General Patient Chart Audit Form

There are many ways an audit can be performed, however one suggested method is to randomly select ten active patient charts with at least 3-5 prior visits - the most recent visit should have taken place within the past 6-12 months. For each item place an 'X' in the appropriate box when answering the questions. Use "N/A" to score items that do not apply to a given chart. Perform audits periodically and compare previous audit forms to monitor improvement.

Audit Category	YES	NO	N/A
Are standard abbreviations and symbols used?			
If standard abbreviations are not used, is a legend of the non-standard abbreviations and symbols included with each patient's chart?			
Is each entry signed or initialed by the treating doctor of chiropractic?			
If an assistant or other professional performs any of the services, is that indicated in the note and signed or initialed by that person?			
Is the patient's name and date of birth on every page for identification and authentication purposes?			
If notes are handwritten, are they legible and indelible?			
Are the notes in chronological order?			
Are any corrections to notes made appropriately?			
Are there notes for every patient encounter?			
For services (including CMT, therapeutic procedures, and therapeutic modalities) rendered, does the note include the following:			
Is there rationale for performing each service?			
Is the type of service (and any settings, etc. associated with that service) documented?			
Are the specific body regions or areas that treatment was rendered to shown in the medical record?			
Is the length of time of the service (if required by CPT) recorded?			
Does the level of CMT billed match the number of spinal levels treated with a diagnosis indicated for each?			
If manual therapy was performed on the same visit as CMT, and billed, was the manual therapy performed in a separate region from the CMT and documented as such? Was the -59 modifier used?			
Is the diagnosis(es) and/or assessment listed or referenced for each date of service?			
Is a care plan recorded or referenced for each date of service?			

Does the treatment plan include the expected duration and frequency of visits?			
Does the treatment plan include specific, objective measurable treatment goals?			
Are objective findings including diagnostic testing results (including those received from outside sources) referenced appropriately?			
Was informed consent obtained and documented in the chart?			
Is all of the necessary demographic information for the patient captured?			
Does the documentation support the level of evaluation and management service that was billed?			
If patient information was sent to another provider, is the accounting of the release of records properly documented in the chart?			
If non-covered services were performed, is there a properly executed and signed waiver present?			
TOTAL			

The above Audit Tool can be scored by simply adding the number of items answered YES and NO and divide the number of YES entries by the total number of items answered Yes or NO to arrive at a percentage of affirmative items. Doctors should retain audit results and seek to attain a score of 100% for each chart and make modifications in documentation procedures until that score is reached. The Assessment Chart below can be used for scoring.

Assessment

Category	Description	Values
YES	'Y'	
NO	'N'	
Total = Y + N	Number of Answers	
Percentage	Y/Number of Answers x 100	_____%