Guidelines for Naturopathic Clinical Records Scoring Tool

PART I: IDENTIFICATION PARAMETERS

Points	Patient Name
2	Patient name is on every page of the file.
1	Patient name is on most pages of the file.
0	Patient name is not or rarely noted in the file.

	Patient DOB or Unique ID#
2	Patient DOB or unique ID# is on every page of the file.
1	Patient DOB or unique ID# is on most pages of the file.
0	Patient DOB or unique ID# is not or rarely noted in the file.

	Provider Name
2	Provider's name (not clinic name) is on every page of the file.
1	Provider's name (not clinic name) is on most pages of the file.
0	Provider's name (not clinic name) is not or rarely noted in the file.

	Provider Address
2	Provider's address is on every page of the file.
1	Provider's address is on most pages of the file.
0	Provider's address is not or rarely noted in the file.

	Provider Phone Number
2	Provider's phone number is on every page of the file.
1	Provider's phone number present on some pages of the file.
0	Provider's phone number not present on any pages of the file

	Date of Visit
2	The date is noted every time there is an entry in the chart.
0	There are one or more entries in the chart that are not dated.

	Signed/Initials
3	The author of record is legibly identified, and the chart note is signed by hand or digitally or initialed at the end of each date of service.
2	The author of record is legibly identified, and the chart note is signed by hand or digitally or initialed at the end of every page.
1	The author of record is not legibly identified, and the chart note is signed or initialed at the end of each date of service or page.
0	The author of records does not sign their chart notes.

PART II: INITIAL EVALUATION

Patient Chief Complaint(s)

	Problem(s)
2	There is a complete history for all chief complaints.
1	There is a complete history for some chief complaints.
0	History of chief complaint(s) is not present.

	Onset of Problem(s)
2	The onset/duration of symptoms is present for all chief complaints.
1	The onset/duration of symptoms is present for some chief complaints.
0	Onset/duration is not listed for any chief complaints.

	History of chief complaint(s)
2	Chief complaint(s) is listed, and history is complete.
1	Chief complaint(s) is listed, but incomplete.
0	Chief complaint(s) is not identified.

	Symptoms experienced
4	Symptoms for all chief complaints are listed with modalities (provocation, palliation, etc.)
3	Symptoms of all chief complaints are noted without listing of modalities.
2	Symptoms of some chief complaints are listed with modalities.
1	Symptoms of some chief complaints are listed without modalities.
0	Symptoms are not listed.

	Associated symptoms
2	Associated symptoms are noted for all chief complaints.
1	Associated symptoms are noted for some chief complaints.
0	Associated symptoms are not noted.

	Severity and degree of debilitation
2	Severity and degree of debilitation is listed for all chief complaints.
1	Severity and degree of debilitation is listed for some chief complaints.
0	Severity and degree of debilitation is not listed for any chief complaints.

	Review of systems (ROS)
4	ROS is complete.
1-3	ROS is partially complete.
0	ROS is absent.

	Relevant family history
2	Family history is complete.
1	Family history is incomplete.
0	There is no family history.

	Current medications/supplements
2	Rx and Nx are noted.
0	Rx and Nx not noted.

	Relevant Past Medical History (PMH)
2	PMH is noted.
0	PMH is not noted.

	Secondary complaints, history, modalities, etc.
4	Complete documentation of secondary complaints is noted.
3-0	Less than complete documentation of secondary complaints is noted.

Preventative Health

The chart documents for preventive health (PH) factors in the patient-completed forms, the clinical history, and examination or in some other way. One point for each.

1	Smoking Status
1	Exercise Status

Objective Findings

	Vitals
3	All vital signs are documented.
2	Most vital signs are documented.
1	Some vital signs are documented.
0	Vital signs are not taken/documented.

Pertinent Physical Exam Performed

	Pertinent Physical Examination (when appropriate)/ Physical Examination is Appropriate to chief complaint(s)
4	Physical examination performed is appropriate and complete.
3	Physical examination is appropriate but incomplete.
2	Physical examination is incomplete and less than appropriate.
1	Physical examination performed is inappropriate and incomplete.
0	Physical examination is not performed.

	Appropriate to secondary complaint(s)
2	Physical examination is appropriate and complete.
1	Physical examination is appropriate but incomplete.
0	Physical examination is not performed.

	Documentation of findings
2	Physical examination findings are legible and understandable.
1	Physical examination is listed but difficult to interpret.
0	Physical examination findings are not documented.

	Mental/Emotional Assessment
2	Mental/emotional assessment is made and is clearly documented.
1	Mental/emotional assessment is documented but unclear.
0	Mental/emotional assessment is not documented.

	Relevant labs and diagnostic evaluation
2	Relevant labs and diagnostic evaluation were performed and clearly documented.
1	Relevant labs and diagnostic evaluation were performed but documentation is unclear.
0	Relevant labs and diagnostic evaluation were not performed.

Diagnosis

	Initial Diagnosis (Diagnoses) and assessment
3	Diagnosis and assessment are present and clearly documented.
2	Diagnosis and assessment are present but vague and poorly documented.
1	Diagnosis and assessment are vague and do not appear to comply with symptoms, history and PE.
0	Diagnosis/assessment is not documented.

	Indications for laboratory assessment and/or x-ray (if applicable)
2	Indications for possible labs and/or x-rays are clear and well documented.
1	Indications for possible labs and/or x-rays are poorly documented.
0	No indications are documented.

