Medical Records Audit - Form number:		**Audit Date:**	
Patient details (UHID / IP Number)			
Patient Name & Age			
Date of Admission & Date of Discharge			
S. No	**Medical Records Audit - Compliance parameters**	**Compliance**	**Details of Non-compliance**
1	Pages have patient ID		
2	Contains demographic details or personal data		
3	Person providing care identified on each chart entry		
4	Entries are dated		
5	Entries are legible		
6	Allergies and adverse drug reactions are prominent		
7	Admission record and care plan properly documented		
8	Appropriate past medical & relevant details are documented		
9	Smoking, alcohol, or substance abuse history documented		
10	Lab and other tests ordered as appropriate & reports documented		
11	Working diagnoses are consistent with findings		

12	Plan of action/treatment are consistent with diagnosis(es)		
13	Procedural/Operation notes are documented		
14	Relevant Post Operation/Procedural investigations are advised (Eg: Post OP - Pathology/lab samples for necessary correlation/confirmations)		
15	Evidence of appropriate use of consultants		
16	Evidence of continuity and coordination of care between primary and specialty consultants		
17	Consultant summaries, lab, and imaging study results reflect primary care physician review		
18	Immunization record is complete where needed		
19	Prescriptions properly documented		
20	Medication charts are appropriately filled		
21	Medication charts documentation - Chronology is maintained		
22	Informed consent noted for all procedures and appropriate prescriptions		
23	Patients are adequately informed (i.e., there is documentation of patient education, follow-up instructions)		
24	Phone call orders are properly documented		
25	Charts are organized in a consistent manner internally		
26	DAMA forms are properly filled with necessary documentation		
27	Chart contents are securely fastened to the jacket		

28	No inappropriate information is in the chart (e.g., subjective or personal remarks about patient, family, or other caregivers)		
29	No inappropriate alterations or omissions (e.g., erasures, missing pages)		
30	Discharge summary contains all relevant details (Cause of Death, Treatment Provided, Lab reports etc)		
Medical records audit conducted by			
S.No	Name of the authorised auditor	Designation	Signature
1			
2			
3			
Corrective actions identified for Acknowledgement by concerned care provider/department			

S. No	Corrective/Preventive action concerned	Department /HOD concerned	Responsible care provider/HOD - Signature of acknowledgement - Name & Date
1			
2			
3			
4			

Any other concerns or comments by concerned care provider/Departmental HOD for consideration of the Medical Records Audit Committee
Discussions / referred literature/ References

Comments of Authorized Signatory

Final authorization signature for implementation of corrective/preventive actions

S.No	Name of the Authorized signatory	Designation	Signature
1			
2			

Instructions:

Case Sheets to be selected for Medical Records Audit process:

1. DAMA Case Sheets
2. MLC Case Sheets
3. Death Case Sheets
4. Case Sheets with Surgical Procedures
5. Case Sheets with Blood Transfusion Records
6. Transfer Out Case Sheets
7. Referral Case Sheets
8. Long Stay/ Extended Stay Case Sheets
9. Case Sheets with ICU Records

Every Month – 10 of the above cases can be selected for Medical Record Audit. Audit findings can be documented in the Medical Record Audit Form.