MEDICAL RECORDS CHECKLIST
To monitor compliance with approved policies for documentation, storage and maintenance of patient records.

<table>
<thead>
<tr>
<th>Monitor's Name</th>
<th>Patient Identification</th>
<th>Date</th>
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All records are filed according to approved procedure and are easily retrievable.

1. Patient medical records are maintained by unit system in alphabetical order. **Yes** **No**
2. Patient's year of surgery is displayed on medical record cover for identification **Yes** **No**

All documentation and signatures are legible.

1. Signatures match signature and initial index. **Yes** **No**
2. Where written words are not legible, the word is printed and initialed by writer. **Yes** **No**
3. Documentation consistently not legible is reported to the Quality Management Committee. **Yes** **No**

Errors are properly corrected.

1. Erasures and white-out are not used and errors are not “scribbled” over. **Yes** **No**
2. Corrected words to be corrected are struck through with one line, leaving original word legible and labeled according to policy; correction is documented and initialed. **Yes** **No**

Patient information is dictated and transcribed in a timely manner.

1. Operative reports are dictated immediately after surgery in accordance with policy and Medical Staff Bylaws. **Yes** **No**
2. Reports are transcribed, proofread for errors, and presented for signature 24 hours or less following dictation. **Yes** **No**

Forms with pertinent information are in the patient’s medical record.

1. Informed consent records are properly signed, dated, and witnessed. **Yes** **No**
2. Orders are signed, verbal orders signed and countersigned. **Yes** **No**
3. History includes chief complaint, present illness, past medical history, pertinent social history, and pertinent family history. **Yes** **No**
4. Physical exam complete and signed. **Yes** **No**
5. Pre-anesthesia assessment documented and signed by a physician. **Yes** **No**
6. Results of ordered diagnostic and assessment tests are documented. **Yes** **No**
7. Medication, treatment, and procedures administered under physician orders. **Yes** **No**
8. Consults are documented and signed. **Yes** **No**
9. Anesthesia record documents agents used and mode of administration. **Yes** **No**
10. Intra-operative record is complete, signed, and includes pre- and post-operative diagnosis. **Yes** **No**
11. Infection classification is documented. **Yes** **No**
12. Post-operative notes and discharge information complete and signed. **Yes** **No**
13. Post-operative instructions are signed and copy remains in the medical record. **Yes** **No**

Medical Records Checklist (1 of 2)
| 14. | Post-operative, follow-up call is documented and signed. | Yes | No |
| 15. | Discharge summary documented or dictation date noted. | Yes | No |
| 16. | Operative report documented and signed or dictation date noted. | Yes | No |
| 17. | Tissue reports documented and signed (if tissue sent). | Yes | No |

**Incomplete medical records are monitored according to policy.**

| 1. | Incomplete medical records are filed separately from complete records with the same security measures. | Yes | No |
| 2. | Incomplete medical records are reviewed at least bi-weekly and appropriate measures are implemented to complete the record. | Yes | No |