
| Age: _______________   Sex: M / F      Date of birth: ______________________________  Primary language: ______________ |
| Personal physician: ________________________________________  Referred by: Mr. / Ms. / Dr. ________________________ |
| Phone: ___________________________________________________  Phone: __________________________________________ |

Complaints:

| Nature: |
| Location: |
| Duration: |
| Onset: |
| Spontaneous/Injury/Activity |
| Course: |
| Aggravating/Alleviating: |
| Treatment: |

Vital Signs:   Ht ___________      Wt ___________      Temp ___________      Pulse ___________      BP ________  /  ________

Continued on next page ▶
Medical History

Allergies (circle)
Antibiotics: Penicillin  Sulfa  Keflex  

Pain Meds: Codeine  Morphine  Aspirin  NSAIDs  

Other: Shellfish  Iodine  Adhesive Tape  General / Local Anes.  Latex  

Illnesses:  

Drugs: (Prescription/Prescribed by, Over-the-Counter, Herbal Remedies) 

Prior Surgery:  

Hospitalizations/Injuries: Dates? Complications?  

Social History
Occupation:  

Marital Status: S  M  D  W  

Alcohol: Type  

Tobacco:  

Family History
DM  CAD  HTN  MI  CA  Thyroid  RA  Other:  

Review of Systems
Major illnesses: Diabetes (Type 1 of Type 2) / Heart disease / Hypertension / Chest pain angina / MI / Cancer / Mitral Valve Prolapse / Murmur / Arrhythmia / Stroke / CHF/ Pacemaker

Respiratory: Asthma / Bronchitis / Emphysema / Frequent colds / Sinus problems / Infections / Shortness of breath / COPD / Lung disease or breathing problems / Tuberculosis / Smoker

EENT: Sinus problems or infections / Tonsillitis / Throat infections / Glaucoma / Cataracts / Eye of vision problems / Headaches / Migraines / Ear infections / Hearing deficit

Gastrointestinal: Ulcers / Reflux / Hiatal hernia / Stomach disorder / Bowel disorder / Irritable bowel syndrome / Hemorrhoids / GI or rectal bleeding / Rectal fissures

Genito-Urinary: Kidney or bladder infections / Kidney stones / Prostate / STD  

Vascular disease/Blood disorders: Poor circulation / PVD / Leg or calf pain / Night cramps / Rest pain / Vein problems / Swelling / Spider veins / Varicose veins / Phlebitis / Leg ulcers / Blood clots / DVT / PE / Bleeding or clotting disorders / Easy bruising / Anemia / Sickle cell / Transfusions

Arthritis: Rheumatoid / Oseot / Gout / Other arthritis  

Skin disorders: Psoriasis / Skin cancer

Psychological: Anxiety / Depression / Psychiatric condition / Drug or alcohol dependency  

Misc. illnesses: Epilepsy or seizures / Thyroid disease / Muscle disease / Hepatitis / HIV or AIDS / Pregnancy - Childbirth / Lyme disease / Other:  

Continued on next page ▶
### Lower Extremity Examination

#### Vascular:

<table>
<thead>
<tr>
<th>Pulses:</th>
<th>Skin:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT</td>
<td>Temp</td>
</tr>
<tr>
<td>DP</td>
<td>Color</td>
</tr>
<tr>
<td>Other</td>
<td>Hair</td>
</tr>
<tr>
<td></td>
<td>Texture</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>CFT</td>
<td>R ______ sec</td>
</tr>
<tr>
<td></td>
<td>L ______ sec</td>
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</tbody>
</table>

#### Venous:

<table>
<thead>
<tr>
<th>Edema</th>
<th>Hemosiderin</th>
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<tbody>
<tr>
<td>Telangiect.</td>
<td>Stasis dermatitis</td>
</tr>
<tr>
<td>Varicosities</td>
<td>Stasis ulcer</td>
</tr>
<tr>
<td>Hx DVT</td>
<td>Post Phlebitic Syndrome</td>
</tr>
</tbody>
</table>

#### Neurologic:

<table>
<thead>
<tr>
<th>Sensation</th>
<th>Reflexes:</th>
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<tbody>
<tr>
<td>Position</td>
<td>Patellar</td>
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<tr>
<td>Vibration</td>
<td>Achilles</td>
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<tr>
<td>Muscle strength</td>
<td>Babinski</td>
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<td></td>
<td>Weakness</td>
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<td></td>
<td>Paralysis</td>
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<td></td>
<td>Spasticity</td>
</tr>
<tr>
<td></td>
<td>Clonus</td>
</tr>
<tr>
<td>Gait</td>
<td>Other (Neuroma / Tinel's/Semmes-Weinstein)</td>
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</tbody>
</table>

#### Dermatologic:

<table>
<thead>
<tr>
<th>General</th>
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<tbody>
<tr>
<td>Nails</td>
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<tr>
<td>Hyperkeratosis</td>
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<tr>
<td>Ulcer</td>
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<tr>
<td>Lesion</td>
</tr>
<tr>
<td>Scar</td>
</tr>
<tr>
<td>Tinea</td>
</tr>
<tr>
<td>Verruca</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Continued on next page ➤
Structural/Biomechanical:

Foot type _____________________________________________________________
Ankle _________________________________________________________________
STJ/Rearfoot __________________________________________________________
Heel pain ____________________________________________________________
TNJ - CC/Mid-tarsal _____________________________________________________
Midfoot/Lis Franc _____________________________________________________
Forefoot/Lesser Met ___________________________________________________
Hallux/1st Met _______________________________________________________
Digital/Lesser MPJ ____________________________________________________

Diagnostic Testing:

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Results</th>
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</tbody>
</table>

Diagnostic/Impression:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Plan of Treatment:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Patient Discussion:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

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Progress Note Documentation

Each patient encounter should be documented in a consistent format and should accurately capture the essence of the visit. A common, widely accepted method of progress note documentation is the SOAP (Subjective, Objective, Assessment, and Plan) method. It is a problem-oriented method of recordkeeping that provides a structure in which to organize a large amount of information. These records are easy to review if kept properly, and reduce the potential for overlooking a problem.

Subjective component

The subjective component is the information relevant to the current visit you obtain by talking to the patient, family members, or friends. Subjective documentation includes:

- An introductory statement summarizing a description of the patient, the main reason for the visit/chief complaint (the patient can be quoted);
- Past medical history, family history, systems review, social history, and risk factors;
- History of present illness, including onset, location, duration, character (sharp, dull, radiating), alleviating/aggravating factors, temporal pattern (every morning, all day, at night, etc.);
- The patient’s view of the cause of the problem;
- Home remedies the patient has tried;
- Any other medical treatment the patient has received for the problem; and
- Current medications and allergies.

Any new problems or complaints should also be listed here.

Objective component

The objective component is measurable and observable information that you obtain during the visit. Objective documentation includes:

- Your observations (bandage dirty/wet, patient is crying, etc.);
- Physical examination findings (include pertinent positive and negative findings);
- Laboratory data (include pertinent positive and negative findings);
- Vital signs;
- Measurements (size of a wound, IM angle, induration);
- Descriptions (lesions, wounds);
- Results of diagnostic tests; and
- Any complications or unexpected outcomes.

Assessment component

The assessment component is your interpretation/assessment of subjective and objective findings of the patient’s condition/problem or level of progress. The assessment determines whether the problem has been resolved or if further care is required. Assessment documentation includes:

- Identification of each active problem (list individually with a corresponding number – this list should correspond to your “problem list” maintained at the front of the medical record);
- The diagnosis or differential for each problem;
- The evidence/rationale for your assessment*;
- Physical/social implications (non-ambulatory status, time off from work);
- Severity and urgency of each problem;
- Prognosis with and without treatment;
- Progress with current treatment; and
- Complicating factors.
* Rational for Treatment Decisions
It is extremely important to document your rational for your treatment decisions. Why did you change your plan of treatment? Why did you not follow standard treatment? Why did you ignore a clinical alert by your electronic health record system? Why did you perform a particular treatment? You may have a very good, sound medical reason for your treatment (or non-treatment) decisions, but if you do not document your rationale in the patient’s medical record, it may be difficult to defend your actions should a malpractice claim arise.

Plan component
The plan component is your specific plan for treatment of the patient and the rationale for your plan. For each active problem listed, plan documentation includes:

- Discussion of diagnosis/differential diagnosis with the patient and treatment options;
- Diagnostic studies, tests, and/or consultations ordered;
- Therapy/medications ordered;
- Patient education and instructions (advice, return appointments, what to do if symptoms worsen);
- Goals of care; and
- Expected duration of treatment.

