

## TEXAS MEDICAL BOARD RULES ON ADEQUATE MEDICAL RECORDS

1. The documentation of each patient encounter should include:
  - a. reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
  - b. an assessment, clinical impression, or diagnosis;
  - c. plan for care (including discharge plan if appropriate); and
  - d. the date and legible identity of the observer.
2. Past and present diagnoses should be accessible to the treating and/or consulting physician.
3. The rationale for and results of diagnostic and other ancillary services should be included in the medical record.
4. The patient's progress, including response to treatment, change in diagnosis, and patient's non-compliance should be documented.
5. Relevant risk factors should be identified.
6. The written plan for care should include when appropriate:
  - a. treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
  - b. any referrals and consultations;
  - c. patient/family education, and
  - d. specific instructions for follow up.
7. Any written consents for treatment or surgery requested from the patient/family by the physician.
8. Billing codes, including CPT and ICD-9 CM codes, reported on health insurance claim forms or billing statements should be supported by the documentation in the medical record.
9. Any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.
10. Records received from another physician or health care provider involved in the care or treatment of the patient shall be maintained as part of the patient's medical records.