MEDICAL RECORD REVIEW TOOL

HOSPITAL NAME :	<print name of hospital here>	Date Of Review :	<reviewer enters date of review here>

STD	DOCUMENTATION REQUIREMENT	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL Y/N	
		#			#			#			#			#				
		DX:			DX:			DX:			DX:			DX:				
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N
CONSENTS																		
PFR.6.3	General consent																	
PFR.6.4	Surgical or Invasive Procedures Consent																	
	Anaesthesia and Moderate and Deep Sedation Consent																	
	Blood and Blood Products Consent																	
	High risk Procedures and Treatments Consent																	
ASC. 5.1	Risks, benefits and alternatives of anaesthesia																	
ASC.7.1	Risks, benefits, potential complications and alternatives of surgery																	
PFR.8	Clinical research, investigation, and trials consent																	
ASSESSMENTS																		
AOP.1.4.1	Medical assessment in 24 hours. Updates if less than 30 days old Nursing assessment in 24 hours																	
AOP.1.5	Assessment findings are documented within 24 hours of admission (Medical & Nursing)																	
AOP.1.5.1	Medical assessment documented prior to surgery																	
AOP.1.6	Nutritional and functional screening																	
AOP.1.11	Early screening for discharge planning																	
AOP.1.7	Screening for pain on admission																	
AOP.2	Physician reassessment daily for acute patients																	
PFE.2	Education needs assessment																	

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		#			#			#			#			#				
		DX:			DX:			DX:			DX:			DX:				
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N
ASC.3	Pre-sedation assessment																	
ASC.4	Pre-anaesthesia assessment																	
OTHER																		
ASC.5	Anaesthesia Plan																	
ASC.7.2	Written Surgical Report – Description of the surgical procedures, findings, and any surgical specimens – A postoperative diagnosis – The names of the surgeon and surgical assistants – Available before the patient leaves the post-anaesthesia recovery area																	
ASC.6	Arrival and discharge times for post anaesthesia care																	
MMU.4	List of current medication taken prior to admission																	
MMU.4.3	Medication prescribed or ordered and administered are recorded																	
PFE.2.1	Assessment includes: – The patient's and family's beliefs and values; – Their literacy, educational level, and language; – Emotional barriers and motivations; – Physical and cognitive limitations; and – The patient's willingness to receive information																	
MCI.19.3	The author, date and time (When required) of every entry																	

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		#			#			#			#			#				
		DX:			DX:			DX:			DX:			DX:				
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N
ACC.3.2	Discharge Summary Contains: – Reason for admission – Significant physical and other findings – Significant diagnoses and co-morbidities – Diagnostic and therapeutic procedures performed – Significant medications and other treatments – The patient's condition at the time of discharge – Discharge medications, all of the medications to be taken at home – Follow-up instructions																	
ACC.4.4	Transferred Patients: – Name of the health care organisation and the individual agreeing to receive the patient – The reason(s) for transfer – Any special conditions related to transfer – Any change of patient condition or status during transfer																	

REMARKS:	

NAME OF REVIEWER:			SIGNATURE OF REVIEWER:	