Unresolved problems from previous visits should be addressed in subsequent visits. If the patient is not progressing as expected, reassess and document any change in the treatment plan.

An Example
The following is an example of SOAP documentation for a patient presenting for follow-up of a diabetic ulcer.

5/27/15 – 9:30 a.m.

S: Pt. returns today for follow-up of Grade II ulcer at the 3rd MPJ, L foot. Pt. reports new onset of drainage from L foot ulcer - began 2 days ago – pt. can’t relate to any contributing factor. Pt. “changing the bandage every day.” Pt. states he checks his blood sugar daily and “it runs in the 100’s.” He stated he last saw his PCP 2 months ago.

O: Vascular exam = Posterior tibial pulse R foot & Dorsalis pedis pulses, bilaterally are weakly palpable; Posterior tibial pulse L foot is non-palpable. Capillary filling time = < 3 sec X 10. Bilat. feet cool to touch. Neuro exam = sharp, dull, and light touch are all diminished, bilat. feet. Decreased plantar protective sensation, bilat. Pt. has positive hx. of paresthesias. ROM is unchanged; muscle strength is unchanged. Dermatological exam = bluish discoloration of the skin; skin dry, cracked, and peeling; and loss of hair, bilat. Wagner Grade II ulcer sub MPJ#3, L foot measuring .5 X .5 cm with probing to subcutaneous tissue, but not bone, with mild active clear drainage with no odor or redness. No edema, bilat. Pt. has thickened, dystrophic nails with subungual debris.

A:  1) NIDDM w/peripheral neuropathy, stable – PCP following
    2) Diminished pulses, bilateral – needs referral to vascular specialist for further evaluation
    3) Distal Onychomycosis, ongoing – receives quarterly nail debridments.
    4) Grade II ulcer, L foot, not improving – off-loading will be necessary to improve healing.
       Vascular referral as stated in #2. Prognosis is guarded.
    5) Drainage from L foot ulcer – no clinical signs of infection, needs to be monitored.

P:  1) Encouraged pt. to keep follow-up appointments with PCP to monitor diabetes.
    2) Pt. to see Dr. John Doe for vascular workup. Appt. scheduled for 2:00 p.m. tomorrow.
       Will review consultation report with pt. at next visit in one week.
    3) Patient to return in one month for regularly scheduled nail debridements.
4) Obtained informed consent from pt. for ulcer debridement. Performed sharp debridement of ulcer, full thickness skin & subq. tissue. Hyperkeratotic & devitalized tissue was removed to a clean, bleeding base. Antibiotic ointment, dispersion padding, and dry sterile dressing applied. Instructed pt. to continue daily dressing changes; not to bear any weight on the left foot; and to return for a recheck in one week or sooner if condition worsens. Crutches dispensed to pt and crutch training provided. Pt. demonstrated ability to appropriately walk and go up and down stairs with crutches.

5) Will continue to monitor L foot ulcer for signs/symptoms of infection.

“Canned Notes”
The advent of electronic medical record (EMR) systems has streamlined, and in many instances improved, the documentation process. However, you should be aware of the risks of using “canned notes” (notes that are derived from a database of standard information formats or templates) that are available with some EMR systems.

These standard notes can be cut and pasted into the patient’s medical record, thus saving considerable time in documentation. Risks occur when the same note is entered on the same patient during multiple visits; the note includes extraneous information, not associated with the reason for the visit or plan of treatment; or the note is not modified specifically for the individual patient.

EMR documentation, as with paper record documentation, should provide an accurate, complete record of the care and treatment provided to the patient. In order to appropriately document care utilizing EMR:

- Make sure documentation is tailored to the individual patient to include the reason for the visit, care rendered, rationale for treatment and plan for future treatment.
- Address each patient complaint or problem.
- Consistently utilize a list of chronic and acute patient problems with onset and resolution dates.
- Provide evidence of review of all laboratory findings, diagnostic reports, consultation reports, pathology reports, etc.
- Indicate the rationale for any deviation from the plan of care.
- Avoid documentation of “fluff” - information that is not associated with the reason for the patient’s visit or plan of treatment.
- Make sure medical record documentation reflects a true and accurate picture of the patient’s condition.
- Document and address all adverse or unexpected outcomes.
- Make sure documentation reflects the standard of care (e.g., pre-operative testing, medical clearance, treatment for a particular condition, etc.)
Wounds/Lesions

Wounds
Adequately describe all wounds to include location, specific size measurements, accurate grading, drainage, odor, redness, and swelling. A description of each wound should be documented at each visit.

Consider the following actual case example involving failure to adequately document the patient’s wound and other important aspects of the patient’s care:

The patient was a 43-year-old male who presented to the insured podiatric physician with complaints of an ulcer under the second metatarsal of the right foot. He had a history of severe diabetes and obesity. He was on hemodialysis and had non-palpable pedal pulses. The podiatrist diagnosed a “Stage 3” ulcer 2.5 X 3 cm in size. No infection was noted. The podiatrist prescribed an antibiotic ointment and an Apex Ambulator shoe.

The patient returned three weeks later. The ulcer had decreased to 1 X 1.5 cm; however, the wound had an odor. A culture was obtained along with a bone scan and x-ray. No antibiotics were given and a prescription for Regranex was written. The patient was instructed to return in four weeks. The bone scan was negative for osteomyelitis and the culture was positive for methicillin susceptible Staph aureus. The podiatrist phoned in a prescription for Augmentin.

When the patient returned for the next office visit, the ulcer appeared smaller in size and the podiatrist felt the infection had cleared and the ulcer was improving. The ulcer was still documented as “Stage 3.” The patient was instructed to return in four weeks. The patient returned as instructed. At that time, the podiatrist felt the ulcer was less deep and there was no sign of infection. The ulcer was again classified as “Stage 3” and the patient was instructed to return in four weeks. The patient was seen every four weeks for the next three months. At each visit, the podiatrist did not note any signs of infection and felt the wound was no worse nor no better. He continued to classify the ulcer as “Stage 3.”

The patient was then hospitalized for three days by an internal medicine physician for an unrelated condition. On admission, the ulcer had no signs of infection, but was documented as being “deep” with a foul odor. Upon discharge from the hospital, the patient continued treatment with the podiatrist. At an office visit the following month the podiatrist thought the patient should be seen by a vascular surgeon since Regranex had been used for four months without a marked improvement. The office visit note indicates that the patient was referred to a vascular surgeon, but there is no indication that the patient actually saw the surgeon.

The last visit with the podiatrist was the end of the following month. At that visit, the podiatrist noted a stage 3 ulcer that measured 0.3 X 2 cm. The podiatrist found no sign of infection, no drainage, and no sign of osteomyelitis. The patient was instructed to return in nine weeks.

Less than two weeks after the last visit, the patient was admitted to the hospital. He was found to have a fever of >102, an elevated white count, and a Stage 4 (2.5 to 3 cm) ulcer on the planter aspect of the metatarsal area of his right foot. A MRI was positive for osteomyelitis of the third metatarsal head.

The patient underwent six weeks of IV antibiotic therapy. He was admitted to the hospital again the following month with gangrene of his second and third toes extending into the planter aspect. During that hospitalization his second, third and fourth right toes were amputated. His condition worsened and he eventually underwent a below-the-knee amputation of the right leg.

The patient filed a lawsuit against the podiatrist alleging the podiatrist was negligent in:
- Failure to refer patient to a vascular surgeon for vascular studies to assess his circulation during the first two years of treatment;
- Failure to diagnose a foot infection;
- Failure to order numerous diagnostic tests to determine the nature and extent of his infection;
- Failure to order the appropriate antibiotic medication for the appropriate period of time; and
- Failure to perform the proper treatment.
The discovery process yielded the following:

- There were material and substantial deficiencies and discrepancies in documentation by the podiatrist in the patient’s medical record which would raise credibility issues and seriously undermine the weight which a jury might otherwise attach to the podiatrist’s testimony.
- The podiatrist consistently described the patient’s ulcer as “Stage 3” in the patient’s medical records. However, he testified that the ulcer was actually “Stage 1.” (Expert witnesses testified that classification of a Grade 3 ulcer on five separate visits without referral for a vascular consultation or further diagnostic studies would be a breach of the standard of care.)
- Many of the office notes failed to mention:
  - The size and/or depth of the ulcer
  - The presence or absence of redness, swelling or drainage
  - Patient instructions for the care of the ulcer
- The podiatrist stated the patient was non-adherent, but the patient stated he was adherent with all instructions. There was no documentation in the medical records regarding patient adherence or non-adherence.
- There was no note for one office visit.
- The podiatrist did not tell the patient that it was urgent to be seen by a vascular surgeon and did not follow-up to see that arrangements were made for an appointment with a vascular surgeon.
- The podiatrist stated that at the last office visit he asked the patient to return in nine weeks because he assumed a vascular surgeon was following the patient.
- The defense experts found the treatment rendered to the patient by the podiatrist to be passive, minimally responsive to the condition presented, and barely or not meeting the standard of care. The patient was reappointed every four weeks for the majority of his treatment with the podiatrist when more frequent follow-up and diagnostic testing was warranted.

