PATIENT RECORD STANDARDS

Date adopted: October 25, 2019
Last updated: October 25, 2019

It is the position of the Board that patient records should be constructed containing these minimum standards which apply to all phases of care:

- All patient information must be recorded in the patient record, along with pertinent clinical information for each encounter. A description of past conditions and trauma, past treatment received, current treatment being received from other health care providers, and a description of the patient's current condition including onset and description of trauma if trauma occurred. Documentation that family history has been evaluated.

- Each page of the record must include the name of the patient and provider/facility. Daily notes documenting current subjective complaints as described by the patient, any change in objective findings if noted during that visit, a listing of all procedures provided during that visit, and all information that is exchanged and will affect that patient's treatment. A description by the chiropractor each time an incident occurs that results in an aggravation of the patient's condition or a new developing condition.

- All tests, procedures, modalities, and other professional services performed must be documented. Examinations performed to determine a preliminary or final diagnosis based on indicated diagnostic tests, with a record of findings of each test performed. Results of reexaminations that are performed to evaluate significant changes in a patient's condition, including tests that were positive or deviated from results used to indicate normal findings.

- Clinical findings and rationale for decision making and necessity of care must be documented. A diagnosis supported by documented subjective and objective findings, or clearly qualified as an opinion. A treatment plan that describes the procedures and treatment used for the conditions identified, including approximate frequency of care.

- If hand-written, records should be legible and indelible. When symbols or abbreviations are used, a key that explains their meanings must accompany each file when requested in writing by the patient or a third party.

- Entries must be contemporaneous, and errors should be corrected with an addendum/amendment.

- Records should be chronologically organized.

- Records must be accessible to the patient or guardian in a timely fashion.