

## Suffolk Health Plan - Ambulatory Medical Record Review Tool

Member Name								
NHP ID #				<b>D.O.B</b>				
Clinic Site:				Network Code:				
Provider Name:				Provider ID # :				
Reviewer Name:				Date Reviewed:				
	Chart #	of				Yes	No	N/A
<b>I . DOCUMENTATION STANDARDS</b>								
1. Legibility	(if not legible stop the review process)!!!!							
<b>2. Progress notes elements</b>								
	a. All notes are dated							
	b. Patient's name recorded on each page							
	c. Author identification-signature/legible identification							
<b>3. Patient contact information(address, phone number and emergency contact name and phone number. )</b>								
<b>4. Chart elements:</b>								
	a. Allergies							
	b. Medical problem list							
	c. Current medication record							
	d. Consultation report/correspondence in the chart							
	e. Does the patient have Advanced Directives?							
	f. Are there copies of the Advanced Directives in the chart?							
<b>II. BASELINE CLINICAL ASSESSMENT</b>								
<b>1. Comprehensive history-collected or reviewed by medical provider:</b>								
	a. Comprehensive Medical history (Illnesses and operations etc.)							
	b. Family history							
	c. Immunizations							
	d. Behavioral Health Assessment (BHA) >12 years old							
	e. Was a Behavioral Health Assessment tool used?							
	f. If the BHA was positive, was there follow-up and coordination between the PCP and the BH specialist?							
<b>2. Comprehensive Physical exam (Review of systems)</b>								
<b>3. Anticipatory Guidance</b>								
<b>4. Did the provider refer the patient to the Early Intervention Program for development delay in children?</b>								
<b>5. HIV</b>								
	a. HIV test?							
	b. Documentation of HIV pre-, post-test counseling/consent							
<b>6. Preventive services-members seen at least two times have evidence of</b>								
	appropriate preventive screening activities:							
	a. Age 0-12 months	Height, weight, head circ. on growth chart						
	b. Birth to 25 months	Lead screening (lead level by age 2)						
	c. 26 months-72 months	Exposure risk history						
	d. 7-12 years	Blood pressure recorded once						
	e. 13-21 years	STD & sex education documented						
	f. All patients 12 and over	Tobacco Screening						
	g. All patients 12 and over	ETOH/ Substance abuse screening						
	h. All patients 12 and over	Did the Provider advise the patient to stop smoking, drinking alcohol and drug abuse?						
	i. All patients 12 and over	BMI screening & education						
	j. All patients 12 and over	nutrition assessment & education						
	k. All patients 12 and over	exercise screening &						
	l. Sex. active female	Pap q3 years						
	m. Females >18	Domestic Violence Screening						
	n. Male 35-65, Female 45-65	Cholesterol q5 years						
	o. Female >65 or high risk	Osteoporosis Screening						
	p. All patients >50 years	Stool guaiacs q1 year or flexible sigmoidoscopy 5 years/colonoscopy in last ten years						



## Suffolk Health Plan - Ambulatory Medical Record Review Tool
