

Table 23-1.

CHECKLIST SAMPLE: CHART REVIEW

Criteria	Components
Basic information to be retrieved from a chart review	<ul style="list-style-type: none"> • Date of onset • Admitting diagnosis • Medical history (pertinent medical problems, procedures, preexisting conditions that may affect the evaluation or intervention) • Current medical intervention (medications, procedures, rehabilitation efforts, and progress) • Current medical status (client getting better or deteriorating, intervention plan, discharge plan, results of recent tests, and DNR status; information can be found in nursing and medical notes) • Personal information (age, marital status, family configuration, residence, work history, financial information) • Medication lists (will any medications affect intervention?)
Components pertinent to occupational therapy (where you will find the information)	<ul style="list-style-type: none"> • Medical section (physician notes, pertinent past medical history, general information on social situation, response to intervention, course of intervention, referrals to specialists, upcoming surgeries or procedures, precautions, complications during acute phase that might affect recovery [e.g., infection, hydrocephalus, respiratory distress, seizures]) • Nursing section (day-to-day status, response to intervention or disability, often report response to splinting, positioning, activities of daily living, and mobility performances) • Test section (laboratory reports, radiography, computed tomography, magnetic resonance imaging) • Medication lists (sometimes grouped in this section are vital signs, weights, calorie counts) • Professionals section (physical therapy, speech pathology, social work, therapeutic recreation, neuropsychology, vocational rehabilitation evaluations, and progress notes); some institutions have continuous problem-oriented records, and these reports are within the body of the medical section

Adapted from York, C. D., & MacRae, N. (1993). *Class handout*. Biddeford, ME: Occupational Therapy Department, University of New England.

Initial Notes

Initial notes are essentially evaluation notes with the specific form varying among entities: general medical, mental health, home health, public education, etc. The initial documentation process can be divided into three stages: actions before meeting the client, the client interview, and actions after the interview.

Actions Before Meeting the Client

Data collection begins before the client interview. Table 23-1 provides an overview of what and where a therapist working in an acute care physical disabilities setting would look to gather data during an initial assessment from a chart review. If it is possible, the practitioner begins by examining medical records, reports of previous assessments, results of educational testing, and other pertinent documents (Figure 23-2). At this stage, the therapist needs to form a mental “picture” of the client and an idea of what the practitioner is being asked to do. Practitioners should note the following:

- Who is the referral agent (e.g., a physician, a parent, a classroom teacher, another therapist)?
- What is being asked of the therapist (e.g., an orthosis, a safety evaluation, a fine motor writing evaluation)?



Figure 23-2. Chart review.

- If the referral is not clear, then the practitioner needs to follow up with the referring professional to get more information on what outcome is needed.