STI Medical Record Audit Tool

AUDIT DATE: _____ **County: _____**

MONITOR: _____

Instructions for monitor:

- Request copies of medical records for STI visits made within 8-12 weeks of the audit date.
- The collection of medical records should meet the following requirements:
  - At least 1 male and 1 female client examination performed by each STI provider (MD, APP, ERRN)
  - At least 3 (total) adolescent clients (≤19 years old) who had a positive test result for chlamydia or gonorrhea and were treated at the agency. These records should include the original STI visit as well as subsequent treatment visits.
  - If information should be present and is not, place "0" in the box
  - If information is present place a "√" in the box
  - If the information is not applicable place "NA" in the box
  - All sections and elements referenced on this tool originate from DHHS 2808 Form, available at https://epi.publichealth.nc.gov/cd/lhds/manuals/std/clinical/DHHS-2808-SexuallyTransmittedDiseases.pdf

Chart Number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Medical Record Number, Date of Encounter Sex (M/F genitalia), Date of Birth and Age										
Payer Source for Client: M = Medicaid SP = Self-Pay PI= Private Insurance										
Primary Provider ID (initials of provider)										
1. Select Elements of Medical Record Documentation										
a. All elements of the "Physical Examination" section form are individually addressed.										
b. Printed record should display all applicable elements of the 2808 form.										
c. If applicable, client refusal of full physical exam is documented.										
d. Telephone calls, letters, home visits, etc. are documented to reflect agency policy regarding client follow-up for additional therapy, test of cure, etc. (Agency's follow up policy should be available for review.)										
e. Allergies and adverse drug reactions are prominently noted										
f. Type of allergic reaction or adverse reaction is described in notes.										
2. Entries are signed with name and title of staff making entry:										
a. Interviewer, if not the clinician										
b. Interpreter										
c. STD ERRN										
d. Medical Provider										
e. Treatment nurse, if not the clinician										
f. Disease Intervention Specialist										
g. Others										

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3.	**History and Risk Assessment**									
a.	STI History									
b.	Documents client's stated reason for visit									
c.	Recent antibiotics and present medications are documented by name and last dose									
d.	Vaccine history									
e.	HIV status and HIV testing history									
f.	Sexual Risk Assessment section is complete									
g.	"For Women" section is complete									
h.	Details of symptom parameters are described									
4.	**Physical Examination and Laboratory Specimen Collection**									
a.	Upper body									
b.	Lower body									
c.	Did the client receive testing appropriate to sites of exposure, symptoms, and clinical findings?									
d.	Ordered lab procedures are documented									
e.	Stat lab results are recorded in the current record									
5.	**Assessment and Treatment**									
a.	Clinical impression(s) are correctly documented									
b.	Did the client receive appropriate treatment based on symptoms, clinical findings, and testing?									
c.	Treatment follows most current CDC STD Treatment guidelines									
d.	Prescriptions and refills are documented, if applicable									
6.	**Education, Counseling, Follow Up**									
a.	Control measures are documented, if applicable									
b.	Instructions and counseling correspond with clinical impression(s) and therapy									
c.	Condoms and educational materials offered *(per AA610)*									
d.	Instructions include a 3-month re-screen or test of cure, if applicable									
e.	Instructions include a follow up plan for test results									
f.	Partner notification plan(s) and # of partner cards given to client are documented									
7.	**Evidence of Service Integration**									
a.	Family Planning/Women's Health									
b.	Immunizations									
c.	DIS									
d.	Other									
8.	**Billing and Coding (STD ERRNs ONLY)**									
a.	STD ERRN time is documented in minutes and units									
b.	Billing Sheet reflects correct coding with ICD-10 and CPT codes									

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MONITOR'S COMMENTS: Please list chart number before each comment.