













San Francisco Health Plan
Medical Record Review Preparation Checklist (Organized by Section)
Use This Tool with DHCS FSR Medical Record Review Survey Standards.

 = There is a resource tool available on this site.

Notes:	
Format Criteria	
<input type="checkbox"/> First and last name & unique member identifier is on each page of a medical record system.	
<input type="checkbox"/> Evidence of member's DOB, home/work phone numbers, parent/guardian (if minor).	
<input type="checkbox"/> Emergency "contact" is identified. Includes name, relationship, and phone number. Documented, if none or declined to state.	
<input type="checkbox"/> Printed and/or electronic medical records are maintained and organized.	
<input type="checkbox"/> Member's assigned and/or rendering primary care physician (PCP) is identified.	
<input type="checkbox"/> Member's primary language or hearing/speech-impaired persons status are prominently noted.	
<input type="checkbox"/> Evidence of linguistic service needs (oral interpreters, signers, or bilingual providers). 	
<input type="checkbox"/> Qualified person or entity providing medical interpretation is identified and documented. 	
<input type="checkbox"/> Person or entity providing medical interpretation is identified. Or, refusal of service documented at least once in medical record. 	
<input type="checkbox"/> A health care provider is required by law to have in writing that a member received and signed the Notice of Privacy. 	
<input type="checkbox"/> Any forms provided to a member in their language also includes English translation or has a reference to the English version.	
Documentation Criteria	
<input type="checkbox"/> Allergies and adverse reactions are listed easily and consistently; prominently noted.	
<input type="checkbox"/> Chronic problems and/or significant conditions are listed in a separate 'problem list' or progress notes.	
<input type="checkbox"/> Current continuous medications are listed. Discontinued meds are noted.	
<input type="checkbox"/> Consent for treatment form is documented in the medical record. 	
<input type="checkbox"/> Release of Medical Records forms, when indicated, are documented. 	
<input type="checkbox"/> Informed Consent forms for any invasive procedures, e.g. cutting/puncturing/ skin or inserting instruments into the body. 	
<input type="checkbox"/> Documentation that Advance Health Care Directive Information is offered. 	
<input type="checkbox"/> All entries are documented with personnel first initial, last name, title, date (month/day/year). Written, stamped, EMR validated.	
<input type="checkbox"/> Errors are corrected according to legal medical documentation standards.	
Continuity/Coordination of Care Criteria	
<input type="checkbox"/> Each visit includes history of present illness or reason for visit is documented.	
<input type="checkbox"/> Working diagnoses are consistent with findings/objective information.	
<input type="checkbox"/> Treatment plans are consistent with diagnoses.	
<input type="checkbox"/> Instruction for follow-up care is documented. A defined time for return or follow-up is documented; 'PRN' is ok.	
<input type="checkbox"/> Unresolved/continuing problems are addressed in subsequent visit(s).	
<input type="checkbox"/> There is evidence of practitioner review of consult/referral reports and diagnostic test results. 	
<input type="checkbox"/> There is evidence of follow-up of specialty referrals made, and results/reports of diagnostic tests, when appropriate. 	
<input type="checkbox"/> Missed primary care appointments and outreach efforts/follow-up contacts are documented. 	