The claim was resolved during mediation.

Lesions
Lesions should be carefully described to include the precise location, size/dimensions, and color. The lesion’s surface features should also be described. For example:

- Is the lesion smooth vs rough?
- Is the lesion flat vs. raised?
- Is there a break in the skin?
- Is there a presence or absence of dried blood, pus, or other fluids?
- Is the skin thickened?
- Is the arrangement of the lesion well-defined or spread out?
- Is the border well circumscribed vs. irregular?

Once a suspicious lesion is identified, immediately perform a biopsy, if you are skilled in such procedures, or refer the patient to an appropriate specialist for evaluation and biopsy. Make sure you have implemented a fail-safe tracking system in your office to make sure that all biopsy results and consultation reports are timely received, reviewed by you, relayed to the patient, and documented in the patient’s record. Also, ensure that any necessary follow-up is completed.

Progress note documentation should include:

- The referral, if applicable, including:
  - Your rationale for the referral;
  - The name of the referral doctor;
  - The date of the appointment; and
  - Patient education, including the reason for the referral, the importance of the referral, and the risks of not keeping the referral appointment.
- All written, oral, or electronic correspondence with or on behalf of the patient, such as:
Informed Consent

Informed consent discussions need to be held with patients, and documented, for any treatment or procedure that has the potential for significant risk. This results in the patient’s educated decision either to pursue or refuse certain treatments or procedures. It lets the patient know that complications can and do occur, even in the absence of negligence, and that all treatments involve some element of risk. While persons other than the physician may perform administrative tasks, such as obtaining the patient’s signature on a form, handing out an educational pamphlet or showing a video, it is the physician’s responsibility to complete the actual consent process. Examples of when to obtain informed consent include:

- Any surgical procedure that involves entry into the body, either through an incision or through a natural body opening;
- Any procedure requiring the use of anesthesia or moderate sedation;
- Non-surgical procedures, including the administration of medicines, that involve more than a slight risk of harm to the patient or that may cause a change in the patient’s body structure (e.g., chemotherapy, hormone treatments);
- Non-surgical invasive diagnostic and/or therapeutic procedures;
- Radiation therapy;
- Intravenous injection of contrast material;
- All experimental procedures; and
- All other procedures that the practitioner determines to require a specific explanation to the patient (e.g., podiatric treatment of patients with diabetes or peripheral vascular disease at greater risk for complication including loss of toe, foot, limb or life.)

Any doubts about the necessity of obtaining a special consent from the patient should be resolved in favor of obtaining consent.

Informed consent is a process of communication with the patient so that the patient is given enough information to make an informed decision to have or not to have a particular treatment or procedure. When a patient signs a consent form, he or she is attesting to the fact that the informed consent process took place.

The informed consent discussion with the patient should be held by the doctor who will actually perform the procedure, and that doctor’s name should be listed on the consent form as the doctor who will be performing the procedure. Some doctors utilize the consent form as a guide for the informed consent discussion and ask the patient to sign the form at the end of the discussion. Other doctors have the informed consent discussion with the patient and ask the patient to sign the consent form at a later time. Either way, for elective procedures, the informed consent discussion should take place a sufficient amount of time prior to the planned treatment or procedure in order to give the patient time to think about the informed consent discussion, to ask questions, and make an informed decision. This also avoids any issue of pressure, duress or the influence of medications. During the discussion, you should use language the patient can understand and avoid the use of “medical jargon.”

The following information should be discussed with the patient and documented in the medical record:
1. The nature of the patient’s illness, the diagnosis, the proposed treatment plan and the prognosis.
2. A description of the recommended procedure or treatment and its purpose.
3. The probable outcome, particularly if it is difficult to predict, and the patient’s expected post-procedure/treatment course.
4. The most likely risks and side effects, the potential benefits, as well as the potential complications of the procedure or treatment.
5. Reasonable alternative methods of treatment or non-treatment including the risks, benefits, complications, and the prognosis associated with each alternative or with non-treatment.

If any element of informed consent (diagnosis, procedure, risks, benefits, etc.) changes after the patient signs a consent form, another informed consent discussion should take place and another form should be signed.

Additionally, if a significant amount of time passes after an informed consent discussion with the patient prior to the surgery (for example, the surgery or procedure has to be postponed for several weeks) it is prudent for the doctor to review the informed consent discussion with the patient and have the patient resign and date the consent form if nothing has changed, or sign a new consent form, if needed.

Informed consent for treatment of patients who do not have the capacity to consent, such as minors or patients with dementia, should be obtained from the patient’s legal representative. A legal representative may be a parent, legal guardian, or other person authorized under state or other applicable law to act on behalf of the patient in making healthcare decisions, such as the next of kin. It is important to be familiar with your individual state laws regarding appropriate informed consent procedures for minors or others lacking the capacity to provide consent.

A sample informed consent form can be found on the next page. This form can be utilized for any podiatric procedure, no matter how minor or how complicated. This form includes several diagrams from which you can choose the one most appropriate for the planned procedure to further educate the patient by illustrating where incisions will be made, bodes will be cut, skin removed, etc.
SAMPLE FORM

Note: This authorization is to be reviewed with the patient and signed by the patient PRIOR to the date of surgery, at a surgical consult or pre-surgery visit. It should not be reviewed for the first time and signed on the day of surgery.

Consent for Surgery

Patient: ____________________________________________    Date of Birth: ___________________________________

You have the right and responsibility to make decisions about your health care. Your doctor can give you information and advice, BUT IT IS YOUR DECISION WHETHER OR NOT TO HAVE SURGERY OR TREATMENT.

1. I give my permission to Dr. ________________________________ to perform the following operation/procedure/treatment on me:
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________
Site/Location __________________________________________________________ Side__________________________________
The purpose of the operation or procedure is to: ________________________________________________________________

2. I understand that the potential benefits and outcomes of the operation/procedure/treatment include, but are not limited to:
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________

3. I understand that the potential risks and complications of the operation/procedure/treatment include, but are not limited to (check only those that apply):
   _ Infected ________________________________________________________ _ Allergic reaction to suture or other implanted materials
   _ Redness and/or swelling of operated areas ___________________________ _ Damage to blood supply/circulation (such as blood clots)
   _ Poor healing of incisions and/or bones ________________________________ _ Damage to nerves (burning, tingling, stinging, numbness)
   _ Failure of the incisions and/or bones to heal __________________________ _ Loss of implant through degeneration/breakdown
   _ Excessive bleeding ________________________________________________ _ Loss of toe, foot, limb or life
   _ Operation/procedure/treatment may not work __________________________ _ Permanent swelling/enlargement of toe, foot or leg
   _ Condition or pain may come back ____________________________________ _ Paralysis/paraplegia/quadruplegia
   _ Condition/disability may get worse __________________________________ _ Brain damage
   _ Bad or allergic reaction to anesthesia ________________________________ _ More treatment or surgery may be needed
   _ Painful or large scars _____________________________________________ _ Significant or permanent pain (such as CRPS)
   _ Calluses or sores may develop on the foot ____________________________ _ Stroke/heart attack/death
   _ Fracture/break or dislocation of a bone ______________________________ _ Other: ______________________________________
   _ Swollen toe/stiff toe/shorter toe/lifted toe ____________________________ _ Other: ______________________________________
   _ Difficulty in walking/wearing shoes/playing sports ____________________ _ Other: ______________________________________

4. My doctor has discussed other options to this surgery/procedure/treatment for my condition with me. These include but are not limited to (check only those that apply):
   _ Wide shoes or change in shoe gear _________________________________ _ Orthotic shoe inserts ____________________________ _ No treatment at all
   _ Periodic care _____________________________________________________ _ Change in job ________________________________ _ Other: ____________________________
   _ Antibiotics ______________________________________________________ _ Injections ________________________________ _ Other: ____________________________
   _ Padding and strapping _____________________________________________ _ Physical therapy ____________________________ _ Other: ____________________________

5. Serial Procedures - I understand that I will receive a series of the same treatments over a time period not to exceed _____ days
from _____ / _____ / _____. N/A ________________________________

6. I understand that other health care providers such as surgical assistants, physician assistants, nurses, and other surgical staff
may assist the doctor named above in performing my surgery. A surgical resident(s) may participate in some or all of
the surgery. I give my permission for them to do so.

