

There is no one-size-fits-all definition of the legal record for patient charts because laws and regulations governing the content vary by practice setting and by state. However, there are common principles that should be followed in practice.

The following has been compiled by the OBNM to assist you with patient charting.

Patient charts must meet the following:

1. All pages in a patient's chart must contain physician identification, patient name or identification number, date, and page number.
2. A completed initial intake form must be in each patient chart. New patient information must contain date of visit, current name, previous names used, date of birth, sex, presenting problem (why are they visiting the doctor's office), health history, allergies, medications currently taking and contact information.
3. All entries must be legible, signed and dated.
4. Entries may be created by manual (using permanent ink), mechanical, or electronic means, and must be chronological in order with a signature after each entry.
5. Entries made by persons other than the ND must be signed by the person making the entry, and then co-signed by the ND.
6. Errors and corrections must be made by drawing a single line through the entry so it can easily be read, with corrections made next to the entry, initialed and dated.
7. Each visit must be entered in the patient's chart and must consistently reflect the format chosen by the ND to record time spent at the visit, an evaluation, planning and follow-up intervals. Documentation of each visit must reflect the SOAP format, or other format of the practitioners choosing, which includes all pertinent information to support patient care. Telephone and written communications, including electronic communications, must be kept as part of the patient chart.
8. A completed consent to treatment/informed consent form signed by patient (or guardian) must be kept in the patient chart.
9. Lack of compliance/cooperation from the patient and specific concerns of the ND must be documented in the patient's chart.
10. All prescribed medications, including OTC, as well as dose and duration must be documented. All recommendations and referrals must also be documented.
11. Return visits recommended to the patient must be documented.

You may want to put this in a handy place for reference.