RECORD KEEPING WORKSHEET

**Reference – Standard of Practice S-002: Record Keeping, S-022: Ownership, Storage, Security and Destruction of Patient Health Records, Guideline G-013: Chiropractic Assessments; Guideline G-014: Delegation, Assignment and Referral of Care*

Member Assessed **Assessor**

	Always	Usually	Sometimes	Never	Comments
EQUIPMENT MAINTENANCE AND SAFETY					
1. Member ensures that all equipment (e.g., x-ray, ultrasound, interferential current) and adjusting tables are hygienic, in safe working order, and properly serviced	☐	☐	☐	☐	
DAILY APPOINTMENT RECORD					
2. Member maintains a daily appointment record that sets out the surname and initials of each patient the member examines or treats or to whom member renders any service	☐	☐	☐	☐	

Legend: ✓ = yes X = no N/A = does not apply to the file reviewed

PATIENT HEALTH RECORD

	1	2	3	4	5	6	7	8	9	10	Comments
3. Member maintains a patient health record for each patient which includes:											
(1) patient's name											
(2) patient's address											
(3) patient's birth date											
(4) patient's gender											
(5) date of each of patient's visits to member											
(6) name of treating chiropractor											
(7) address of treating chiropractor											
(8) names of primary care practitioners and the referring health profession (when applicable)											
(9) history of patient, including:											
(a) patient's chief complaint(s), reasons or goals for care											
(b) supporting data											
(c) relevant past health history											
(d) family and social history when indicated by presenting condition(s)											

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	1	2	3	4	5	6	7	8	9	10	Comments
4. A record of consent to examination											
5. Reasonable information about every examination performed by member sufficient to inform the diagnosis/differential diagnosis											
6. Reasonable information about every x-ray examination performed by member or from an outside facility											
7. Reasonable information made by member re:											
(1) every clinical finding of all tests conducted											
(2) diagnosis or clinical impression[1]											
(3) assessment											
8. Copy of every written consent to care or a plan of care[2] and, if appropriate, orthotics and/or acupuncture that are up-to-date and reflective of the patient's current condition and presentation											
9. Reasonable information about who provided the care and location of where the care was delivered											

[1] If a patient file is missing a diagnosis, it is a deficiency, and both ***Communicating a Diagnosis*** and ***Record Keeping*** should be noted as "Deficient" on the Peer Assessor Report Form.
[2] If a patient file is missing a consent form (either not in the file or not signed by the patient), it is a deficiency, and both ***Consent*** and ***Record Keeping*** should be noted as "Deficient" on the Peer Assessor Report Form.

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	1	2	3	4	5	6	7	8	9	10	Comments
10. Record of therapeutic management/care of patient that includes:											
(1) reasonable information about every order made by member for examinations, including *x-ray examinations*, *other diagnostic imaging*, *tests*, *consultations*, and *treatments*, to be performed by any other person											
(a) *x-ray examinations*											
(b) *other diagnostic imaging*											
(c) *tests*											
(d) *consultations*											
(e) *treatments*											
(2) every written report received by member which was performed by other health professionals related to:											
(a) *examinations*											
(b) *other diagnostic imaging*											
(c) *tests*											
(d) *consultations*											
(e) *treatments*											
11. Reasonable information about all advice given by member to patient in written form (e.g. prognosis, plan of management,											

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	1	2	3	4	5	6	7	8	9	10	Comments
expected outcomes of care)											
12. Reasonable information about care or plan of care involving the controlled acts authorized to chiropractors:											
(1) communicating a diagnosis or clinical impression[3] including appropriate language sufficient to describe the type, location, chronicity and other relevant elements of the diagnosis											
(2) moving the joints of the spine including level of spine contacted and specific type of adjustment or treatment delivered											
(3) putting a finger beyond the anal verge for the purpose of manipulating the tailbone											
13. Reasonable information about a procedure that was commenced but not completed, including reasons for non-completion											
14. Reasonable information about every comparative assessment that includes evidence of the performance of three or more analytical assessment tools relevant to the patient's case as well as any revisions/updates to diagnosis, care/plan of care, and											

[3] If a patient file is missing a diagnosis, it is a deficiency, and both ***Communicating a Diagnosis*** and ***Record Keeping*** should be noted as "Deficient" on the Peer Assessor Report Form.

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	1	2	3	4	5	6	7	8	9	10	Comments
informed consent											
15. Every part of a patient health record has a reference identifying the patient											
16. Every entry in a patient health record includes:											
(1) date											
(2) the person who made the entry can be identified											
17. Member maintains *every patient health record*, *every financial record* and *every x-ray* for at least seven years following the patient's visit; or, if the patient is younger than 18 years old at the time of his/her last visit, the day the patient became or would have become 18 years old											
(1) *every patient health record*											
(2) *every financial record*											
(3) *every x-ray*											

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FINANCIAL RECORD

18. MEMBER MAINTAINS A FINANCIAL RECORD FOR EACH PATIENT THAT INCLUDES:		**Y**	**N**	
(1)	Date of service	☐	☐	_____
(2)	Services billed	☐	☐	_____
				_____
(3)	Location of service	☐	☐	
(4)	Payment received	☐	☐	_____
(5)	Balance of account	☐	☐	_____

(6) Financial Information is kept (circle one):

a) Electronically

b) Paper version

c) Both

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DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Refer to Standard of Practice S-001: Chiropractic Scope of Practice

	Training/Proficiency	Consent[4]		Comments
		General	Specific	
19. Member uses the following diagnostic and therapeutic procedures:				
1.		☐	☐	
2.		☐	☐	
3.		☐	☐	
4.		☐	☐	
5.		☐	☐	
6.		☐	☐	
7.		☐	☐	
8.		☐	☐	
9.		☐	☐	
10.		☐	☐	

[4] Indicate if member uses a general consent form or a separate, technique-specific consent form.

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