Record keeping by physicians in non-hospital settings

Practice guide

Collège des médecins du Québec

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Foreword

Following major changes to certain regulations, the Collège des médecins du Québec has updated the guide *La rédaction et la tenue des dossiers par le médecin en cabinet de consultation et en CLSC*, first published in September 2006. In effect since May 31, 2012, the *Regulation respecting records, places of practice and the cessation of practice by a physician* is an update of several standards that the physician must respect in regard to the organization of places of practice and the management of records and other documents. Like previous regulations, its general provisions stipulate that a physician must create and maintain a medical record for any person who consults him (in whatever place the consultation occurs), participates in a research project or is the subject of a report, or for any population or any group targeted by a public health intervention. In the update, however, it is specified that in the case of a physician who practices in a centre operated by an establishment within the meaning of the Act, the user record drawn up and maintained by the establishment is considered a medical record and the physician is required to enter into it all information mentioned in this Regulation.

Traditionally, there are two types of medical practice in Quebec: in an institution and in an office. However, the boundaries between offices and institutions are becoming increasingly permeable. On the one hand, family physicians do not work solely in their office: they are increasingly called upon to contribute to the delivery of care and services in institutions. On the other hand, increasingly specialized care is moving out of institutions, to delivery sites that are no longer traditional physicians’ offices. New organizational models have multiplied in recent years, falling somewhere between the institution and the office; common to both is the delivery of care outside hospital centres.

While the rules for medical record keeping will now apply to all physicians irrespective of their place of practice, certain rules may vary if the physician practices in an institution, since the institution may have its own rules. Consequently, there are always two practice guides on the subject: *La tenue des dossiers par le médecin en centre hospitalier de soins généraux et spécialisés*, published in December 2005, intended more specifically for physicians practicing in hospital centres, and this guide for physicians practicing in non-hospital settings.

It is important to note that this guide applies to all types of activities performed by a physician in all places of practice in non-hospital settings and, in some cases, to ambulatory care in institutions. It therefore applies to both the professional activities of physicians who practice clinical medicine in an office or specialized medical centre and those of physicians who act as experts or consultants within a company or for a public or parapublic agency. For example, this new guide will be of interest to physicians who do walk-in duty at a polyclinic, who work in prisons, health and social services centre (CSSS) offices, in public health at a regional health and social services agency, as well to those who work in ambulatory care in an institution (CHSGS, CHU or CSSS), a family medicine group (FMG) or a family medicine unit (FMU).

 Needless to say, this guide applies to students and residents if they practice in the settings covered in the guide during their clinical rotations. They must familiarize themselves with these rules and ensure they are incorporated into their actual and future practice.

Note: The practice guides mentioned in this publication are available in French only.
Table of contents

Introduction .................................................................................................................. 4

1. Six reasons for keeping good medical records ........................................... 5
   1.1 Memory aid for the physician ................................................................. 5
   1.2 Communication tool .................................................................................. 5
   1.3 Reflection of the physician’s competence .............................................. 5
   1.4 Legal protection instrument ................................................................... 6
   1.5 Attestation of services rendered ............................................................. 6
   1.6 Teaching and research .............................................................................. 6

2. Medical record keeping: general considerations ............................................ 7
   2.1 Patient identification .................................................................................. 7
   2.2 Legibility ..................................................................................................... 7
   2.3 Note entry timeframes .............................................................................. 7
   2.4 Filing ........................................................................................................... 8
   2.5 Corrections and additions ......................................................................... 8
   2.6 Indexing ...................................................................................................... 8
   2.7 Registers .................................................................................................... 9

