Charting Template/Outline

The Record Should Contain:

- Comprehensive Medical and Dental History
    - Review the history thoroughly at the first visit, make notation or any pertinent information gained in the health history and patient interview in the clinical record and update the health information at all subsequent visits
    - The health history should be reviewed, documented, and any modifications of treatment needed as a result of the Medical condition of the patient should be noted and followed
    - Revisit with a more comprehensive review as needed (the more compromised the patient's health, the more often the medical history should be reviewed. Err on the side of caution). Note any deviations from the norm.
    - Do a Rx review and run a drug interaction screen. (epocrates/lexacon) http://www.epocrates.com or http://www.lexi.com
    - Review histories before each visit thereafter even if seen 2 times on the same day and document any significant findings

- **Documented**
    - Detailed Clinical Evaluation
        - Document the oral cancer screening was performed and identify any abnormal conditions
        - Periodontal screening (including full mouth probing for any patient over 18 years of age at the first visit and repeated as often as indicated)
        - Patients that have undergone or are in active periodontal treatment period should have a full periodontal exam that includes probing at every hygiene visit
    - Hard and soft tissue evaluation
        - Note condition of soft tissues: lips, gingiva, buccal mucosa, tongue palate:
        - Periodontal evaluation/charting for every patient (establish your office's protocol)
        - Hard tissues: Bone and teeth
        - The record should be complete and specify what information was evaluated to determine the treatment recommended/provided
    - Images
        - Record the need for any radiographs taken
        - Record that the radiographs were taken

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            - Note: Images must be diagnostic and provide a distinct view
                - (Two bitewing images that provide the same view should be documented as "two bitewings taken, one diagnostic"
                - Multiple radiographic images that provide the same view and information should be billed as one radiograph
        - Record that the images were reviewed
        - Record Abnormal findings
        - Images may also include:
            - Soft Tissues/Photos
            - Hard Tissues/Radiographs/Photos

- TMJ evaluation

- Caries Risk Assessment: CAMBRA

- Chief Complaint
    - Why is the patient in your office? (Even if "just for a checkup")
    - Establish the expectations from the patient and record them
    - If no problem is stated, record the reason for the visit. "I need a checkup".
    - Be aware that the chief complaint may change so note each visit

- List a definitive diagnosis
    - Establish the diagnosis for each abnormality and record it
    - Treatment Plans should address all abnormalities
    - Complete documentation includes the diagnostic tools used to arrive at that definitive diagnosis
    - Diagnosis should list the location and extent of the pathology

- Informed consent should include:
    - Treatment needed
    - Reason for treatment recommendations
    - Material treatment risks
    - Benefits
    - Clinically accepted alternatives
    - Cost relative to treatment recommendations

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- Treatment Rendered should list:
  - Anesthesia: amounts, types, and locations
  - Numbness
  - Procedure
  - Materials used
  - Any negative outcomes
    - Record the plan to deal with the negative outcome
    - Inform the patient
    - Deal with additional treatment/referrals
  - Refusal of any kind or request to modify treatment

- Reason for next appointment
  - Treatment should be sequenced to address the condition of greatest concern
  - Address the chief complaint
  - Address the reason for the sequence
  - Get agreement from the patient for the next appointment

- Note any referrals
  - Where was the patient referred?
  - Reason for the referral
  - Lack of compliance

- All Prescriptions written
  - List prescriptions separately and include number and strengths
  - Indicate what the prescription is to treat
  - Inform the patient of any possible side effects
  - What to do if they experience any untoward effects from the medications
  - (Check with your state regarding the Rx. database)

- All phone conversations
  - Conversations with business staff
  - Conversations with clinical staff
  - Conversation with the Doctor
  - Conversation with the referring Doctor re that patient

- Cancelled/Missed Appointments

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- Compliance can be very important to outcomes

Remember!

- Make your notations at **the time of the visit, phone call, conversation**
- **Subjective comments about the patient are not to be recorded in the treatment record!**
- **Be very careful with your choice of words.**

This list is not exhaustive! But it is well on the way to protect and defend you and your practice.

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