



Use this documentation prompter as a supplement to your standard medical record documentation. Documenting these key elements, when appropriate:

1. aids the physician in organizing his or her thoughts
2. enhances the quality of patient care
3. provides diagnosis and procedure information needed to bill and receive reimbursement
4. provides necessary information needed by third party payers to justify services billed
5. may mitigate the effects of litigation

*All documentation must be legible.*

#### *HISTORY*

**Chief** complaint, present illness  
**Significant** medical/surgical history (existing comorbid conditions, current medications, allergies)  
**Review** of systems  
**Substantiation** for admission vs. outpatient observation/care  
**Failed** outpatient therapy  
**Relation** between current and previous recent admission(s)

#### *PHYSICAL*

**Vital** signs and physical findings (comment on abnormal)  
**Patient** distress, acuteness/severity of illness  
**Patient** frailty/dependency/mental status

#### *TREATMENT PLAN*

**Provisional** diagnosis  
**Treatment** plan and treatment limitations, if applicable (e.g., patient/family requests limited services)

#### *INVASIVE PROCEDURES*

**Rationale** for invasive procedures  
**Informed** consent (if applicable)  
**Patient's** medical clearance for surgery  
**Complete** anesthesia record  
**Complete** operative notes  
**Postanesthesia** recovery notes

#### *ORDERS*

**Admission** status (when admitted from observation/outpatient with date/time)  
**Physician(s)** responsible for patient care/management (e.g., Dr. Doe responsible for surgical care/mgmt.)

#### *PROGRESS NOTES*

**Status** of unresolved problems  
**Major** changes in condition and treatment plan  
**Untoward** events and outcome  
**Abnormal** lab/x-ray/other diagnostic results with comment and appropriate follow-up  
**Contradictory** observations from allied health professionals

#### *DISCHARGE SUMMARY*

**Principal** diagnosis  
**Secondary** diagnoses that affected the hospitalization and/or were treated and/or evaluated during the admission  
**Principal** and secondary procedures  
**Abnormal** and unavailable lab/x-ray/other diagnostic reports with comment and plans for appropriate follow-up  
**Patient's** level of functioning and medical stability (if not fully stable, indicate why discharge appropriate)  
**Special** problems (e.g., discharge AMA, patient request for limited services, etc.)  
**Discharge** instructions (e.g., activity, diet, medications, wound care, caregiver arrangements, patient acknowledgement of discharge instructions, etc.)  
**Follow-up** visits for patient medical management (when and by whom)

#### *ADDENDUM*

**Abnormal** findings returned post-discharge (comments/treatment plan)

**Medical record components should always be completed on time and according to certifying/accrediting guidelines.**