3. The content of the medical note .................................................................... 11
   3.1 Date and time ............................................................................................. 11
   3.2 Reason for the consultation ..................................................................... 11
   3.3 History ....................................................................................................... 11
   3.4 Objective examination ............................................................................. 11
   3.5 Diagnosis .................................................................................................. 12
   3.6 Investigation plan ..................................................................................... 12
   3.7 Pharmacological and non-pharmacological treatment ............................ 12
   3.8 Injections, vaccinations, desensitization .............................................. 13
   3.9 Communication with the patient .............................................................. 13
   3.10 Patient follow-up ..................................................................................... 13
   3.11 Signature .................................................................................................. 14
4. Record keeping for specific types of consultations .......................... 15
  4.1 Walk-in assessment ........................................................................... 15
  4.2 Assessment of long-term management or follow-up ....................... 16
  4.2.1 Record summary ............................................................................ 16
  4.2.2 List of medications ......................................................................... 18
  4.2.3 Medical note .................................................................................... 19
  4.2.4 Follow-up forms ............................................................................. 19
  4.3 Periodic health evaluation (annual check-up) .................................... 20
  4.4 Obstetrical follow-up ........................................................................ 20
  4.5 Pediatric follow-up ........................................................................... 21
  4.6 Patient experiencing a loss of autonomy ........................................... 22
  4.7 Home visits ....................................................................................... 23
  4.8 Patient with mental health problems ................................................ 24
  4.8.1 Clinical assessment .......................................................................... 24
  4.8.2 Treatment plan ............................................................................... 27
  4.8.3 Mental health follow-up .................................................................. 28
  4.9 Minor surgical procedure report ....................................................... 28
  4.10 In-office surgical procedures under sedation/analgesia, regional anesthesia or general anesthesia ......................................................... 29
  4.11 Telephone calls ............................................................................... 30

5. Electronic records .............................................................................. 31

6. Writing a medical prescription ............................................................. 31

7. Medical record self-evaluation .............................................................. 32

Conclusion .............................................................................................. 32

Appendices ............................................................................................... 33
  A Record summary .................................................................................... 34
  B List of medications ................................................................................ 35
  C Follow-up sheet — Type 1 or type 2 diabetes ........................................ 36
  D Follow-up sheet — Cardiovascular diseases ......................................... 37
  E Follow-up sheet — Anticoagulant therapy ............................................ 38
  F Adult periodic health evaluation ............................................................ 39
  G Folstein’s Mental State Test ................................................................... 40
  H Medical record self-evaluation sheet .................................................... 42
The practice guide *Record keeping by physicians in non-hospital settings* is intended to help physicians improve their medical record keeping on a day-to-day basis. It does not take the place of legislation or regulations regarding medical record keeping, but supplements them by focusing on their application, in addition to providing numerous recommendations. It is therefore both a normative reference and a practical tool.

The experience gained from the interventions of the Professional Inspection Committee and the Syndic, the guides published previously on the subject and the numerous articles published over the years, in particular in the publication *Le Collège*, were used as references in developing this new edition.

This guide is based on the *Regulation respecting records, places of practice and the cessation of practice by a physician*, adopted by the Collège des médecins du Québec under the Professional Code. This regulation provides a framework for numerous aspects of the professional practice of physicians practicing in offices and institutions, in particular record keeping, retention and maintenance. This document also takes other legislation and regulations into consideration, such as the *Code of Ethics of Physicians* and certain provisions of the *Act respecting health services and social services* (ARHSSS).

These provisions set forth institutions’ obligations with respect to patient record keeping, indicating, for example, the information that must be included in an institution's records, in particular in the context of outpatient consultations, such as at an CSSS (FMU, FMG, CLSC).

Since medical practice in hospitals with outpatients is similar in several respects to that in non-hospital settings, it is reasonable to propose a single standard of quality for medical record keeping, even if some aspects of record management may differ.

This guide proposes that the physician review the benefits of more rigorous record keeping for himself and his patient. It is an opportunity to take a critical look at his record-keeping practices and to learn about some tools he might find useful. Each physician may then use his creativity to customize a system that will meet his needs and satisfy regulatory requirements.

