Guidelines for Charting Medical Records:

The purpose of the medical chart:

The "medical chart" is our way of digesting medical records in a disability case. Using a table format, we write a detailed synopsis of each individual medical record, in chronological order. We frequently quote significant language directly. There are several purposes for charting: It provides a complete, chronological picture of a client's medical history. The very process of charting helps you understand the client's medical conditions at a deep level. In addition, the completed chart is an invaluable tool for preparing documents such as letters to doctors, affidavits, and legal memos. The time invested in charting saves time flipping through medical records and "re-learning" the case when we later draft documents. It can be searched and easily reviewed, unlike the medical records themselves.

When you review medical records you will quickly find that they are full of abbreviations and symbols, which you must understand. The following website, which provides a list of symbols and abbreviations is linked on our coursepage: http://him.duhs.duke.edu/modules/HIM_university/index.php?id=8. Of course, you can also just do a web search. If you have a questions or are working with hand-written records, please consult your supervising attorney.

An essential ingredient for useful and efficient charting is some knowledge of your client's illnesses. Without that context, your charting will take longer and you may miss important information. Before you start charting, do some basic medical research. There are numerous resources on our coursepage, the web, and in our clinic library. In particular, we recommend Dr. David Morton, *Medical Issues in Social Security Disability*. This resource is on the bookshelf in our pod.

When you chart medical records, you should always be thinking about what you need to provde your disability case. In a nutshell, those things are:

- The client's **impairments** – that is, **diagnoses**.
- The **medical signs and symptoms** that establish those diagnoses, including **physical exam, laboratory values** (especially CD4 count and viral load), **diagnostic tests** (e.g. x-rays, EKG, liver biopsy), etc.
- The client's **symptoms** that result from those impairments.
- The **frequency, duration**, and **intensity** of those symptom
- How those symptoms affect the client's **functioning**
- The **treatment** and **prognosis** for each impairment

You should chart information that supports our client's case, as well as information that undercuts our client's claim. We need everything relevant, whether it is good or bad. We can't ignore the bad evidence.

Types of documents you will find in the medical file:

1.   **Clinic/Office visit notes:** Often typed; sometimes handwritten. These range from very detailed to sketchy. In smaller clinics, they may be handwritten on a pre-printed form. Typically, they will include the patient's complaints, medical history, physical, impressions, current medications, treatment plan. The medical history includes anything in the patient's past medical history. Some of these conditions will have been resolved already, for instance a bout of candidiasis that has been treated. Others will be ongoing, such as HIV, Hepatitis C, depression.

    Clinic/Office notes should be charted BEFORE other records. They will give the "big picture," including the impressions and treatment plan of the primary treating physician.

    At teaching hospitals, such as Duke or UNC, the note will often be written by a physician in training or nurse practitioner (eg a resident or fellow) and there will be a note that they have been reviewed by the attending physician. In this case, it's generally the resident or fellow who actually saw the patient.

    Most physician/provider notes include the same standard components, not necessarily in the following order.

    Components of Office Visit Notes:

- **Vital signs**: height, weight, blood pressure, heart rate – *chart this if possibly relevant to your client's case – e.g. there are issues of weight loss, high blood pressure, etc.*

- **List of Medications** (sometimes includes both current and discontinued meds) – *always include medications – if they mostly remain constant, just record changes in medications*

- **History**: Past medical history, reported by the patient or from prior records. *This should be noted once in the chart, unless there is some change*

- **Present Complaint**: what brought the patient in today – this will be patient's explanation of symptoms, what brought them on, etc. *This should always be noted in the chart*

- **Review of Systems**: provider asks patient whether there are any complaints in any of the body systems. This part of the note contains what the patient says, not what the doctor observes. *Note anything that is other than normal. Also note normals if they are germane to any impairment the client is claiming. For example, if the claimant claims to have a back pain, and the musculoskeletal system is marked normal, you would want to note this, as it undercuts the claim.*

- **Physical Examination**: doctor examines patient and records results. *As with the Review of Systems, include abnormals as well as normals in an area of claimed impairment*

- **Assessment**: discussion of possibilities, diagnoses. *Always must be charged*

- **Plan**: actions to be taken, including medications prescribed, consultations or tests ordered. *Always chart this.*

2. **Consult notes:** These are the clinic/office notes of a consulting physician. For example, the family doctor or Infectious Diseases doc may have sent the client to see a specialist in another field, such as a neurologist, liver doc, etc. These notes will be organized in the same manner as the general clinic notes and should be charted in the same manner. The consult notes should be charted along with the clinic/office notes.

