Patient Record / Chart Minimum Requirements
Things We Are All Accountable For

Client Information Portion of Record

- Check for client alerts - update and/or remove if needed
- When entering phone number you must click mobile and SMS enabled unless the client indicates it is a landline or they refuse text. Each phone number must have a first name written in the description. The default number is the phone number put as the primary on the new client application
- When entering street address be sure to capitalize each word and to spell the town correctly
- If client enters a 2nd person authorized during an emergency, this is to be entered as the second person on the chart. If they do not but a different person brings the pet, you need to find out that person's name (especially if they are partners) and enter them as the 2nd person on the account
- If the client is referred by someone, choose "word of mouth" as the referral type and then go below to the client referral area and choose the client who referred from the drop down menu

Patient Information Portion of Record (top of record and general information tab)

- Check for patient alerts - update and/or remove if needed
- Photo of pet
- Correct sex, breed, color
- Microchip area should either have a number or, if you scanned, and no chip, "no chip"
- If follow ups are present they should be scheduled
- Reminders according to the process should exist
- Patient medication list should include all chronic medications that the patient arrived to the practice taking and any that we have prescribed since

Patient Medical Record (primarily the view by groups tab)

- Reason for Visit: should be a reason for each appointment and for any referral/specialty/ER visits that get uploaded
- History section: should include at least one emotional record and preferences, nothing else necessary
- Exams: each nurse, doctor, or anesthetic visit should receive an exam form, exam form must have a reason for visit and save vitals is necessary as well as save and back to medical record
- Diagnoses: any time a condition is diagnosed (either by us or referring dr) it should be documented here. We do not use diagnosis codes, just type it in. If it is a major or lifelong condition "create master problem list" should be checked
- Treatments: charges entered here - sometimes easier if you enter by charge type search bar instead of quick find search bar
- Anesthetic Monitoring Forms: These forms are created for internal anesthesia patients
- Antech Lab Orders and IDEXX Lab Results - laboratory results from in and out of clinic
- Lab Results - internal manually read lab results such as radiographs and dtm readings

- Plan: use for PVP Plans, Laser Therapy Plans, and Chronic Med/RX Diet Plan, Note that medical plans from appointments are in exam form but if they are chronically recommended that should be copied to chronic med plan as well, exam assistant team if dr has not created the necessary plan, please send a tasklist to remind them
- Note: a private place to make notes about appointment to communicate with team if necessary, if so place in the appointment reason for visit “see note”
- Communication Log: every client communication that occurs should be recorded here, if emails are sent from evet they will also be tracked here and one can check if client opened the email
- HPVC Surgical/Anesthesia Documents: anesthetic consent forms, copied paperwork from anesthesia day, sedation worksheets with drug recordings written on
- Images - medical - xrays, ultrasound, microscope images, photos of lesions - all should be clearly labeled so that multiple images do not have to be open to be viewed
- Outside Lab or Prior Clinic Lab Results - for lab tests sent elsewhere than Idexx and Antech (ex: Royal Canin Genetic) and for test results from other clinics
- Patient Consultation Forms: nutrition coaching, behavior coaching, telemedicine forms that clients fill out
- Patient History Forms: history forms filled out by clients for appointments
- Prior Records- records from other clinics should be titled by the clinic they came from
- Specialist/ER Reports - title by clinic they came from, follow specialist/er report proven process
- Documents: any document from create patient document, uploaded documents that clients sent that are not records (ex: poop journals)
- Note: exam forms and treatments should always be checked to have the correct provider

Weight and Prescription History Tabs

- Weight History - be sure that if you aren’t weighing the pet you press “skip” instead of “save”, check that there is only one weight per day, if the record asks you if you want to “update the weight” do so if the weight on the screen is the accurate one
- Prescription History - remember that prescriptions filled through our COVETRUS online store will be located at the very bottom of the prescription history page