

Acupuncture Records Checklist

- The patient name on all pages.
- All pages secured into the treatment folder.
- Organized chronologically (most recent date on top).
- Write legibly, be consistent, clear and concise.
- Maintain record in ink, use the same pen for each entry on the same day.
- Do not alter the records, do not erase or use correction fluid.
- Fill in all blanks, do no skip lines or leave spaces, line through large blocks of space.
- Do not “squeeze in” notes and do not indent.
- Make additions and changes appropriately.
- Record all patient contact.
- Missed appointments documented.
- Telephone messages documented.
- Entries dated, timed and initialed.
- Patient non-compliance documented.
- Initial reports (X-ray, lab, diagnostic, consultant) before filing.
- Dictation and correspondence and reports proofread, initialed before filing.
- Maintain a legend for any abbreviations used.
- Document the reason for the visit, any unusual events and avoid or explain contradictions.
- Clinical findings (positive/negative) documented and the problem or complaint list is current.
- Treatment plan documented.
- Entries are objective, do not criticize other providers or their treatment methods.
- Properly identify the record, the record keeper, the technique employed, the table and room used and the meridians treated.
- Patient instructions are documented.
- Informed consent is in the chart.
- Be certain that the “Release of Records Authorization” form in the chart is correct and valid.
- Referral letters, or prescription is in the chart.
- Herb list is current, when due to refill, reactions or allergies.
- Patient education materials given to patient is documented.
- Customize the forms you use.
- Keep financial and clinical information separate.
- Retain the records forever because of the statue of limitations on malpractice cases.
- Signature of the provider of services.