A physician’s lack of time or his desire to focus more on the patient than on the record are the reasons most frequently cited to explain inadequate record keeping. Yet there are many reasons for requiring proper medical record keeping, and it is important to recognize that poor record keeping can give the impression of poor management. We cannot insist enough on the need, for the physician, to force himself to keep impeccable records, since the medical record is a document with multiple objectives. A physician who is rigorous in his record keeping is already on the way to quality professional practice.
1. **Six reasons for keeping good medical records**

A physician is required to create and maintain a single medical record per place of practice for any person who consults him, who contacts him directly or is referred to him by a third party, in whatever place the consultation occurs (office, company, home, etc.). The same requirement applies when he contacts a patient, for example, to give him a test result, when a patient participates in one of his research projects or for any individual or group targeted by a public health intervention.

Physicians who practice in a group may maintain a single medical record per person. In this situation, the medical record must be accessible at all times to all the physicians in the group.

The medical record is therefore an indispensable tool that fulfils many functions.

1.1 **Memory aid for the physician**

The medical record is first and foremost an essential memory aid for a physician who wishes to provide quality care and effective follow-up over time to his patient. It gives a detailed picture of the patient’s state of health and any developments in his condition as well as documenting any interventions carried out by the physician and other professionals, as in a family medicine group (FMG).

1.2 **Communication tool**

Since care is becoming increasingly complex and many professionals may now be called upon to contribute to a patient’s care, the transmission of information is an important issue. The medical record is precisely the right communication tool, for it allows all the relevant information, once the patient’s consent has been obtained, to be transmitted to the individuals and agencies concerned: other physicians or professionals contributing to care as well as health care institutions or any other agency that requests it (e.g., employer or insurance company).

The record should contain only the relevant elements obtained during the data collection, investigation and treatment of the patient. The medical record should never be used to comment on administrative problems or conflicts between professionals regarding a care episode. Nor must it contain inappropriate personal comments or judgements about the patient (e.g., “patient not very intelligent”).

1.3 **Reflection of the physician’s competence**

If it is created in such a way that the patient’s health problems are accurately presented and the physician’s clinical approach and proposed management can be clearly understood, the record becomes a reflection of his competence.

Consequently, it is an excellent tool that can be used to assess the quality of his professional practice.
1.4 Legal protection instrument

Since the medical record is an accurate account of the care provided to the patient, it is an important legal protection instrument for the physician.

The elements included the record must therefore be relevant and complete so that they reflect the patient’s specific health issues.

1.5 Attestation of services rendered

The medical record is an attestation of the services rendered, and their nature, to a patient or a third-party payer, in particular the Régie de l’assurance maladie du Québec. It is advisable to account for any billing for services in the record, in the event of future litigation.

1.6 Teaching and research

The medical record is a valuable document for teaching, research and compiling statistics. It provides an account of the clinical indicators monitored by the physician.

The record reflects the quality of care and follow-up the physician has provided to his patient.
2. Medical record keeping: general considerations

All medical records must satisfy well-defined requirements and comply with specific rules.

All documents or entries in the record must be in French or English.

2.1 Patient identification

To comply with regulations, patient identification must include: the patient’s surname and first name, sex, date of birth and address, which must be updated regularly. It is useful to note the patient’s health insurance number and telephone number and his pharmacist’s telephone number. In addition, each new page added to the record must be identified with the patient’s name or record number.

2.2 Legibility

The legibility of the notes is extremely important, since it reduces the risk of errors. It is a requirement stipulated in the Regulation respecting records, places of practice and the cessation of practice by a physician. All physicians must ensure that their notes are legible to other health care providers. The speed at which notes are written often results in poor legibility.

For physicians whose handwriting is a problem, writing notes in print can be helpful, especially for the diagnosis and treatment. Voice recognition software, usually available at an affordable price, can also be used. However, this type of tool does require, at least in the beginning, hours of correction, but the results are good.

2.3 Note entry timeframes

The note must be written up and entered in the record during the consultation or immediately afterwards. In fact, a note entry delay must be kept to a minimum. The information must be entered when it is fresh in the physician’s mind and his memory is still accurate. The note will always take precedence over memory.

If the physician is unable to write up his note on the same day, he should indicate the date the note was written as well as the date of the consultation.