7. I consent to the use of anesthesia, except for ____________________________.

8. I consent to the taking of x-rays; blood samples and/or urine samples for laboratory testing; and other tests that may
be necessary.

Continued on next page ➤
9. I consent to the use and transfusion of blood and blood products if my doctor feels it is necessary. I understand that my doctor will not be responsible for any bad reactions as a result of a transfusion.

10. I consent to the disposal of any tissues or parts which may be taken out during the procedure.

11. I have told my doctor about all my allergies. (LIST ALLERGIES) _________________________________________________________
________________________________________________________________________________________________________________
12. I have told my doctor:
   a. About all of the drugs I take, including prescription and over-the-counter medications, herbal products, nutritional supplements, and recreational drugs;
   b. About all of my medical conditions such as allergies, pregnancy, epilepsy, herpes, HIV/AIDS, diabetes, circulation problems, etc. that I am aware of;
   c. If I smoke;
   d. If I use alcohol.
I will accept full responsibility for any problems with my treatment that may result because of my failure or refusal to tell my doctor about these things.

13. I understand that no guarantees or promises have been made to me about the results of this operation/procedure/treatment.

14. I understand that sometimes during surgery, it is discovered that additional surgery may be needed. I give my doctor permission to do additional surgery if he/she feels it is necessary.

I certify that I have read, or had the form read and explained to me, and that I fully understand its contents. I have been given ample opportunity to ask questions. My questions have been answered to my satisfaction. All blanks or statements that required completion were completed before I signed this form. I drew a line through all statements that I do not approve before I signed this form.

| I understand the risks, benefits, and alternatives to the proposed operation, procedure, or treatment. I consent to the operation, procedure, or treatment to be performed. YES _____ NO _____ |
|---------------------------------|------------------|
| Signature of patient            | Date/Time        |
| Witness                         | Date/Time        |

The patient is unable to consent because: _________________________________________________________
Therefore I consent for the patient.

<table>
<thead>
<tr>
<th>Legal representative of patient</th>
<th>Date/Time</th>
</tr>
</thead>
</table>

| Relationship                   |           |

| I declare that I have personally explained the above information to the patient or the patient’s legal representative. |
|----------------------------------------------------------------------|------------------|
| Physician                                                            | Date/Time        |
These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: ___________________________ Date: ________________

Witness Signature: ___________________________________________ Date: ________________
These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: ____________________________ Date: ______________

Witness Signature: _________________________________________________ Date: ______________

Legend: Area(s) to be cut and/or removed.

Continued on next page ➤
These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: ____________________________ Date: ____________________

Witness Signature: ____________________________ Date: ____________________

Legend: Bones to be cut and/or removed or moved.
These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: ___________________________ Date: ________________

Witness Signature: ___________________________ Date: ________________

Legend: Bones to be cut and/or removed or moved.
These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: ___________________________ Date: ________________

Witness Signature: ___________________________________ Date: ________________
These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: ____________________________ Date: __________________

Witness Signature: ____________________________________________ Date: __________________

Continued on next page ➤

Legend: Bones to be cut and/or removed or moved.
These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: ____________________________ Date: ______________

Witness Signature: ____________________________ Date: ______________

Legend: Bones to be cut and/or removed or moved.
These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: _____________________________ Date: ________________

Witness Signature: ___________________________________________ Date: ________________

Legend: Areas to be cut and/or removed or moved.
Legend: Area to be cut and/or removed or moved.

These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: ___________________________ Date: ________________

Witness Signature: ________________________________________________ Date: ________________

Continued on next page ➤
Legend: Area to be cut and/or removed or moved.

These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: ___________________________ Date: ________________

Witness Signature: _____________________________________________ Date: ________________

Continued on next page ➤
Legend: Area to be cut and/or removed or moved.

These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: _____________________________ Date: ________________

Witness Signature: _________________________________________________ Date: ________________

Continued on next page ►
Legend: Area to be cut and/or removed or moved.

These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: ________________________________ Date: ________________

Witness Signature: ______________________________________________________ Date: ________________
Legend: Area to be cut and/or removed or moved.

These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: _____________________________ Date: ________________________

Witness Signature: _____________________________________________ Date: ________________________
Legend: Area to be cut and/or removed or moved.

These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: ___________________________________________ Date: ____________________

Witness Signature: ___________________________________________ Date: ____________________

Continued on next page ➤
Legend: Area to be cut and/or removed or moved.

These diagrams were explained to me and I understand them.

Patient or Legal Representative Signature: ___________________________________ Date: ________________

Witness Signature: __________________________________________________________ Date: ________________


**Refusal to Consent**

A patient has the right to refuse treatment. However, it is the responsibility of the physician to make sure the patient’s decision to refuse treatment is an informed decision. If a patient refuses a recommended plan of treatment, it is important that you undergo and document an “informed refusal” discussion with the patient. This process is basically the same as for informed consent discussions.

The patient’s refusal may be due to a lack of understanding of the recommended treatment, the patient’s inability to comply with the plan of treatment for one reason or another, or the patient’s inability to pay for the procedure. For example, the patient may be a single mother who cannot afford to be off work for several weeks, or the patient may be an elderly person who cannot afford his Medicare deductible.

Therefore, patient education is crucial. Provide the patient with specific, detailed information regarding the recommended treatment including the benefits and risks of the treatment; and any risks connected with the failure to undergo the treatment. Additionally, discuss with the patient reasonable alternative treatment possibilities and the risks and benefits of each. All discussions and educational efforts should be documented in the patient’s medical record along with the fact that the patient was made aware and understands the risks of non-compliance with the recommended plan of treatment.

Documenting refusal of care is particularly important where the patient refuses care because of monetary considerations such as lack of Medicare coverage. It is crucial in those instances that the provider document that the patient took into consideration factors independent of his or her financial status by additionally weighing the medical risks at issue.

Provide the patient with specific, detailed information regarding any risks connected with the failure to undergo the proposed care or treatment, and document that discussion. Document the specific risks you discussed with the patient and any alternative treatments you may have recommended. Also document the patient’s response to your medical recommendation. Ultimately, the decision whether to undergo a certain treatment remains at all times with the patient, regardless of the patient’s reasons for refusal. If the patient exhibits knowledge of the proposed procedure and the risks of refusal and still refuses, it is recommended that the practitioner ask the patient sign a “refusal of treatment form” specifically acknowledging what you discussed, and that the patient understands the risks of not receiving the treatment, and had decided to refuse treatment nonetheless.

In order to further reduce the practitioner’s liability in the event the patient suffers a poor outcome as a result of the non-compliance, the practitioner may consider formally terminating his/her relationship with the patient.

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**Pre-, Intra- and Post-Op Care**

Consider the following actual case in which the podiatric physician failed to justify her decision to perform surgery.

*The patient was a 37-year-old, professional woman who was very athletic. She presented to the podiatric physician with complaints of painful bumps on her feet bilaterally of a few years duration. However, her right foot was the most symptomatic.*

*The podiatrist performed a history and physical examination and took X-rays. She diagnosed hallux abducto valgus, bilateral; tailor’s bunion, bilateral; dislocation of the second MPJ, right and hammertoes of digits 2 – 5, right. The podiatrist discussed treatment options which included conservative care and surgical correction. The patient stated she had tried conservative measures without success and wished to have surgery.*

*Three months later, the podiatrist performed a bunionectomy with distal osteotomy, second metatarsal osteotomy, arthroplasty of toes 2 - 5, excision of a cyst and a tailor’s bunionectomy on the right foot. Recovery was slow with pain complaints involving the second, third and fourth interspaces. The podiatrist treated the patient with injections of the second and third interspace and placed her in a Dynasplint.*
At six months post-op, the podiatrist took the patient back to surgery for neuroma excisions of the second and third interspaces with tenotomy and capsulotomy of the fifth MPJ. There was no improvement in the patient’s pain and narcotics were prescribed on a consistent basis. Later, Neurontin and Lyrica were added for pain control.

