

Documentation Protocols for Chiropractic Office Visits

More than ever, adequate documentation of patient encounters is an essential part of patient care. Here are some guidelines for record keeping which may serve to focus your attention on this important aspect of practice.

- 1. Records must be legible.** Other care providers depend on your records. They must be able to read them. You must be able to read them 5 years from now.
- 2. Entries must be dated.** Include the year. 5 years later you won't know which October it was.
- 3. Entries may be changed, but not obliterated.** If you notice an error, draw a single line through the script, date and initial it, then make your correction.
- 4. Note the date for follow-up.** Tell your patient when to follow up with you, but to let you know sooner if any problems arise.
- 5. Note that consent discussion has occurred.** State that risks, benefits and alternatives have been discussed. Patient questions should be noted. If a family member is present, identify that person in your record. Note that "patient requests cervical adjustment."
- 6. Document patient non-cooperation.** If a patient misses appointments, fails to comply with instructions about activities, or continues detrimental actions, enter it in the record.
- 7. Document phone calls.** Note questions or comments. Follow up should also be noted.
- 8. Document patient education offered or provided.** Note instructions given about lifting, sleeping, or exercise.
- 9. Outside test results should be noted.** Initial a report received from an outside MRI or other exams. Note when you discuss results with the patient.
- 10. Don't leave blank spaces on the page.** Adding entries at a later time is unacceptable unless accurately dated. Don't leave yourself open to accusations of doctoring the records.
- 11. Entries must be signed.** Initials are acceptable, but signature is preferable. Don't sign for someone else.
- 12. Records must be written in ink.** Go ahead and invest in a pen, it's a business expense. Pencils are fine in 2nd grade, but not for documentation.
- 13. Record normal findings as well as abnormal.** "If you don't record it, you didn't do it."
- 14. Record patient comments about concurrent care with other doctors.** Also document your attempts to receive information from other providers.
- 15. Use standard abbreviations, or construct a glossary of your own symbols.**
- 16. Avoid critical comments about other providers.** Patient records are not the place for performance reviews.
- 17. All pages must contain the patients name and ID number.** Goes without saying.

All this in addition to the standard SOAP.