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Facility Site Review Survey Preparation Checklist
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WCC = Well Child Check	Notes:
<input type="checkbox"/> Initial Health Assessment (IHA) = Comp. H&P + Individual Health Education Behavioral Assessment (IHEBA) 🗑️	
<input type="checkbox"/> Subsequent Comprehensive Health Assessment = Comp. H&P + Subsequent Periodic IHEBA	
<input type="checkbox"/> Anthropometric measurements	
<input type="checkbox"/> Obesity screening	
<input type="checkbox"/> Blood pressure screening	
<input type="checkbox"/> Developmental surveillance	
<input type="checkbox"/> Developmental screening	
<input type="checkbox"/> Autism spectrum disorder screening 🗑️	
<input type="checkbox"/> Psychosocial / Behavioral assessment 🗑️	
<input type="checkbox"/> Depression screening 🗑️	
<input type="checkbox"/> Sexual activity risk assessment	
<input type="checkbox"/> Intimate partner violence screening	
<input type="checkbox"/> Contraceptive care	
<input type="checkbox"/> STI screening on all sexually active adolescents, including Chlamydia, Gonorrhea, and Syphilis	
<input type="checkbox"/> Hepatitis B screening	
<input type="checkbox"/> HIV screening	
<input type="checkbox"/> Vision screening 🗑️	
<input type="checkbox"/> Hearing screening	
<input type="checkbox"/> Nutrition assessment / Breastfeeding support	
<input type="checkbox"/> Folic acid supplementation 🗑️	
<input type="checkbox"/> Dental Home 🗑️	
<input type="checkbox"/> Fluoride varnish 🗑️	
<input type="checkbox"/> Fluoride supplementation 🗑️	
<input type="checkbox"/> Blood lead testing	
<input type="checkbox"/> Newborn blood screening for RUSP including bilirubin	
<input type="checkbox"/> Anemia screening	
<input type="checkbox"/> Lipid screening	
<input type="checkbox"/> Tuberculosis screening 🗑️	
<input type="checkbox"/> Anticipatory guidance	
<input type="checkbox"/> Alcohol/Drug misuse: Screening and behavioral counseling	
<input type="checkbox"/> Tobacco prevention and cessation services	
<input type="checkbox"/> Skin cancer behavior counseling	
<input type="checkbox"/> Vaccines given according to ACIP guidelines 🗑️	
<input type="checkbox"/> Vaccine administration documentation 🗑️	
<input type="checkbox"/> Vaccine Information Statement (VIS) documentation	
<input type="checkbox"/> Immunization registry reporting 🗑️	

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AD = Adult Preventive	Notes:
<input type="checkbox"/> Initial Health Assessment (IHA) = Comp. H&P + Individual Health Education Behavioral Assessment (IHEBA) 🐾	
<input type="checkbox"/> Subsequent Comprehensive Health Assessment = Comp. H&P + Subsequent Periodic IHEBA	
<input type="checkbox"/> Alcohol/Drug misuse: Screening and behavioral counseling	
<input type="checkbox"/> Tobacco use counseling and interventions	
<input type="checkbox"/> Depression screening	
<input type="checkbox"/> High blood pressure screening	
<input type="checkbox"/> Obesity screening and counseling	
<input type="checkbox"/> Tuberculosis screening 🐾	
<input type="checkbox"/> Osteoporosis screening 🐾	
<input type="checkbox"/> Breast cancer preventive medication	
<input type="checkbox"/> Mammogram (Breast cancer screening)	
<input type="checkbox"/> Cervical cancer screening	
<input type="checkbox"/> Sexually transmitted infection screening including Chlamydia, Gonorrhea, and Syphilis	
<input type="checkbox"/> Sexually transmitted infections counseling	
<input type="checkbox"/> HIV screening	
<input type="checkbox"/> Hepatitis B screening	
<input type="checkbox"/> Hepatitis C screening	
<input type="checkbox"/> Intimate Partner Violence screening	
<input type="checkbox"/> Colorectal cancer screening	
<input type="checkbox"/> Diabetic screening and comprehensive diabetic care	
<input type="checkbox"/> Lung cancer screening	
<input type="checkbox"/> Skin cancer behavioral counseling	
<input type="checkbox"/> Abdominal aneurysm screening	
<input type="checkbox"/> Folic acid supplementation 🐾	
<input type="checkbox"/> Vaccines given according to ACIP guidelines 🐾	
<input type="checkbox"/> Vaccine administration documentation 🐾	
<input type="checkbox"/> Vaccine Information Statement (VIS) documentation	
<input type="checkbox"/> Immunization Registry Reporting 🐾	

