New Audit for:	UNIT	MRN	ADMISSION DATE
	[redacted]	[redacted]	[redacted]

#	AUDIT INDICATOR	TYPE	TEACHING POINT
1	Referral present in chart	Chart	REFERRAL
2	Documentation of limited English proficiency	Chart	INTAKE
3	Medical History present with evidence of review	Chart	INTAKE
4	Psychological, social, & environmental factors present with evidence of review	Chart	INTAKE
5	Co-morbidities present with evidence of review	Chart	INTAKE
6	Allergies present with evidence of review	Chart	INTAKE
7	Medications documented	Chart	INTAKE
8	Documentation of Hearing Impairment	Chart	INTAKE
9	Documentation of Visual Impairment	Chart	INTAKE
10	Fall Risk Assessment	Chart	INTAKE
11	Pain Assessment	Chart	INTAKE
12	Learning Style addressed	Chart	INTAKE
13	History of Present Illness/Injury is complete	Chart	INITIAL EVAL
14	Review of Systems is complete	Chart	INITIAL EVAL
15	Objective Impairment Measures Present/Complete	Chart	INITIAL EVAL
16	Outcome Measure Utilized	Chart	INITIAL EVAL
17	Functional Measures Utililized	Chart	INITIAL EVAL
18	History of Present Illness is complete (PMH, Allergies, Meds documented)	Chart	PLAN OF CARE - Initial
19	Objective measures of impairment and function are utilized documented	Chart	PLAN OF CARE - Initial
20	Measurable/Functional Goals linked to eval findings	Chart	PLAN OF CARE - Initial
21	All required elements completed (Diagnosis, Frequency & Duration, Signatures)	Chart	PLAN OF CARE - Initial
22	Interventions identified are active/restorative and provide appropriate parameters	Chart	PLAN OF CARE - Initial
23	Documentation supports medical necessity for treatment	Chart	PLAN OF CARE - Initial
24	Progress towards outcome goals documented	Chart	PLAN OF CARE - 1 st Follow up
25	Updated or modified outcome goals evident	Chart	PLAN OF CARE - 1 st Follow up
26	All required elements completed (Diagnosis, Frequency & Duration, Signatures)	Chart	PLAN OF CARE - 1 st Follow up
27	Documentation reflects MN of ongoing care	Chart	PLAN OF CARE - 2nd Follow up
28	Progress towards outcome goals documented	Chart	PLAN OF CARE - 2nd Follow up
29	Updated or modified outcome goals evident	Chart	PLAN OF CARE - 2nd Follow up
30	All required elements completed (Diagnosis, Frequency & Duration, Signatures)	Chart	PLAN OF CARE - 2nd Follow up
31	Documentation reflects MN of ongoing care	Chart	PLAN OF CARE - 3rd Follow up

32	Progress towards outcome goals documented	Chart	PLAN OF CARE - 3rd Follow up
33	Updated or modified outcome goals evident	Chart	PLAN OF CARE - 3rd Follow up
34	All required elements completed (Diagnosis, Frequency & Duration, Signatures)	Chart	PLAN OF CARE - 3rd Follow up
35	Documentation reflects MN of ongoing care	Chart	PROGRESS NOTES
36	Functional or objective response to treatment documented	Chart	PROGRESS NOTES
37	Progress towards outcome goals documented	Chart	PROGRESS NOTES
38	Progress Note dated & signed by therapist every 10 visits	Chart	PROGRESS NOTES
39	Subjective reports of current status is documented	Chart	TREATMENT NOTES
40	Documentation of interventions present with parameters	Chart	TREATMENT NOTES
41	Objective changes in impairments/functional limitations evident in record	Chart	TREATMENT NOTES
42	Appropriate use and documentation on flow sheets	Chart	TREATMENT NOTES
43	Direct and total treatment time identified	Chart	TREATMENT NOTES
44	Direct treatment time and treatment units correspond	Chart	TREATMENT NOTES
45	Home exercise program provided and signed by patient	Chart	TREATMENT NOTES
46	Treatment notes support skilled interventions	Chart	TREATMENT NOTES
47	Legible	Chart	OTHER
48	Signature page present	Chart	OTHER
49	Errors corrected per UCHC policy	Chart	OTHER
50	Appropriate abbreviations used	Chart	OTHER
51	At least 2 patient identifiers on each page	Chart	OTHER
52	Student, PTA notes co-signed	Chart	OTHER

SUBMIT