The operative report for any surgical, endoscopic or radiological procedure must be written up or dictated within 24 hours of the procedure.
2.4 Filing

The various elements entered in the record should be filed by category in the following order:

- the summary;
- the list of medications;
- the medical observations, including follow-up sheets for chronic diseases and tests;
- complementary test reports: hematology, biochemistry, coagulation, microbiology, etc.;
- medical imaging reports;
- pathology reports, including cytology tests;
- reports from medical consultations, experts, endoscopies, special tests, genetic tests;
- operative and anesthesia reports for major surgical procedures;
- iconographic documents;
- occupational disease data;
- legal authorizations, including medical and administrative forms; ¹
- any other documents.

This type of filing method makes it easier to consult and “streamline” the medical record. The chronological order must be respected for each category.

2.5 Corrections and additions

Any corrections and additions made to the medical record must be easy to distinguish from the initial notes. An element that has already been entered in the record must never be deleted, altered, or blacked out, for example by running a line through it so that it is no longer legible. Instead the physician must write an additional note dated the day the correction was made.

Moreover, the deletion, alteration and correction of medical information in the record at the patient’s request are illegal and subject to disciplinary sanctions if this information is relevant and important for the diagnosis or treatment of a health problem, unless it is incorrect. If so, the physician writes up an additional note and makes the correction.

These comments also apply to electronic medical records; therefore, a note in the record may not be corrected a posteriori without respecting the above-mentioned guidelines.

2.6 Indexing

The physician must use a system allowing the orderly filing and indexing of the medical records. For more information on this topic, consult the guide *L’organisation des lieux et la gestion des dossiers médicaux en milieu extrahospitalier.*

1. A copy of all the relevant forms or letters (e.g., leave from work, insurance, legal authorizations, documents received from or intended for the Commission de la santé et de la sécurité du travail and the Société de l’assurance automobile du Québec) must be entered in the record.
2.7 Registers

A physician must, for every non-hospital setting he practices in, create and maintain five mandatory registers, unless the medical activities he practices do not require a register to be created.

**Patient register**

**Definition**
Register that identifies all the individuals who have consulted him, including those assessed at home or without an appointment as well as any surgical or invasive procedure performed during the consultation — excluding injections and infiltrations of medications — and the type of anesthesia administered.

**Alternative**
If this information is contained in the appointment book or billing register of the Régie de l’assurance maladie du Québec, the latter may take the place of the patient register.

**Retention period**
This mandatory register must be maintained for one year.

**Objective**
This register identifies each physician’s day-to-day activities.

**Procedures register**

**Definition**
Register that identifies all the individuals who underwent a surgical or invasive procedure that involved sending out a specimen of a part of the human body or an object.

**Retention period**
This mandatory register must be maintained for five years.

**Objective**
This register must be used to provide a comprehensive follow-up of every anatomic pathology test request.
## Incidents and accidents register

**Definition**  
Register that identifies any incidents and accidents that occurred during or in connection with an invasive medical procedure requiring anesthesia, sedation or analgesia as well as any preventive measures taken.

**Retention period**  
This mandatory register must be maintained for five years.

**Objective**  
This register is part of a culture of security. It must be used to monitor the measures taken to prevent repeat incidents (near miss) or accidents. It is not a register of "typical" complications. It must be kept where the procedure is performed and for all physicians' activities in order to allow a joint approach to problems and solutions.

Translation of definitions from the Ministère de la Santé et des Services sociaux:
- Incident: an action or situation that does not have consequences on the user's health status or well-being, but the outcome of which is unusual and could have consequences under different circumstances.
- Accident: an action or situation where the risk materializes and has or could have consequences on the user's health status or well-being.

## Research subject register

**Definition**  
Register that identifies all the individuals he assesses, treats or whose treatment he supervises as part of a research project.

**Retention period**  
This mandatory register must be maintained for five years after completion of the research project.

## Parenteral benzodiazepines, controlled drugs and narcotics registers

**Definition**  
Register that identifies:
- the nature and quantity of the substances he has in his possession;
- the identity of all individuals to whom he provides or administers these substances;
- the nature and quantity of substances he has disposed of and the method and date of disposal.