3. **Emergency Room visits:** These are generally a pre-printed (or computer generated) form, with record of vital signs, complaints, physical exam, medications given. Because it's pre-printed, often the only indicator will be a symbol of "**+**" or "**-**". The "+" means that the symptom is present. The "–" means it's not.

When charting, be sure to note all symptoms, their duration and intensity. Intensity of pain will be measured on a scale of 1-10, with 10 being high. Be sure to include pain intensity.

ER records will indicate whether the patient was discharged or admitted to the hospital. Be sure to record this information. If the patient was admitted, chart the hospital admission as a separate entry.

4. **Hospital Admissions:** There will often be a huge pile of daily records (nursing notes), consults with specialists, studies, tests, etc. Do NOT chart everything. Start by charting the discharge summary in detail. Then chart the admission note and any consult or test result that was highlighted in the discharge summary. Scan through the rest of the records. Discuss with your supervisor any other records that you think are worth charting. Retain the rest of the records in the file.

5. **Labs:** These are reports of various lab tests, generally from blood or urine. Do not chart these until after you have charted the clinic notes and hospital records. Until you know what's important for your client's case, only chart labs that are not normal. These will usually be noted in the lab report or "H" for "high" or "L" for "low." Often the lab report will include a "reference range," which tells what is considered "normal." Include the reference range when charting (at least on the first entry). You can also find out what's "normal" for a particular lab through various medical research tools (including, often, just googling).

6. **Mental Health/Psychiatric Office Notes:** These are a somewhat special animal. They will often be sketchy and difficult to extract from the provider, for privacy and therapeutic reasons. Record any symptoms noted, their duration and intensity. Any

details about medical or work issues are important too. Often the record will include a diagnosis in a "multiaxis" format. Include the diagnoses for each of the five axes. The final axis is the "GAF" or "Global Assessment of Functioning." Be sure to include the GAF score in your notes. This is a standard (though very subjective) numbering system that will give some idea of the severity of the client's illness and its effect on functioning.

General Principals of Charting:

1.   Don't chart blind. The medical records will make a lot more sense if you have a basic understanding of the conditions your client has. Give yourself an overview of the major illnesses through basic medical research. There are many links on our website. You can also get basic information through quick web searches. Continue referring to medical references as you chart.

2.   Do your charting in good size chunks. Most students find that they are most productive when they chart in blocks of at least two hours. Charting requires getting organized and focused, which can be difficult to do in the hustle and bustle of daily pod activity. For this reason, you may want to do your charting in the Clinic conference room, or during non-business hours.

3.   By the same token, DON'T PROCRASTINATE about charting. It can be overwhelming to face a thick stack of medical records, but if you don't get started, you will never produce anything for your client.

4.   Start by charting the clinic notes. This will give you the big picture. DO NOT start by trying to chart labs!

5.   Look up all unfamiliar medical terms and abbreviations. It's helpful to insert the definition in brackets in your medical chart. Then, when you, your supervisor, or a future student refers to the chart, it won't be necessary to look up the term/abbreviation again.

6.   Always record the CD4 count and viral load. They will often be referenced in the clinic notes as well as lab records.

7.   Record all medications the client is taking or has taken. The first time you enter a particular medication, please look it up (easily done through googling) and indicate in brackets what the medication is for. If you want, keep a separate page with more detailed information about the particular medication, or links to references on the drug.

8.   When noting symptoms, include the frequency, intensity and duration.

9.   Include non-medical information if relevant. Medical records can be an excellent source of information on the client's employment, efforts at employment, living situation, drug/alcohol use, and other aspects of the client's life that may impact the disability case. Always include references to any work the client may be doing or seeking. Also, rsome records which may seem irrelevant– e.g. a broken hand -- may be relevant to claims that the client has a mental impairment that renders her/him unable to get along with others.