Treatment Modalities & Procedures (done in house the day of the visit, if applicable)

	Treatment appropriate to subjective and objective findings
2	Treatment plan listed is relevant to the chief and secondary complaints
1	Treatment plan is partially relevant to the chief and secondary complaints.
0	Treatment plan is not relevant to chief and secondary complaints.

	Modalities and procedures appropriately documented
2	Modalities and procedures are well documented and complete.
1	Modalities and procedure are poorly documented or incomplete.
0	Modalities and procedures are not documented.

Treatment Plan Documentation

	Medicines: type, dosage and frequency prescribed
2	Type of medication, dosage, and frequency consistently listed.
1	Type if medication, dosage and frequency not consistently listed.
0	Medications listed without dosages, frequency.

	Exercise, PT, and diet recommendations
2	Prescriptions for exercise, PT and diet listed clearly.
1	Prescriptions for exercise, PT and diet listed, but not clearly.
0	Prescriptions for exercise, PT and diet not listed.

	Patient "Homework" prescribed
2	Homework (diet diaries, etc.) listed in notes clearly.
1	Homework referred to but not clearly.
0	No homework assignments listed.

	Counseling performed
2	Counseling performed at visit clearly indicated.
1	Counseling performed at visit poorly documented.
0	No counseling notes present in chart.

	Patient instructions
2	There is a copy of a patient instructions sheet included in the notes.
1	There are comments that patient instruction has been given.
0	There are no patient instructions noted.

	Informed Consent (PARQ)
4	The elements of informed consent are present (PARQ). One point for each. "PARQ" is acceptable. PARQ consent form with all 4 elements is preferred. P=Procedures, A=Alternatives, R=Risks, Q=Questions

PART III: DAILY VISIT NOTES

Daily visit notes need to be encounter specific for each date of service and contain both qualitative and quantitative elements evident for the subjective and objective portions of the documentation. EMR generated documentation is commonly identical to the letter, comma and space, with only minor word changes; therefore it does not reflect medical necessity. Daily visit notes submitted with repetitive entries lacking encounter specific information will cause the entire clinical record to fail this review process.

S.O.A.P.

Subjective

	Interim History
2	Interim history is well documented.
1	Interim history is poorly documented.
0	Interim history is not documented.
	Response to treatment and compliance is well documented
2	Response and compliance is well documented.
1	Response and compliance is poorly documented.
0	Response and compliance is not documented.

Objective

	Examination/Evaluation findings (if appropriate)
4	Appropriate physical examination/evaluation performed and completely documented.
3	Appropriate physical examination/evaluation performed and poorly documented.
2	Inadequate examination/evaluation performed but well documented.
1	Inadequate examination/evaluation and documentation.
0	No examination/evaluation documented.

	Mental/Emotional Assessment
2	Mental/emotional assessment performed and well documented.
1	Mental/emotional examination performed but documentation unclear.
0	No mental/emotional evaluation noted.

Assessment

	Assessment of response to treatment
4	Response to treatment detailed, complete, and well documented.
3	Response to treatment noted, not detailed, or well documented.
2	Response to treatment noted, not well detailed or well documented.
1	Response to treatment noted, without detail (i.e. "doing well")
0	No response to treatment noted.

	New diagnosis/diagnoses (if appropriate)
2	New diagnosis (diagnoses) documented in detail.
1	New diagnosis (diagnoses) mentioned, but not in detail.
0	New diagnosis (diagnoses) listed but not followed up.

Plan/Prognosis

	Treatment Plan modifications/additions/ dosages/frequency of medications
2	Changes in medications documented and explained.
1	Changes in medications documented but not explained.
0	Changes in medications not documented.

	Dietary modifications
2	Dietary modifications documented and explained.
1	Dietary modifications documented, but not explained.
0	No dietary modifications documented.

	Patient instructions
2	Patient instructions modified and explained.
1	Patient instructions modified, but no note made of explanation to patient.
0	No patient instructions included.

PART IV: OVERALL EVALUATION OF FILE

Clerical

	Legibility
4	Notes are typed.
3	Can read the whole file without difficulty.
2	Can read most of the file without difficulty.
1	Can read a small part of the file without difficulty.
0	Cannot read the file at all.

	Abbreviations understandable
1	The provider uses standard abbreviations that are understandable.
0	The provider does not use standard abbreviations.

	Sufficient space available on notes
1	There is enough space on the notes to add additional information without having to condense the writing so as to render it illegible.
0	There is not enough space for additional notes.

	Copy quality
1	The copies are clear enough to read without difficulty and no significant elements are cut off.
0	The copies are too dark or washed out, or significant elements are cut off.

	If there is evidence of referral to another specialist or PCP, is there indication of a report or other follow up?
1	A report or other follow up information is in the chart.
0	There is no report or other follow up in the chart.

Clinical

	Treatment consistent with diagnosis?
6	Treatment is consistent with diagnosis.
3	Treatment consistency with diagnosis is unclear or incomplete.
0	Treatment is inconsistent with diagnosis or there is no diagnosis present.

	Treatment plan follow-up is appropriate?
6	Treatment plan follow-up is appropriate.
3	Treatment plan follow-up is unclear or incomplete.
0	Treatment plan follow-up is non-existent.