**Retention period**  
This mandatory register must be maintained for five years.

The physician must ensure that the method used to destroy registers ensures the protection of confidential information, as specified in the guide *L'organisation des lieux et la gestion des dossiers médicaux en milieu extrahospitalier*, chapter 3.
3. **The content of the medical note**

The medical note is the central element of the record. It shows the physician’s approach to the problem the patient is consulting him about, including the decision-making process. It must include the elements described in this section.

### 3.1 Date and time

Every consultation and all other entries in the record must be dated. The time must also be noted if it is an emergency consultation or if a specific time period is particularly important.

This requirement also applies to any additional notes concerning a particular consultation and written at a later date.

### 3.2 Reason for the consultation

The reason for the consultation must be clearly identified. It must be entered in the record concisely and accurately.

### 3.3 History

The history is the most important part of the patient assessment, since it contributes as much to the physician’s understanding of the problem as the physical examination and complementary tests. The following elements must be described in detail in the history:

- the symptomatology and duration of symptoms (history of the presenting complaint);
- all the relevant positive and negative findings related to the reason for the consultation;
- the presence of previous episodes or trauma;
- any interventions already tried;
- the list of medications;
- allergies;
- any other relevant elements.

### 3.4 Objective examination

The physician’s objective examination must be pertinent to the history of the presenting complaint. All relevant positive and negative findings must be carefully noted. The objective examination includes, among other things, if they are considered useful:

- the basic parameters (vital signs): temperature, blood pressure, pulse;
- the respiratory rate;
- weight, height, body mass index and waist circumference.

The use of a template for the history or the physical examination does not exempt the physician from specifying the relevant positive and negative signs and symptoms.
3.5 Diagnosis

The diagnosis must be presented as accurately as possible. When available, it is always preferable to use recognized nomenclatures (e.g., the DSM nomenclature in psychiatry) or recognized classifications of professional associations, such as the International Classification of Diseases (ICD-10-CA).

Furthermore, the physician must avoid entering a diagnosis in the record that is descriptive or that describes the complaint (symptom) in the patient’s words. If the problem has not been differentiated, a differential diagnosis proposing the most likely diagnoses should be entered in the record.

3.6 Investigation plan

The investigation plan must be detailed. It must include all requests for complementary tests. Some tests may be grouped together based on recognized designations in practice settings (e.g., “hepatic work-up” or “lipid profile”, which correspond to predetermined parameters); terms such as “work-up” or “labs” are not sufficiently informative. The physician may also keep a copy of the request form for complementary tests so that he does not have to write up the tests requested again in the medical record.

The investigation plan must also include any consultations requested and any transfers to other professionals. For some tests (e.g., medical imaging), the physician must ensure that any clinical information relevant to their interpretation is noted in the forms.

3.7 Pharmacological and non-pharmacological treatment

All types of treatment must be well documented in the record.

For pharmacological treatment, the note in the record must specify:

- the name of the medication (preferably the generic name);
- the pharmaceutical form (capsule, tablet, syrup, etc.);
- the strength or concentration;
- the dosage (frequency, route of administration and, where applicable, the interval between doses);
- the quantity prescribed and the length of treatment as well as the number of refills authorized.

When narcotics are prescribed, the total dose should be entered in the record as well as any split doses, where applicable. The reason for the prescription or any dosage changes must also be documented.

Non-pharmacological treatments (e.g., exercise, diet) must also be noted in the record, along with any important information or any explanations given to the patient.
3.8 Injections, vaccinations, desensitization

Any act relating to an injection, vaccination or desensitization must be described in full in the record.

For each biological product injected, the note or the table provided for this purpose should include:

- the indication for administering the product;
- the absence of contraindications, indicating the main ones;
- the presence or absence of a reaction when administered previously;
- the name of the product injected;
- the concentration;
- the quantity;
- the route and site of administration;
- the product batch number.

The physician should also note that the patient has been informed of:

- the risks of adverse reactions (or side effects) following the injection;
- the length of time he must wait before leaving the office.

