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PATIENT RECORD SELECTION INSTRUCTIONS AND GUIDELINES

Internal Medicine

Peer assessment (PA) instructions

The PA aims to identify opportunities to enhance your medical record keeping and also facilitate a discussion with your assessor about clinical care. Comprehensive and complete medical records will ensure that a physician unfamiliar with your practice (or a given patient) can easily and effectively provide appropriate care. This applies to all physicians (including locum and part-time) and to all settings, including walk-in and multi-

prescribing profile for review as part of the peer assessment process. We recommend you also review the College's practice standard *Medical Records Documentation* and the PPEP assessment standard *Medical Record for the Internist in a Community-based Office Setting* on the College website.

Guidelines

1. Chart selection is key

The charts you select should be representative of your practice. Your charts should clearly demonstrate:

completeness in consultations

completeness in documentation of follow-up medical encounters

how you have contributed to the longitudinal and preventative care of the patient.

2. Ensure you have all the components of a complete chart

Refer to the PPEP assessment standard *Medical Record for the Internist in a Community-based Office Setting* for a full description of expectations for the medical record including consultation report, encounter notes, and CPP.

Each of the 10 charts should include:

consultation report – the consultation report should indicate:

- patient demographics
- chief complaint/reason for referral
- history of presenting illness with evidence (pertinent positive and negatives) to determine diagnosis(es)
- current medications and doses
- allergies (or lack thereof)
- past medical and surgical history
- family history
- personal and social history
- substance use history and current use (or lack thereof)
- diagnostic conclusions
- treatments or interventions initiated
- recommendations for follow-up by the referring physicians
- referrals to continuing care consultant or other consultants
- advice or next steps provided to patient

descriptions of all patient visits – progress notes should explain why the patient came to the office, what was found (developments since last visit, response to therapy), what was done, and why

a complete, up-to-date problem list

a complete, up-to-date medication list

an up-to-date record of allergies (of lack thereof)

investigations ordered by, requested by, or copied to the physician