The podiatrist performed a third surgery 11 months after the initial surgery. This surgery consisted of excision of a recurrent fourth interspace neuroma, capsulotomy, scar revision and pin removal. The surgery failed to provide relief from pain in the forefoot and the patient continued to ask for large quantities of narcotics.

When the podiatrist ceased to prescribe narcotics four months later, the patient decided to seek another opinion. She was concerned about the progression of her pain and the lack of determining etiology.

The patient saw an orthopedic surgeon a week after her last appointment with the podiatrist. In addition to pain, she complained that her fifth toe was in varus and the second and third toes were “crooked up.” The orthopedic surgeon felt her symptoms were caused by a recurrent neuroma at the right third interspace. He subsequently performed surgery to remove that neuroma, a neuroma at the second interspace and some scar tissue. Although the patient complained of significant post-operative pain, the orthopedist thought she was progressing well and planned to perform surgery to straighten her fifth toe.

However, the patient did not return to the orthopedic surgeon. Instead, she went to a different orthopedic surgeon for another opinion who diagnosed her with CRPS. That orthopedic surgeon reviewed the pre- and post-operative X-rays taken by the podiatrist and told her she did not have a bunion and did not need the surgeries performed by the podiatrist. He related the CRPS to the multiple surgeries on her right foot and referred her to a pain management specialist.

The patient received treatment for CRPS and ultimately had a permanent spinal cord stimulator placed. She continued to treat with the pain management specialist and reported that she is no longer able to work.

The patient filed a lawsuit against the podiatrist alleging:

- The initial surgery performed by the podiatrist was unnecessary and unjustified.
- The initial surgery performed by the podiatrist was improperly performed.
- Failure to provide sufficient information for informed consent.
- Failure to timely diagnose CRPS and refer to treatment.

Podiatric, internal medicine and neurology experts for the defense reviewed the case and identified several problems with the defense of this case:

- The bunions were very difficult to discern on the pre-operative X-rays taken by the podiatrist which made justification for the initial surgery difficult.
- The podiatrist’s initial pre-operative history and physical examination documentation was limited and did not support the need for surgery.
- The records failed to describe any problem or deformity at the digital level, other than the fifth toe, prior to surgery, and there was no description of the patient’s complaint history or the location of her complaints. Additionally, there was no documentation of the podiatrist’s rationale for surgery.
- An Independent medical examination of the patient confirmed the claimant had CRPS.

While the fact that the patient developed CRPS was defensible, the lack of documented justification for the initial surgery significantly hampered the defense of this case. Therefore, the case was resolved through mediation for a significant amount of money.
Office-Based Surgery

Documentation of surgery performed in the office should reflect compliance with state requirements or guidelines, if applicable, or with the standard of care and should include:

- Preoperative assessment, including the preoperative diagnosis and rationale for surgery, and surgical clearance by appropriate medical specialist, if indicated;
- The patient’s written informed consent;
- Verification of the patient’s identity, the surgery to be performed, and the site of the surgery just prior to performance of the surgery;
- Appropriate patient assessment and monitoring (according to the type of anesthesia/analgesia/sedation administered) during the surgery;
- The name, dose, and route of any anesthetics and/or medications administered;
- The patient’s vital signs prior to, during, and immediately following the surgery;
- Specimens or tissue collected and disposition (e.g., sent to pathology);
- Placement of drains, hardware, etc.;
- Dressings applied;
- The times the surgery began and ended;
- Operative report, including:
  - Description of findings;
  - Technical procedures performed;
  - Post-operative diagnosis;
  - Name(s) of surgeon and assistants, if any;
  - Sharps, instrument, and sponge counts, if applicable; and
  - Any complications.
- A copy of written discharge instructions given to the patient, including:
  - Procedure performed;
  - Information regarding potential complications;
  - Telephone number(s) to call if questions or complications;
  - Instructions for medications and pain management;
  - Other instructions (e.g., non-weight bearing, use of ice packs, dressings, etc.); and
  - Date and time of follow-up visit.
- The name of person accompanying patient, if applicable.

Referrals and Consultations

It is important to thoroughly document all referrals for consultations, labwork, diagnostic testing, etc. you feel are necessary for the ongoing care and treatment of patients. Failure to document and follow-up on patient referrals can lead to patients “falling through the cracks.” Allegations of failure to follow-up on patient care can be difficult to defend if there is no documentation to prove a reasonable effort was made to contact the patient who missed a referral appointment, to track down a missing report, or to take action based upon a referral report. Progress note documentation of referrals should include:

- The reason for the referral;
- The name of the referral doctor, lab, or other healthcare provider;
- The phone call or letter to the referral doctor/order for labwork, testing, etc.;
- The date of the appointment;
- Patient instructions/education;
- Date of receipt of the referral report;
- Date you reviewed the referral report;
- Follow-up actions taken if the referral report is not received in a timely manner;
- The date you reviewed the referral report with the patient;
- Your discussion of the results with the patient;
- The plan for future treatment;
• The name of the provider who will be assuming future care of the patient if other than you; and
• Any follow-up actions taken based upon the referral report.

## Medications/Sample Drugs

Many medication errors can be prevented by paying careful attention to documentation concerning medications. Prescriptions should be legible and dangerous abbreviations, symbols and dose expressions eliminated.

The Joint Commission developed the following list of “Do Not Use” abbreviations:

<table>
<thead>
<tr>
<th>Do Not Use1</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U, u (unit)</td>
<td>Mistaken for “Q” (zero), the number “4” (four) or “cc”</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number “10” (ten)</td>
<td>Write “International Unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily)</td>
<td>Mistaken for each other Period after the Q mistaken for “I” and the “O” mistaken for “I”</td>
<td>Write “daily”</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d., qod (every other day)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)^2</td>
<td>Decimal point is missed</td>
<td>Write X mg Write 0.X mg</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MS</td>
<td>Can mean morphine sulfate or magnesium sulfate Confused for one another</td>
<td>Write “morphine sulfate”</td>
</tr>
<tr>
<td>MSO4 and MgSO4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes
1. Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.
2. Exception: A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/ tube sizes. It may not be used in medication orders or other medication-related documentation.

* The Institute for Safe Medication

Additional problematic abbreviations, symbols, and dose designations identified by the Joint Commission include:

- Symbols for greater than (>) and less than (<) because they may be mistaken for the number 7, the letter L, or for each other. The requirement would be to write out the words “greater than” or “less than.”
- Abbreviations for drug names because similar abbreviations for multiple drugs may lead to confusion. The requirement would be to write out drug names in full.
- Apothecary units (e.g., grain, dram, minimum) because they are virtually obsolete, unfamiliar to many practitioners, and may be confused with metric units. The requirement would be to use metric units instead.
- The symbol for “at” (@), which may be mistaken for the number 2. The requirement would be to write out the word “at.”
- The abbreviation “cc” because it can be mistaken for the abbreviation “U” for units, which currently does appear on the do-not-use list. The requirement would be to write mL or milliliters.
- The abbreviation “Mg,” (micrograms), which can be confused for mg (milligrams), resulting in a 1,000-fold overdose. The requirement would be to write “mcg” or “micrograms.”

The Institute for Safe Medication Practices (ISMP) also developed a list of error-prone abbreviations, symbols, and dose designations which can be found on the ISMP website at http://www.ismp.org/Tools/errorproneabbreviations.pdf

If drug samples are dispensed from the office, each sample should be labeled with:

- The name of the patient;
- The brand and/or generic name of the drug;
- The strength of the drug per dosage unit;
- Clear directions for use by the patient; and
- Any necessary cautionary statements or use instructions such as, “May cause drowsiness” or “take with food.”
Prescriptions or drug samples dispensed from the office at your direction should be thoroughly documented in the patient’s medical record, including:

- Complete order;
- The purpose of the medication;
- Specific instructions given;
- Questions asked and answered;
- Any adverse reaction the patient has to a medication; and
- The date a medication has been discontinued.

A patient’s current medications and medication history can easily be tracked by maintaining a medication flowsheet.

Communications

Patient Education

“I didn’t know I was supposed to stay off my foot.” “You never told me I shouldn’t get the dressing wet.” Sound familiar? These and similar allegations are common when a patient sues following a poor outcome. The importance of documenting all patient educational sessions and instructions cannot be emphasized enough.