3.9 Communication with the patient

All written, telephone or electronic communication with the patient should be carefully documented in the record, whether it concern, for example, a risk assessment, the relevance of a given investigation or the choice of treatment when there is more than one option.

It may also be advisable to document any conversations with other professionals regarding the patient’s condition and the care required or provided.

3.10 Patient follow-up

All the elements of the recommended follow-up must be entered in the record, namely:

- when the next visit is scheduled;
- factors for which the patient should consult earlier than planned;
- when the next complementary tests are scheduled.
3.11 Signature

The physician must put his signature underneath any entry he makes, or initial it, if he is not the only person entering information or documents in the medical or research record. In addition, the physician must sign or initial any entry or transcription made by one of his duly authorized employees who is not a member of a professional order.

In short, a well-written note provides a record of the consultation and the clinical approach.

It is:
• legible;
• relevant;
• objective;
• informative.
4. Record keeping for specific types of consultations

4.1 Walk-in assessment

Writing a medical note for a walk-in assessment is a significant challenge for a number of reasons. Overcrowding in “walk-in” clinics often forces a physician to work under pressure. He therefore has a short time to not only see patients whom he is often meeting for the first time and with whom he must quickly establish a good relationship, but also to determine an appropriate diagnosis and treatment plan. Walk-in clinic patients are also more likely to present with new acute conditions. In such conditions, the physician is particularly prone to errors or omissions, which can have serious consequences for the patient and the physician.

The medical observation must be complete even if it is succinct. In order to keep the time it takes to write up the note to a minimum, the physician may use a standardized form or a checklist. Using this type of form by no means exempts him from his obligation to write up a complete note tailored to the clinical situation.

The physician must be especially attentive to the relevant personal and family history, use of medication, allergies and substance abuse. He can update the record summary.

For certain health problems, the patient’s attitude and behaviour are extremely important and must be described as accurately as possible without making any value judgements. The note should also include a description of the patient’s general condition, his basic parameters (vital signs) as well as any relevant positive and negative findings.

Symptomatic diagnoses (e.g., headache, sore throat, low back pain), which are common with this type of consultation, must be avoided. A differential diagnosis is necessary if the diagnosis cannot be pinpointed at this stage.

The treatment proposed during a walk-in assessment, whether it is pharmacological or non-pharmacological, must be detailed. In addition, the follow-up, which is often particularly important in this type of consultation, must be described precisely.

It is also recommended that the physician document any instances where the patient refuses certain investigations, recommendations or treatments.

- The extent of overcrowding does not excuse a botched or incomplete note.
- A succinct note is not necessarily an incomplete note.
4.2 Assessment of long-term management or follow-up

Record keeping is particularly important in long-term patient management and follow-up. It includes the following elements.

4.2.1 Record summary

The Regulation respecting records, places of practice and the cessation of practice by a physician (art. 6, 13°) stipulates that the physician must include “a summary of the record containing an up-to-date summary of the information useful to a global assessment of the state of health of any patient who is in the physician's charge or who regularly consults him.”

While filling out a record summary (Appendix A) may seem to create more work at first, it allows the clinician to gain valuable time during subsequent consultations.

The “Record summary” form is the cornerstone of record keeping for long-term patient management and follow-up.

The summary has a number of advantages:

• at a glance, it summarizes the patient’s overall state of health and allows the physician to be more efficient;
• it simplifies the work of any colleagues who may have to see the patient;
• it is useful when choosing medications;
• it can be used to quickly check the contraindications for a medication;
• it means that the physician does not have to write up certain information again in the progress notes;
• it reduces the risk of omitting any elements in the longitudinal follow-up;
• it greatly simplifies writing up a synopsis of the record or a response to a request for information from insurers or a third party;
• it is easy to append, if necessary, to consultation or transfer requests.