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OB/CPSP = Obstetrics Preventive	Notes:
Initial Prenatal Visit	
<input type="checkbox"/> Comprehensive Physical Exam	
<input type="checkbox"/> ICA completed within 4 weeks of entry to prenatal care	
<input type="checkbox"/> Obstetrical and Medical History	
<input type="checkbox"/> Physical Exam	
<input type="checkbox"/> Dental Assessment	
<input type="checkbox"/> Lab Tests	
<input type="checkbox"/> Bacteriuria Screening	
<input type="checkbox"/> Rh Incompatibility Screening	
<input type="checkbox"/> Diabetes Screening	
<input type="checkbox"/> Hepatitis B Virus Screening	
<input type="checkbox"/> Chlamydia Infection Screening	
<input type="checkbox"/> Syphilis Infection Screening	
<input type="checkbox"/> Gonorrhea Infection Screening	
First Trimester Comprehensive Assessment	
<input type="checkbox"/> Nutrition	
<input type="checkbox"/> Psychosocial Assessment	
<input type="checkbox"/> Maternal Mental Health Screening	
<input type="checkbox"/> Social Needs Assessment	
<input type="checkbox"/> Substance Use / Abuse Assessment	
<input type="checkbox"/> Health Education	
<input type="checkbox"/> Preeclampsia Screening	
<input type="checkbox"/> Intimate Partner Violence	
Second Trimester Comprehensive Assessment	
<input type="checkbox"/> Individualized Care Plan (ICP)	
<input type="checkbox"/> Nutrition	
<input type="checkbox"/> Psychosocial Assessment	
<input type="checkbox"/> Maternal Mental Health Screening	
<input type="checkbox"/> Social Needs Assessment	
<input type="checkbox"/> Substance Use / Abuse Assessment	
<input type="checkbox"/> Health Education	
<input type="checkbox"/> Preeclampsia Screening	
<input type="checkbox"/> Intimate Partner Violence	
Third Trimester Comprehensive Assessment	
<input type="checkbox"/> Individualized Care Plan (ICP)	
<input type="checkbox"/> Nutrition	
<input type="checkbox"/> Psychosocial Assessment	
<input type="checkbox"/> Maternal Mental Health Screening	
<input type="checkbox"/> Social Needs Assessment	
<input type="checkbox"/> Substance Use / Abuse Assessment	
<input type="checkbox"/> Health Education	
<input type="checkbox"/> Preeclampsia Screening	
<input type="checkbox"/> Intimate Partner Violence	
<input type="checkbox"/> Screening for Strep B	
<input type="checkbox"/> Tdap Immunization	
<input type="checkbox"/> Prenatal Care Visit Periodicity according to most recent ACOG	
<input type="checkbox"/> Influenza Vaccine	
<input type="checkbox"/> Referral to WIC and Assessment of Infant Feeding Status	

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Third Trimester Comprehensive Assessment Continued	
<input type="checkbox"/> HIV-Related Services Offered	
<input type="checkbox"/> AFP/Genetic Screening Offered	
<input type="checkbox"/> Family Planning Evaluation	
<input type="checkbox"/> Comprehensive Postpartum Assessment	
<input type="checkbox"/> Individualized Care Plan (ICP)	
<input type="checkbox"/> Nutrition	
<input type="checkbox"/> Psychosocial Assessment	
<input type="checkbox"/> Maternal Mental Health Screening	
<input type="checkbox"/> Social Needs Assessment	
<input type="checkbox"/> Substance Use / Abuse Assessment	
<input type="checkbox"/> Health Education	
<input type="checkbox"/> Comprehensive Physical Exam	

Based upon APL 20-004



1	Format		10
2	Documentation		10
3	Coordination/Continuity		11
4	Pediatric Preventive		42
5	Adult Preventive		36
6	OB Preventive		See Guidelines

Cross check they have all Policy and Procedures

Cross check they have all required logs.