Here are some general considerations for documentation of patient education and instructions:

- Review instructions with the patient/family and document each session.
- Ensure the patient and/or the patient’s caregiver comprehends the instructions by asking them to repeat or demonstrate the instructions.
- Ask for and record any questions related to your instructions and the answers you provide.
- Instructions should be specific and individualized for the patient.
- Supplement oral instructions with written instructions and place a copy in the patient’s medical record.
- Document the titles of any supplemental educational materials used such as written materials, videotapes, interactive computer instructional programs, etc. Be sure to keep a copy of all educational resources used in case they are needed for future reference.

Patient Non-adherence

It is not uncommon for a patient to sue his/her doctor following a poor outcome. However, many times the reason for the patient’s poor outcome is the patient’s non-adherence with instructions or the plan of treatment rather than malpractice on the part of the doctor. These cases are much easier to defend if the patient’s non-adherence is well documented.

Document all observations and patient statements of non-adherence. For example, a patient was instructed to be non-weight bearing, to keep the dressing dry, and not to remove the dressing following foot surgery. However, at the first post-operative visit, it is clear from observing the patient’s dressing that he did not adhere to the instructions. Documentation could be something like this:

“Patient presents for his first post-operative visit. Noted the bottom of the dressing to be dirty, worn, and loose. When the patient was asked if he walked bearing weight on his operative foot, he stated, ‘I walked around the house a little without my crutches.’ When the patient was asked if he removed the dressing, he stated, ‘I took the dressing off to see what my foot looked like, but I put it right back on.’”
**Telephone Calls**

An issue that many times becomes a credibility issue in a lawsuit is whether or not a phone call took place. It is important to document all calls to or from a patient and all calls made on behalf of the patient (such as scheduling tests, referral appointments, etc.) regarding the patient’s care and treatment in the patient’s medical record.

Documentation of phone calls should include:

- Date and time of call;
- The name of the person to whom you are speaking;
- The name and title of the person in your office making/receiving the call;
- The reason for the call;
- Your orders, if applicable;
- Advice or information given; and
- Appointment offered and/or scheduled, if indicated.

It is recommended that you review all messages from patients and advice given by other staff members for appropriateness and co-sign to indicate your review and approval of the advice.

Don't forget to document phone calls you make or receive after hours. Make sure you have telephone documentation forms with you at all times you are on call so that you can document after hours calls while they are fresh in your memory. Then once you return to the office, the telephone documentation form can be placed or scanned in the patient's medical record. Alternatively, you can use your notes to document the call in the medical record, being careful to document the date you are making the entry and the date the call actually took place.

**Electronic Communications**

Healthcare providers are increasingly communicating with patients electronically. Electronic communication can be in the form of e-mail, cell phone calls, texting, social media or ePortals. A large risk of communicating electronically with a patient or other healthcare professionals is the potential for a breach of protected health information. Electronic communication, absent the use of encryption or other security measures, is not secure. HIPAA Privacy and Security rules must be closely followed.

In addition to privacy and security concerns, there are malpractice concerns with electronic communication. One significant concern is the failure to include electronic communications in the patient's medical record. Any electronic communication to/from or concerning a patient should be preserved for the medical record. Examples include the texting of orders, providing podiatric advice to a patient, scheduling an appointment. If electronic communications are not included in the patient’s medical record, an issue may arise where the physician will not be able to provide proof of an action or justify his/her medical decisions.

It is recommended that you obtain informed consent from the patient in order to communicate with him/her electronically or via a personal electronic device. Because email and texting are so “immediate,” patients may come to expect that a doctor will respond within minutes when, in fact, the doctor is not available to respond until the next day. Accordingly, if a doctor chooses to communicate electronically, there must be clear disclaimers about response times.
[name of doctor or office practice] offers his/her/our patients the opportunity to communicate by e-mail. This form provides information about the risks of e-mail, guidelines for e-mail communication and how we will use e-mail communication. It also will be used to document your consent for us to communicate with you by e-mail.

**RISKS**
Communication by e-mail has a number of risks which include, but are not limited to, the following:

- E-mail can be circulated, forwarded and stored in paper and electronic files.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
- E-mail can be received by unintended recipients.
- E-mail can be intercepted, altered, forwarded or used without authorization or detection.
- E-mail senders can easily type in the wrong e-mail address.
- E-mail can be used to introduce viruses into computer systems.

**HOW WE WILL USE E-MAIL**
1) We will limit e-mail correspondence to established patients who are adults 18 years or older, or the legal representatives of established patients.
2) We will use e-mail to communicate with you only about non-sensitive and non-urgent issues such as:
   - Questions about prescriptions, use of medical equipment or devices, etc.
   - Routine follow-up questions
   - Appointment scheduling
   - Billing questions
3) All e-mails to or from you will be made a part of your medical record. You will have the same right of access to such e-mails as you do to the remainder of your medical file.
4) Your e-mail messages may be forwarded to another office staff member as necessary for appropriate handling.
5) We will not disclose your e-mails to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.
6) If you request, we will e-mail your health information to you or to a third party designated by you.

**IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL...CALL 911.**
Also, do not use e-mail for urgent problems. If you have an urgent problem, call our office [office phone number] or go to an urgent care facility.

**GUIDELINES FOR E-MAIL COMMUNICATION**
1) Include the general topic of the message in the “subject” line of your e-mail. For example, “advice,” “prescription,” “appointment” or “billing question.”
2) The e-mail message should not be time-sensitive. While we try to respond to e-mail messages daily, it may take up to three (3) working days for us to respond to your message. Urgent messages or needs should be relayed to us using regular telephone communication.
3) Include your name and phone number in the body of the message.
4) Review your message to make sure it is clear and that all relevant information is included before sending.
5) Send us an e-mail confirming receipt of our message after you have received and read an e-mail message from us.
6) If your e-mail requires a response from us, and you have not heard back from us within three (3) working days, call our office to follow-up to determine if we received your e-mail.
7) Take precautions to protect the confidentiality of e-mail, such as safeguarding your computer password and using screen savers.
8) Inform us of changes in your email address.
CONSENT

I, ____________________________, am:

   a) an established patient of [name of doctor or office practice].
   b) the legal representative of an established patient.

   ____________________________
   (print patient's name)

I may want to communicate with [name of doctor or office practice] and the office staff by e-mail. I understand the risks of communicating by e-mail, in particular the privacy risks explained in this form. I understand that [name of doctor or office practice] cannot guarantee the security and confidentiality of e-mail communication. [name of doctor or office practice] will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

I understand that I may also communicate with [doctor or office practice name] by telephone or during a scheduled appointment, and that e-mail is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information.

I understand that either I or [name of doctor or office practice] may stop using e-mail as a means of communication upon my written request.

I understand that I may revoke this consent at any time by so advising [name of doctor or office practice] in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from [name of doctor or office practice].

   ____________________________
   (print name)

   ____________________________
   (signature)

   ____________________________
   (date)

* Keep the original or top copy in the patient’s medical record and give the patient a copy for his/her reference.
Unexpected Outcomes

It is not uncommon for a patient to suffer an unexpected outcome such as an adverse reaction to a medication, a surgical complication, a fall in the exam room, delayed healing, a misdiagnosis, etc. that may or may not be the result of malpractice. Regardless, doctors can reduce their risk of being named in a lawsuit if steps are taken to mitigate the risk. Mitigation steps include clear and honest communication with the patient and/or the patient’s family regarding the facts surrounding the unexpected outcome and documentation of those facts in the patient’s medical record.

As soon as possible after discovering an unexpected outcome, document the event in the patient’s medical record. Documentation of unexpected outcomes should be factual. The documentation should not contain subjective comments, blame, or speculation about what happened. After you have disclosed the facts to the patient and/or family, document the information discussed; the date, time, and place of the disclosure; the names of those present; and your plans for subsequent treatment.

Error Correction, Late Entries, Addendums, and Amendments

There are valid instances when correction of an erroneous entry, late entries of necessary clinical information, addendums to prior entries, or amendments to the medical record need to occur. In these instances, appropriate steps should be taken to clearly document who made the entry, when the entry was made, and why the entry was made.

Error Correction

A correction is a change in the information meant to clarify inaccuracies after the original document has been signed or rendered complete. For errors in paper records, draw a single line through the erroneous entry, taking care not to render the erroneous information unreadable, and make the correct entry next to it. All corrections should be initialed and dated. By doing this, it is obvious that a mistake has been made, but it is evident that no concealment of the truth has been attempted. When an entry has been completely hidden (e.g., using correction fluid, erasing, or completely covering), it could be assumed that the person making the entry had something to hide.