2. The “Record summary” form, presented in Appendix A, can be photocopied and entered in the record. It can also be downloaded from the Web site of the Collège des médecins du Québec: www.cmq.org, under Physicians, keyword “Keeping of Records.”
The summary provides an overview of the elements in the patient’s record. To be useful and effective, the summary should contain the following elements:

- information about the patient’s identity;
- the record number from the hospital centre where the patient consults, if necessary;
- significant diagnoses, or the list of relevant problems, as well as the date they were established;
- risk factors;
- any major investigations performed;
- personal and family histories;
- important lifestyle habits: smoking, alcohol, drugs, sedentary lifestyle, occupation;
- allergies or intolerances;
- immunizations;
- the dates of updates of the periodic medical examination or specific preventive examinations;
- the names of relevant consultants;
- any other information considered relevant.

The name and telephone number of a natural helper may also be included in the summary if it is difficult to speak to the patient directly, for example, due to a hearing or cognitive impairment.

The summary can be filled out not only at the first meeting, but also during subsequent meetings in the course of patient management. Of course, to remain relevant, the information in the summary must be updated and each update dated as a point of reference.

Ideally, the summary should be kept on the inside cover of the record.

This gives the physician an overview of the patient’s condition as soon as he opens the record. Using a different colour for the summary can also make it easier to find.
4.2.2 List of medications

The multitude of medications a patient takes can sometimes pose a difficult challenge in terms of management for the physician. Indeed, the different medications prescribed over time may end up noted in different places in the record, and the date new medications were prescribed may be hard to find.

It is therefore vital to keep the list of medications up to date.

The list of medications contains information required for the follow-up and selection of therapeutic agents. It includes:

- pill organizer use;
- the medications prescribed:
  - the name of each medication,
  - the date each medication was prescribed for the first time,
  - the dosage prescribed,
  - the number of units prescribed,
  - the number of refills authorized,
  - the date and reason for discontinuing a medication;
- the samples of medications given to the patient;
- the natural health products and over-the-counter products the patient uses;
- drug allergies;
- the telephone number of the pharmacy the patient usually uses.

Listing all the medications together on the same form makes it easier to spot possible drug interactions. When the list is kept up to date properly, it also makes the subsequent prescribing of medications much easier, especially since the physician does not have to copy all the medications taken and all those prescribed previously into his note.

Recording the number of medications prescribed and the number of refills authorized allows the physician to follow the patient's medication use profile easily. This aspect is especially important for controlled drugs.

The computerized pharmaceutical profile provided by the pharmacist can also be used as a list of medications if it is kept up to date properly and if it is initialed by the physician after verification with the patient.

Ideally, the list of medications (Appendix B) should be kept on a separate page or on the back of the summary. A periodic review is necessary if the patient is taking several active principles. Ideally, the medications should be grouped according to the type of pathology treated.

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3. The "List of medications" form, presented in Appendix B, can be photocopied and entered in the record. It can also be downloaded from the Web site of the Collège des médecins du Québec: www.cmq.org, under Physicians, keyword "Keeping of Records".
4.2.3 Medical note

The record must reflect the patient’s health status and risk profile.

The physician records and reviews any information in the summary or his medical note concerning the health status of the patient consulting him:

- the reason for each consultation;
- the detailed history of the presenting complaint and any developments in the patient’s health problems since the last visit;
- the medications taken (prescription or non-prescription) and the side effects of the prescribed medications;
- the patient’s lifestyle habits, such as smoking and alcohol or drug use, occupation and psychosocial data;
- any allergies the patient has;
- a relevant systems review, based on the presenting complaint and the patient’s age.

Certain elements, if they are recorded in the summary or the list of medications, do not have to be repeated.

The physician must review the patient’s personal and family history and update this information regularly.

The physician must at all costs avoid doing a similar, stereotypical examination for every patient. Instead he should perform a focused physical examination based on what the patient’s history reveals, the target organs or various prevention group recommendations. Any omission of relevant elements from the record must always be explained. In addition, the results of paraclinical examinations and previous consultation reports may have to be documented.

