DBP Letters and Reports: Checklist

Trainee Name ____________________
Report for Patient seen in ____________________ Clinic
Report Date ______________________

Checklist should be completed based on review of the trainee's DBP documentation (e.g., Clinic letters to referring physicians, with copies to families).

Report Goals and Objectives	Objective consistently met	Objective inconsistently met	Objective not met	Objective not applicable	Notes
GOAL 1: REPORT IS WELL-FORMED					
Report is organized and structured according to clinic-specific note sheet.					
Report is non-redundant.					
GOAL 2: REPORT IS COMPREHENSIBLE					
Report is comprehensible.					
Report is coherent and correct, as follows:	---	---	---	---	---
• Spelling is correct					
• Grammar is consistent with formal professional writing guidelines					
Report avoids:	---	---	---	---	---
• Meaningless or vague phrases such as '*eats well*' or '*in no distress*'					
• Use of abbreviations without definition, such as IEP, SARC, ABD, ELBW, etc.					
• Use of informal personal names, such as '*Mom*' or '*Dad*'					
• Use of phrases that could be misunderstood by lay readers such as '*complains of [abdominal pain]*' or '*denies [use of alcohol]*'					
• Use of outdated medical terminology such as '*mongolian spot*' or '*mental retardation*'					
Report clearly distinguishes among: (1) History (information provided by parent/child report or medical record); (2) Observation (information collected directly by physician examination); (3) Interpretation					
GOAL 3: REPORT IS ACCURATE					
Report is complete and thorough. It provides record of clinical care (primary parental concern, assessment, impression, plan of action, outcomes and evaluation of care).					
Report accurately summarizes previous					

Document developed by Developmental-Behavioral Pediatrics
Lucile Packard Children's Hospital at Stanford
http://dbptraining.stanford.edu/
Last update 10/08/13

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evaluations, individualized education plans (IEPs), and psycho-ed testing					
Report reflects professional assessment and does not present unfounded conclusions or personal judgments					
Documentation reflects use of standardized practice guideline templates, when appropriate).					
Documentation is sufficient for primary communication between health professionals.					
Documentation provides clear evidence of patient need in context of determining service eligibility and resource allocation.					
Documentation is legally sufficient, with:	---	---	---	---	---
• Evidence of timely completion as close as possible after episode of care or event					
• Detailed identification of person(s) who provided and documented care					
• Detailed identification of information sources, such as another health care provider, family member, teacher)					
• Detailed documentation of any critical incidents such as harm to patients or medication errors					
GOAL 4: REPORT IS COMPACT					
Report sections are succinct and focused.					
Report reflects appropriate use of electronic templates.					

Resident Name and Signature ______ Attending Name and Signature ______ Date ______

ATTENDING'S COMMENTS:

Documentation quality factors based on:

- Stetson PD, Morrison FP, Bakken S, Johnson SB; eNote Research Team (2008). Preliminary development of the physician documentation quality instrument. J Am Med Inform Assoc. 2008 Jul-Aug;15(4):534-41. Epub 2008 Apr 24.
- Guidelines for Medical Record and Clinical Documentation (WHO-SEARO coding workshop September 2007) downloaded July 18, 2012, http://www.searo.who.int/LinkFiles/2007_Guidelines_for_Clinical_Doc.pdf.