Late Entry

A late entry applies to documentation within the medical record that is entered after the point of care. To make a late entry in paper records, go to the next available space in the record, document the current date and time, reference the entry as a late entry for the date the entry should have been made, document the appropriate information, then date and sign the note. For electronic records, the office should have policies and procedures based on the system used on how to correctly make a late entry in the medical record. The late entry should be clearly noted as a late entry and include the date and time the entry was made. Document the late entry as soon as possible because the later the entry, the less credibility the entry will have.

Addendum

An addendum is a type of late entry used to provide additional information in conjunction with a previous entry. Addendums should be made as soon as possible after the original entry. To enter an addendum go to the next available space; document the current date and time; write “addendum” and state the reason for the addendum, referring back to the original entry by date; identify any source(s) of information used to support the addendum (e.g., lab report); and date and sign the note.

An addendum can also be used to correct an error in documentation that was not noticed timely. For example, “7/1/15 8:00 a.m. - on reviewing my chart notes of 2/28/2015, I noticed that I referred to paresthesia in the patient’s right foot. The patient’s paresthesia occurred and continues to occur in the left foot.”

For corrections to electronic records after the entries have been locked, make an addendum to the record as described above. The original unaltered document should remain as part of the electronic record.
Addendums should NOT be used to state personal opinions, perceptions, or defenses. In the event of a lawsuit, addenda are usually seen as being self-serving and often hurt, rather than help the doctor’s defense.

**Amendment**

An amendment is documentation meant to clarify health information within a health record. Amendments should be made as soon as possible after the need for clarification is identified and should clearly state the current date and time the amendment is made.

Federal law gives patients the right to request that their medical records be amended to correct incomplete or incorrect information. (See the HIPAA Privacy Rule §164.526.) The patient must submit a written request for the amendment. Once the request has been submitted, the doctor must review the request to determine if the request should be granted. The doctor may deny the patient’s request if he/she determines that the information subject to the request:

1. Was not created by the doctor’s office, unless the individual provides a reasonable basis to believe that the originator of the medical record is no longer available to act on the requested information;
2. Would not be available to the patient for inspection (see HIPAA Privacy Rule §164.524 for exceptions to a patient’s right to access protected health information); or
3. Is accurate and complete.

Should the doctor deny the patient’s request for amendment, the doctor must provide the patient with a written explanation of the denial. The patient will then have the right to file a statement of disagreement or to request that the practice include the individual’s request for amendment and the denial letter with any future disclosures of the medical record subject to the request.

If the doctor agrees to amend the record, he/she should enter an addendum to the record stating the change was made at the request of the patient.

Changes to the medical records should not be made after the record has been copied and released, such as to an attorney. Any changes to a record after a copy has been released results in two versions of the record, the copy released without changes and the office records containing the changes. In the event of a lawsuit, suspicions of record alteration will be raised. Any hint of record tampering may completely shatter the credibility of the record and of the defendant and may lead to a plaintiff’s verdict, regardless of the medical facts or merit of the case.

NEVER alter a medical record. If it is determined that medical records have been changed without justification, the credibility of the entire record may be destroyed. Not only will record alteration severely damage the chances of prevailing in a lawsuit, but it may put professional liability coverage for the incident at risk.

The following actual case illustrates the risks of altering medical records.

The patient was a 21 year-old college student when she presented to the podiatric physician requesting post operative care. She had recently undergone surgery to repair a hallux fracture. The injury and subsequent surgical repair occurred when she was traveling out of the country. The podiatrist took x-rays which revealed a status post open reduction, internal fixation intra-articular hallux fracture with malunion, right foot. He removed the sutures, dispensed a surgical shoe, and recommended surgical revision.

Three months later, the podiatrist performed surgery on the right hallux. The procedures listed on the operative report were excision of buried internal Kirshner wires and modified McBride bunionectomy, right foot. The patient received post-operative care during the next six weeks. Then she returned to college and kept sporadic appointments thereafter. At an appointment four months after the surgery, she had complaints of pain involving the right hallux when she wore high-heeled shoes. The podiatrist diagnosed a malunion of the proximal phalanx from the previous fracture. She was advised not to wear high heels.
She returned again nine months later complaining of painful ambulation. The podiatrist noted pain beneath the right second metatarsal head and bilateral painful bony prominence lateral fifth metatarsal base and irritation at lateral fifth metatarsal head. Surgery was discussed, but the patient decided to wait until a longer break from school.

Surgery was performed later that year and consisted of bilateral tailor’s bunionectomies and exostectomy of hypertrophic bone base of the fifth metatarsal right foot. At four months post-op, the patient complained of inability to move her right fifth toe as well as residual deformity of the fifth metatarsal base. She also complained of right ankle instability. The podiatrist noted a fibrous scar over the fifth metatarsophalangeal area, lateral ankle instability, and peroneal tendinitis. He prescribed physical therapy and discussed the possibility of additional surgery.

The patient did not return to the podiatrist, and later sued him alleging:

• Deviation in performance of surgery;
• Lack of informed consent; and
• Fraudulent changing of the patient’s medical records. The discovery process yielded the following:
  • There were multiple discrepancies regarding the procedure(s) actually performed during the initial surgery by the podiatrist. The procedure on the consent form was listed as “surgical open removal of internal pin fixation with correction of fractured hallux, right foot.” The procedure listed on the operative report was “modified McBride bunionectomy, right foot and excision of buried internal Kirshner wires, right hallux.” However, the body of the operative report only described removal of the wires. The patient was billed for a bunion procedure, but post-operative x-rays indicated that no bunionectomy was actually performed.
  • During a deposition of the podiatrist, the patient’s attorney produced two “versions” of the patient’s medical records. There was a version that was given the patient prior to the lawsuit and later given by the patient to her attorney, and another version that was provided to the patient’s attorney and the defense team after litigation began. The podiatrist testified under oath that he must have made the changes the same day he saw the patient, but could not explain how he no longer had a copy of the changed record in his chart. He later admitted to altering the records.
  • A comparison of the two versions of the medical record was performed. The latest version of the patient’s medical record contained numerous pages that had been rewritten in their entirety and other pages that had additions, changes, or modifications.

Though a defense expert witness could support the surgery performed on the patient’s fifth metatarsals, the claim was rendered indefensible because the podiatrist’s credibility was seriously compromised when it was discovered he altered the patient’s records. The claim was resolved prior to trial.
Documentation Review Tool
(for paper and electronic medical records)

PICA is pleased to offer this Documentation Review Tool to our policyholders. The purpose of this tool is to enable you to take a close look at the documentation in your medical records and identify potential areas for improvement.

Please be as objective as possible when answering the questions. The questions are structured so that “No” answers should be addressed in the context of your particular office practice. If areas for improvement are identified, you are encouraged to take corrective action to improve your documentation.

If you should have any questions regarding this tool, please feel free to contact the PICA Risk Management Department at (800) 251-5727, ext. 2107.

