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SELF EVALUATION
ASSESS YOUR OWN MEDICAL RECORDS

Consistently	Needs Improvement	N/A	Medical Record-Keeping Activity
			My record keeping system allows for ready retrieval of an individual patient file.
			My records are legible.
			The patient's identity is clearly evident on each component of the file.
			Each patient file clearly shows full name, address, date of birth, gender.
			The date of each visit or consultation is recorded.
			The family history, functional inquiry and past history (including significant negative observations) is recorded and maintained.
			Allergies are clearly documented.
			Dates of immunization (if relevant) are clearly visible.
			A "cumulative patient profile" (summary sheet) relating to each patient is present and is fully maintained.
			The chief complaint is clearly stated.
			The duration of symptoms is noted.
			An adequate description of the symptoms is present.
			Positive physical findings are recorded.
			Significant negative physical findings are recorded.
			Requests for laboratory tests, xrays, and other investigations are documented.
			Requests for consultations are documented.
			The diagnosis or provisional diagnosis is recorded.
			The treatment plan and/or treatment is recorded.
			Doses and duration of prescribed medications are noted.
			Progress notes relating to the management in the office of patients suffering from chronic conditions are made.
			Pathology reports are retained
			Hospital discharge summaries are retained.
			Operative notes are retained.
			Phone calls are documented.
			I use flow sheets for certain chronic conditions such as diabetes mellitus and anticoagulant therapy.
			There is documented evidence that health maintenance is periodically discussed (topics such as smoking, alcohol consumption, obesity, lifestyle, etc.)
			There is evidence that I periodically review the list of medications being taken by patients suffering from multiple chronic conditions.
			There is a system in place to clearly show that abnormal test results come to my attention. For example, reports initialed.
			There is documented evidence that appropriate follow up has taken place following receipt of such abnormal test results.
			In the event that more than one physician is making entries in the patient file, each physician is identifiable.
			Pediatric growth charts are used.
			Manitoba antenatal forms are used.

***** This document was derived from the College of Physicians and Surgeons of Ontario's Self Evaluation Form.**