CPTNB CHART AUDIT CHECKLIST **Use as a guide to assess your charting habits**	**CHART**				
*Select Charts. Indicate **Y**es, **N**o or **NA** for each criteria*	**1**	**2**	**3**	**4**	**5**
1 CHART CONTAINS AT LEAST 3 PATIENT IDENTIFIERS ON EACH PAGE					
1.1 Name of patient					
1.2 Date of Birth of patient					
and one of:					
1.3 Medicare or Chart # *- OR any of:*					
1.4 Contact Details/Family Physician Name/ Gender					
2. ALL ENTRIES ARE					
2.1 In Chronological Order					
2.2 Legible					
2.3 In Permanent Ink					
2.4 Dated					
2.5 Time of Entry - *or per facility's policy*					
2.6 Signed with Professional Designation (PT or Physiotherapist) *					
** If signature is not legible, name is also printed*					
3. PT's NOTES ARE CLEARLY IDENTIFIABLE IF IN MULTI-DISCIPLINARY CHART					
4. CORRECTIONS / ALTERATIONS ARE					
4.1 Struck through with one line, with PT's initials or per facility's policy*					
4.2 Date of change is specified if mistaken entry is added after note was signed					
** If one line and initials are already incorporated in policy*					
5. INITIAL DOCUMENTATION / DATA BASE INCLUDES					
5.1 History of Present Illness					
5.2 Relevant Past Medical History					
5.3 Current Medications					
5.4 Relevant Tests / Investigations (e.g. Lab, X-Ray, etc.)					
6. INITIAL ASSESSMENT / EVALUATION INCLUDES					
6.1 Patient's Reported Problems					
6.2 Symptoms					
6.3 Evidence of Appropriate Assessments Performed					
6.4 Evidence of Relevant Screening/Safety Tests					
7. IDENTIFICATION OF PATIENT PROBLEM					
7.1 Analysis and Physiotherapy Diagnosis has been charted					
7.2 Problem list is present					
7.3 Treatment plan is present which corresponds with problem list					
7.4 Goals are Patient-centered and Mutually Established with the Patient					
7.5 Goals are related to Problem List & Treatment Plan					
8. TREATMENT NOTES INCLUDE DESCRIPTION OF PLANNED INTERVENTION					
8.1 Duration / Frequency					
8.2 Manual Techniques					

*Select Charts. Indicate **Y**es, **N**o or **NA** for each criteria*	1	2	3	4	5
8.3 Home Program Details (including Exercise Sheets – in file or noted)					
8.4 Walking Aids Noted					
8.5 Exercise Prescription Noted					
For Modalities, includes:					
8.6 Parameters					
8.7 Location					
8.7 Patient Position					
8.8 Documentation that Consent, Risks, Benefits, Contraindications, Precautions were Considered					
8.9 Evidence that Patient Education was Provided					
9. TREATMENT PROVIDED IS CHARTED *and*					
9.1 Results if any, are noted including Adverse Results					
10. PATIENT'S/CAREGIVER'S RESPONSIBILITIES ARE NOTED + EXPLAINED					
11. INFORMED CONSENT IS DOCUMENTED INCLUDING					
11.1 Prior to Assessment /First Treatment					
11.2 With Each Change in Treatment					
11.3 Written permission to communicate with other health professionals, 3rd parties, etc.					
12. PROGRESS NOTES CONTAIN					
12.1 Timely reviews of patient's condition					
12.2 Modifications and Updates Made					
12.3 Documented Outcome Measures					
12.4 Discontinuation of Treatment as Appropriate					
12.5 Recommendations for Ongoing Care OR					
12.6 Transfer to Other Health Professional(s)					
13. PHYSIOTHERAPIST'S ASSISTANTS					
13.1 Chart Notes Indicate if Assistants were Assigned Tasks, *and if so that*					
13.2 Consent was Obtained from the Patient for their Involvement					
14. WRITTEN COMMUNICATIONS (ABOUT/TO/FROM) **PATIENT ARE RETAINED**					
15. DISCHARGE SUMMARY AND PLAN IS DOCUMENTED					
15.1 Date of Discharge / Closure					
15.2 Summary of Patient Status					
16. RECORD RETENTION MEETS MINIMUM (7 YR) CPTNB STANDARD					
Advisory: may need to be much longer for paediatric and young patients					

FOR ANSWER BY ANY PHYSIOTHERAPIST COMPLETING THIS CHART

If another Physiotherapist chooses this chart, could they safely treat this patient without needing additional information?