Data collection grid for the case note audit

Item	Patient 1	2	3	4	5
1. Are the records written in black ink?					
2. Is the patient's name written on every page?					
3. Has the patient's address been recorded?					
4. Has the postcode been recorded?					
5. Has a contact telephone number been recorded?					
6. Has the patient's date of birth been recorded?					
7. Has the name of the patient's GP been recorded?					
8. Have GP's contact details been recorded?					
9. Has date of visit been recorded?					
10. Has information concerning the presenting complaint been recorded?					
11. Has the history of the patient's current complaint been recorded?					
12. Has current medical history been recorded?					
13. Has past medical history been recorded?					
14. Has the patient's family history been recorded?					
15. Has the patient's prescribed medication been recorded?					
16. Has any non-prescribed medication used been recorded?					
17. Has the patient's social history (smoking) been recorded?					
18. Has the patient's social history (alcohol) been recorded?					
19. Has information concerning systemic enquiry (CVS, GI, GU, Neuro, Obs, Gynae) been recorded?					
20. Has the patient's general health and appearance been recorded?					
21. Have all clinical examinations been recorded?					
22. Has pre-examination consent been recorded?					
23. Have all clinical findings been recorded?					
24. Has consent to treatment been recorded?					
25. Has information been provided concerning risk of treatment?					
26. Has the treatment given been recorded?					
27. Has a treatment plan been written?					
28. Has any advice and information given been recorded?					
29. Has any reaction to treatment been recorded?					
30. Have treatment outcomes been recorded?					
31. Has communication with the patient (outside of consultation time) been recorded?					
32. Has communication with 3rd party been recorded?					
33. Was a chaperone present?					
34. Was a student/other observer present?					
35. Have home/domiciliary visits been recorded?					
36. Is every entry to record signed and dated?					
37. Are entries consecutive?					
38. Are any alterations to the records signed and dated?					
39. Have abbreviations been used?					
40. Have any offensive or subjective statements been written?					
41. Has referral for investigation/treatment been recorded?					
42. Patient's age					
43. Patient's sex					

Abbreviations used: Yes = Y; No = N; Not applicable = NA; Male = M; Female = F