DISCLAIMER
This assessment tool is meant to be utilized for risk management purposes. Nothing in this tool should be taken as establishing a standard of care in any locality. For federal, local or state laws, please consult a legal representative in your area. Completion of this tool does not guarantee compliance with federal or state laws/regulations or with accrediting bodies.
<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>1. Two patient identifiers are on each page of paper records;</td>
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<td>or for electronic records, on every page of printed, viewed,</td>
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<td>otherwise transmitted information.</td>
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<td>2. Patient address and contact information is confirmed/</td>
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<td>updated at each visit.</td>
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<td>3. Emergency contact information is present and current.</td>
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<td>4. Person(s) authorized by patient to receive protected health</td>
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<td>information, if any, is documented.</td>
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<td>5. The names and contact information of other physicians the patient is</td>
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<td>currently treating with (e.g., PCP, specialist) is present.</td>
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<td>6. For paper records, all elements of the medical record are</td>
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<td>secured in chart (e.g., no loose papers).</td>
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<td>7. The medical record is consistently organized so that documents are</td>
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<td>easy to find.</td>
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<td>8. All entries are authenticated, timed and dated by person</td>
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<td>making entry.</td>
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<td>9. All scanned documents are date-and time-stamped with the date</td>
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<td>scanned.</td>
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<td>10. All entries are legible and easily interpreted.</td>
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<td>11. Entries are in chronological order.</td>
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<td>12. All entries are specific for each patient and accurately</td>
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<td>describe each encounter.</td>
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<td>13. For paper records, all entries are made in black non-erasable ink.</td>
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<td>14. Patient’s primary language is noted.</td>
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<td>A. If other than English, the name of the interpreter is documented</td>
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<td>for each encounter.</td>
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<td>B. If patient is hearing impaired, the mode of communication is</td>
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<td>documented (e.g., interpreter, passing of notes, etc.).</td>
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<td>15. Health history form, completed by patient, is present.</td>
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<td>A. There is evidence of physician review of health history</td>
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<td>(e.g., initials, statement in progress notes).</td>
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<td>B. Health history is updated annually and/or as indicated based on</td>
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<td>changes in patient’s medical status.</td>
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<td>16. Allergy history is obtained at each visit.</td>
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<td>17. Allergies are noted prominently on record.</td>
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<td>18. Incoming medical reports (consultations, lab, radiology, etc.)</td>
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<td>are initialed and dated by physician prior to filing in chart or</td>
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<td>signed electronically.</td>
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<tr>
<td>ELEMENT</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>COMMENTS</td>
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<td>19. Communication of medical report results to the patient is</td>
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<td>documented.</td>
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<td>20. All telephone calls, electronic or other communications to/from</td>
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<td>patient are documented or placed in the patient's record.</td>
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<td>21. All telephone calls, electronic or other communications made or</td>
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<td>received on the patient’s behalf are documented or placed in the patient’s record.</td>
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<td>22. Documentation of telephone calls includes:</td>
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<td>A. Date and time of call.</td>
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<td>B. Clear indication of whether call was received or made</td>
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<td>(e.g., “call to” or “call received from”).</td>
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<td>C. Name of person physician or office staff member is speaking to.</td>
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<td>D. Name and title of staff member making/receiving call.</td>
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<td>E. Nature of call.</td>
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<td>F. Orders, instructions, information given.</td>
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<td>G. Appointment offered and/or scheduled, if indicated.</td>
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<td>23. After hours calls are documented.</td>
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<td>24. Calls received and/or made by covering physicians are documented.</td>
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<td>25. Telephone advice is reviewed and authorized by the physician</td>
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<td>(e.g., physician’s initials &amp; date).</td>
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<td>26. A medical problems list is maintained.</td>
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<td>A. The medical problems list is reviewed and updated during each visit.</td>
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<td>27. Medication orders include:</td>
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<td>A. Complete name of medication (no abbreviations).</td>
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<td>B. Amount.</td>
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<tr>
<td>C. Dosage.</td>
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<td>D. Duration.</td>
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<td>E. Purpose of medication.</td>
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<td>F. Instructions for use.</td>
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<td>28. Drug samples dispensed from the office are documented, including:</td>
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<td>A. Complete name of medication (no abbreviations).</td>
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<td>B. Amount.</td>
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<td>C. Dosage.</td>
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<td>D. Duration.</td>
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<td>E. Purpose of medication.</td>
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<td>F. Instructions for use.</td>
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<td>29. A medication flowsheet is present.</td>
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<tr>
<td>A. The flowsheet is updated at each patient visit.</td>
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<td>B. The flowsheet includes start/stop dates.</td>
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<td>30. Medication refills are documented.</td>
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<td>ELEMENT</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>COMMENTS</td>
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<td>31. Verbal orders are co-signed by physician.</td>
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<td>32. An initial history and physical performed by the physician is present, including:</td>
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<td>A. A review of systems.</td>
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<td>B. Chief complaint &amp; description of the development of the problem from onset to present.</td>
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<td>C. Lower extremity examination and current clinical condition.</td>
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<td>D. Objective findings (positive and negative).</td>
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<td>F. The presence or absence of functional limitations.</td>
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<td>G. Diagnosis/impression.</td>
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<tr>
<td>I. Treatment administered and anticipated frequency/duration of treatment.</td>
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<td>J. Treatment results.</td>
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<td>K. Prognosis.</td>
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<tr>
<td>L. Medication/lab/diagnostic testing/consultations/therapy ordered.</td>
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<td>M. Whether or not any special procedures are anticipated.</td>
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<tr>
<td>N. Education provided.</td>
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<td>O. Instructions for follow-up.</td>
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<td>33. A progress note is present for each office visit.</td>
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<tr>
<td>34. Progress note documentation includes:</td>
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<td>A. Reason for visit.</td>
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<tr>
<td>B. Patient concerns.</td>
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<tr>
<td>C. Description of examination.</td>
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<td>D. Clinical findings (positive and negative).</td>
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<td>E. Description and measurement of wounds/lesions.</td>
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<td>F. Working diagnosis.</td>
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<td>G. Treatment rendered.</td>
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<td>I. Evidence of patient compliance or non-compliance.</td>
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<td>J. Instructions given.</td>
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<td>K. Date patient is to return.</td>
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<td>35. Patient education is documented, including:</td>
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<td>A. Education or instructions given.</td>
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<td>B. Patient comprehension of instructions.</td>
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<td>C. Patient’s (and/or caregiver’s) questions and answers provided.</td>
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<td>D. Titles of printed, audiovisual or other educational materials given or viewed.</td>
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<td>ELEMENT</td>
<td>YES</td>
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<td>N/A</td>
<td>COMMENTS</td>
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<td>36. Documentation of procedures/surgery performed in the office includes:</td>
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<td>A. Preoperative assessment, including the pre-op diagnosis, rationale for surgery, and if indicated, surgical clearance by appropriate medical specialist.</td>
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<td>B. Completed informed consent form signed and dated by patient prior to the date of surgery.</td>
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<td>C. Verification of patient identification, procedure, and site of procedure prior to performance of procedure.</td>
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<td>D. Appropriate patient assessment and monitoring.</td>
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<td>E. Anesthetics and/or medication administered, including name, dose and route.</td>
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<td>F. Patients vital signs prior to, during (as appropriate according to the type of anesthesia/analgesia/sedation administered) and immediately following the surgery.</td>
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<td>G. Surgical assistants or others present during procedure.</td>
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<td>H. Description of the procedure.</td>
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<td>I. Placement of drains, hardware, implants, etc.</td>
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<td>J. Operative report, if applicable.</td>
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<td>K. Identification of any specimens or tissue collected and their disposition.</td>
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<td>L. Type of dressing applied.</td>
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<td>M. Time procedure began and ended.</td>
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<td>N. Patient condition at discharge.</td>
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<td>O. Copy of written discharge instructions.</td>
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<td>P. Name of person accompanying patient, if applicable.</td>
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<td>37. Informed consent discussion is documented by physician performing treatment/procedure and includes:</td>
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<td>A. Diagnosis, proposed treatment/procedure and prognosis.</td>
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<td>B. Risks and complications.</td>
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<td>C. Benefits.</td>
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<td>D. Alternatives to treatment/procedure.</td>
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<td>E. Opportunities for questions.</td>
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<td>F. Expected outcomes/results.</td>
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<td>G. Consequences if refused or not treated.</td>
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<td>38. Informed consent form is signed and dated by patient.</td>
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<td>39. Informed refusal (including the risks of refusal) is documented by physician in the event patient refuses recommended tests/procedures/referrals.</td>
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<td>A. Informed refusal form is signed and dated by patient.</td>
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<td>40. Missed/cancelled appointments are documented.</td>
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<td>A. Evidence of physician review (e.g., initials and date, note in record) of missed/cancelled appointments.</td>
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<td>B. Attempts to follow-up missed/cancelled appointments are documented.</td>
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</table>
### Documentation Review Tool

*If the response for any component is not Yes or No, please explain in the comments section or check N/A.*

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>41. Office visit notes are entered in the patient record or reports are dictated at the time of the visit.</td>
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<td>42. EMR template notes are reviewed prior to authentication to ensure the documentation is tailored to the individual patient and reflects a true and accurate picture of the patient’s condition and the services performed at that visit. A. Extraneous information not associated with the reason for the visit, plan of treatment, the individual patient or services actually performed at the time of the visit are deleted from template notes prior to authentication.</td>
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<td>43. Dictated reports are transcribed and filed within 48-72 hours of the visit.</td>
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<td>44. There is evidence of physician review of transcribed reports (e.g., initials and date) prior to filing in medical record.</td>
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<td>45. Only standard abbreviations (in accordance with office policy) are used.</td>
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<td>46. Error corrections are made according to office policy.</td>
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