

STD Medical Record Audit Tool

AUDIT DATE: _____

County: _____

MONITOR: _____

Instructions:

- Obtain a copy of the billing sheet for the most recent STD visits within the past 4 weeks.
- If information should be present and is not, place “0” in the box
- If information is present place a “√” in the box
- If the information is not applicable place “NA” in the box

Chart Number	1	2	3	4	5	6	7	8	9	10
	/	/	/	/	/	/	/	/	/	/
Primary Provider ID										
Legal Elements of Medical Record Documentation										
▪ HIPAA consent is signed in accordance with agency policy										
▪ Declination of service is signed if applicable per agency policy										
▪ Pages have client ID on both sides										
▪ Entries are legible										
▪ Entries are dated										
▪ Entries are recorded in chronological order										
Entries are signed with name and title of staff making entry:										
▪ Interviewer, if not the clinician										
▪ Clinician										
▪ Treatment nurse, if not the clinician										
▪ Health Educator										
▪ Social Worker										
▪ Others										
Specific Areas of Review Medical Record										
• Telephone calls, letters, home visits, etc. are documented to reflect agency policy regarding client follow-up for additional therapy, test of cure, etc.										
• Chart is organized per agency policy										
▪ Allergies and adverse drug reactions are prominently noted										
▪ Special service requirements are prominently noted										

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<ul style="list-style-type: none"> ▪ Provision of Care – Based upon the Current CDC and NC DPH Published Guidelines 										
<ul style="list-style-type: none"> ▪ STD History is accurately documented on the Problem List 										
<ul style="list-style-type: none"> ▪ Problem list is Up to Date 										
<ul style="list-style-type: none"> ▪ Did the client receive appropriate care? 										
<ul style="list-style-type: none"> ▪ Reason(s) for visit are documented 										
<ul style="list-style-type: none"> ▪ History about current reason(s) for visit have been documented 										
<ul style="list-style-type: none"> ▪ Recent antibiotics and present medications are documented by name and duration of use 										
<ul style="list-style-type: none"> ▪ Vaccine history is documented if known 										
<ul style="list-style-type: none"> ▪ HIV status and HIV testing history is documented if known 										
<ul style="list-style-type: none"> ▪ Sexual Risk Assessment is complete 										
<ul style="list-style-type: none"> ▪ “For Women” section is complete 										
<ul style="list-style-type: none"> ▪ Details of symptom parameters and sexual risk assessment are described as comments when required for complete understanding 										
Physical Examination is complete and documented										
<ul style="list-style-type: none"> ▪ Upper body 										
<ul style="list-style-type: none"> ▪ Lower body 										
Did the client receive testing appropriate to symptoms and clinical findings?										
<ul style="list-style-type: none"> ▪ Ordered lab procedures are checked and stat lab results are documented 										
<ul style="list-style-type: none"> ▪ Clinical impression(s) are documented 										
Did the client receive treatment appropriate to symptoms, clinical findings, and testing?										
<ul style="list-style-type: none"> ▪ Therapy corresponds with the clinical impression 										
<ul style="list-style-type: none"> ▪ Prescriptions and refills are noted 										
<ul style="list-style-type: none"> ▪ Notes section is used as needed to enhance continuity of care when the client may be seen by a different provider on future visits 										
Prevention										
<ul style="list-style-type: none"> ▪ Control measures are documented 										
<ul style="list-style-type: none"> ▪ Instructions and counseling correspond with clinical impression(s) and therapy 										
<ul style="list-style-type: none"> ▪ Instructions include follow up plan if applicable 										
<ul style="list-style-type: none"> ▪ Partner notification plan is documented 										

