Tips for requesting and reviewing medical records

Medical records should document many aspects of your client's treatment. Knowing what to ask for and who has it can influence the outcome of the case.

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Whether your practice involves medical malpractice, personal injury, toxic tort, or even family law, you will at some point in time have the need to request medical records. Most states have a section in the Rules of Civil Procedure covering the specific request format, time to respond, and charges for medical billing. Be sure to check your state code prior to preparing a request for medical records.

Tips for requesting medical records

Below are some tips for paralegals and attorneys who will need medical records in order to substantiate a claim and answer discovery through production of medical records:

• Interview the client to obtain as complete a medical history as possible. If they have billing records, copy and retain those, as they will contain important contact information for healthcare providers.

• Remember billing and medical records may not be maintained at the same facility, and a separate request for each is needed.

• Obtain the pharmacy billing records prior to and subsequent to the incident in question. Have the potential client bring these for the initial interview. They will contain a thumbnail sketch of the patient's medical care prior to the incident in question, identify prescribing/health-care providers as well as document medication taken (such as pain medication) to aid in supporting damages.

• Many medical records, especially nursing documents, are multiple pages with dates, and signatures only on one

page. You should request that multiple pages be stapled in order, because this is crucial to establish dates, times and providers in a chronological order.

• Often treatment and medications records are double-sided with initials/signatures and comments on the opposite side. Be sure to request double-sided copies, or if single-sided copies, request they be stapled together. These records may contain crucial information in a case.

• As in any case of medical negligence or malpractice, the medical records are extremely important in proving the facts showing negligence, causation and damages.

• Obtain ALL of the nursing home, clinic, urgent care, emergency room, ambulance, visiting nurse, occupational therapy, speech therapy, physical therapy, respiratory therapy records and ALL doctor and hospital records.

• Sometimes urgent care, ambulatory care clinics, emergency rooms, ambulances, nursing and various therapy services, etc., are independent contractors. Establish with the hospital or institution what care the independent contractors provide and where to address medical records requests to ensure you are ordering ALL of the available medical records.

• Even if all of the available medical records are not part of the alleged incident and are not subject to the medical review, they should still be obtained as reference material.

• The records just prior to and after an alleged incident are especially important in providing documentation as to the person's medical condition, the extent of the alleged injuries, as well as an indication of any probable long-lasting complications that may now exist.

Key Point: Information is often obtained from seemingly obscure records, hence the need to request ALL of the medical records.

Components of the medical record

Hospital Records

Hospital records include, but are not limited to:

• **Admission Information/Summary.** Documents date/time of admission, admitting diagnosis, admitting physician and other basic admission information.

• **Discharge Summary.** Documents condition at time of discharge, any post discharge instructions for lab tests, physician appointments and medications prescribed, as well as instructions for physical activity and other treatment modalities.

• **Admission History and Physical.** Documents condition at time of admission, usually performed by admitting physician, but sometimes deferred to a medical resident or physician assistant. There may also be a separate document, "Physician's Admission History and Physical," in some health-care facilities.

• **Physician's Progress Notes**. Daily chronology of patient's progress, often gives rationale behind change in treatment or medication and documents physician visits.

• **Emergency Room Records**. Documents condition upon arrival, chief medical complaint, and may also include emergency room physician evaluation of any tests performed such as ultrasound, radiology and laboratory tests. Recommendations for referral, admission, and/or discharge are obtained here.

• **Consultation Reports** (Physician and other professional.) Documents evaluation and recommended treatment by physicians and other health-care providers asked to consult in reference to patient care.

• **Physician's Orders.** Documents date and time of treatments and medications ordered by treating physicians. These are to be signed by the physician ordering, even if a telephone order was made or verbal order was given to a nurse.

• **Operating Room Records and Report** (Physician, Nursing and Anesthesia Record). Documents procedure performed, surgeons, nurses and anesthesia personnel present during surgery. Also documents patient condition before, during and after surgery. Some hospitals document post-operative care in the PAR (post anesthesia recovery) record.

• **Laboratory Reports**. Documents results of tests performed in the laboratory. Includes not only blood and urine tests, but also cultures of tissue and microscopic exam of tissue.

• **Graph Sheets.** Documents basic vital signs and other basic functions such as urinary and intestinal elimination. Some graphic sheets also document dietary and fluid intake.

• **I and O record**. Documents fluid and solid intake and output on a daily basis. Usually tallied on a daily basis, but may be recorded with each shift (two to three times a day.)

• **Treatment Sheet**. Documents all manner of treatments such as wound care, hot and cold therapy not given in physical therapy, etc.

• **Medication Sheets.** Documents medications given. PRN medication is given on an "as needed" basis and may be listed separately from regularly scheduled medications.

• **X-ray/Radiologist Report**. Documents radiologist's impression of radiology tests. Will also contain name of ordering physician.

• **Physical Therapy Records**. Documents treatments/therapy given in the physical therapy department as well as the patient's response to therapy.

• **Speech Therapy Records.** Documents therapy given by speech pathologist.

• **Occupational Therapy Records**. Documents therapy given by occupational therapist. May be included as part of physical therapy records in some institutions.

• **Nurse's Notes/Nursing Progress Notes.** Chronological documentation of patient's condition, physician visits, changes in condition and treatments given as well as patient responses. Usually written in longhand, but more and more frequently are seen as a computerized record.

• **Nursing Care Plans.** Each patient has a general plan of care, and the foundation is determined by the policy of the health-care facility. However, generally the nursing care plan covers all treatments, medications and therapies ordered for the patient. Goals are also stated for patient care.

• **Interdisciplinary/Multidisciplinary Progress Notes** (Not utilized in all facilities.). Documents progress of each therapeutic department in chronological order, rather than a separate progress note maintained by each department. May include notes made by more than one department, such as speech, physical and occupational therapies.

Other records found but not consistently maintained by all facilities may include:

Records/Treatment Logs:

• **Treatment Records, Nursing Treatment Records** (Sometimes in with the medication records; sometimes listed separately.).

• **Physical Therapy**.

• **Speech Therapy**.

• **Occupational Therapy**.

• **Rehabilitation Therapy, Restorative Services**.

• **Recreational Therapy, Activity Therapy or Service**.

• **Any other form of therapy records**.

• **Visiting Nursing or Home Care Nursing Records**.

• **Records from Independent Medical Laboratories**.

• **Records from Independent Radiology and Nuclear Medicine Services**.

Emergency Service Records

• **Ambulance Records** (EMS - Emergency Medical Service.) These records may be maintained by either an independent EMS service, a municipal fire department or a hospital EMS service.

• **Emergency Room Records** (These are often not part of the hospital records, where the emergency room is operated by an independent contractor.)

In some situations, the records of emergency response personnel such as the local police and rescue portions of the fire department will also apply and will be separate from other EMS records, and a separate request for each entity will be required in order to obtain all records.

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