4.2.4 Follow-up forms

Several types of follow-up forms make continuity of care easier (Appendices C, D and E). They can be used to monitor changes in a laboratory result (e.g., lipid profile), a clinical parameter (e.g., blood pressure) or a medication (e.g., anticoagulant use), or to provide an overview of all the laboratory test results for a single condition (e.g., diabetes).

Follow-up forms provide, at a glance, a good summary of how an important parameter or the condition itself is evolving.

4. The forms “Follow-up sheet – Type 1 or type 2 diabetes”, “Follow-up sheet – Cardiovascular diseases” and “Follow-up sheet – Anticoagulant therapy”, presented in Appendices C, D and E, can be photocopied and entered in the record. They can also be downloaded from the Web site of the Collège des médecins du Québec: www.cmq.org, under Physicians, keyword “Keeping of Records”.
4.3 **Periodic health evaluation (annual check-up)**

Aspects that are important in the periodic health evaluation overlap with elements of the long-term management and follow-up.

In addition to these shared elements, the periodic evaluation comprises a number of specific elements (Appendix F):5

- a review of the patient’s family and social situation;
- the consideration of risk factors specific to this patient or to his age group;
- a focused physical examination based on gender and age;
- management that reflects the consideration of the risk factors present as well as what the patient has been taught or what has been discussed with him in this regard.

4.4 **Obstetrical follow-up**

Any physician who provides follow-up for pregnant women should use the standardized obstetrical record even if he is not the delivering physician.

This record encompasses all the pregnancy follow-up and delivery forms (forms AH-266 to AH-272).6

These forms provide the delivering physician with all the necessary information and satisfy regulatory requirements concerning the contents of medical records in institutions. The results of complementary tests must be noted in this record regularly.

A system must be put in place so that the information obtained during the last obstetrical visits and entered in form AH-269-7 is transmitted to the delivery room at the appropriate time.

---

5. The “Adult periodic health evaluation” sheet, presented in Appendix F, can be photocopied and entered in the record. It can also be downloaded from the Web site of the Collège des médecins du Québec: www.cmq.org, under Physicians, keyword “Keeping of Records”.

6. The physician can obtain these forms by contacting the person in charge of archives in his institution.
4.5 Pediatric follow-up

Record keeping for a pediatric follow-up must not only meet the same requirements as for an adult follow-up, but also take a number of specific elements into account.

For newborns, the physician must be attentive to the following aspects:

- gestational age;
- the history of the pregnancy, including any abnormalities observed on the prenatal ultrasound;
- the birth history;
- the APGAR;
- neonatal complications;
- weight, length and head circumference.

In addition to considering the child’s or teen’s active or evolving problems, the follow-up focuses mainly on:

- diet;
- physical, psychomotor, cognitive and affective development;
- growth curves;
- immunizations;
- variable age-based preventive and anticipatory recommendations (smoking, drugs, physical activity);
- screening for sensory deficits;
- screening for chronic disease (e.g., obesity);
- accident prevention;
- a physical examination, including blood pressure measurement as of 3 years of age.

If growth is normal, the physician must record the head circumference measurement until two years of age, the height and weight growth curves until adolescence and body mass index from 2 to 19 years of age.

---

7. A number of very helpful tools can be used for pediatric record keeping based on the child’s age:
- Healthy ABC: Assessment from Birth to Childhood (0-5 Years), available on the Web site of the Centre de pédagogie appliquée aux sciences de la santé (CPASS) of the Université de Montréal’s Faculty of Medicine (cpass.umontreal.ca, under Activités de formation [French only]), or the Web site of the Collège des médecins du Québec (cmq.org, under Physicians, keyword “Keeping of Records”).
- WHO growth curves and body mass index (BMI) for girls/boys from 2 to 20 years, available on the Web site of the Canadian Paediatric Society.
- The Rourke Baby Record and The Greig Health Record, both available on the Web site of the Canadian Paediatric Society.
4.6 Patient experiencing a loss of autonomy

The method for writing up records for patients experiencing a loss of autonomy is based on
the model proposed for the long-term management and follow-up assessment, combined
with a functional assessment of the following elements:

- activities of daily living (ADL) — eating, bathing, dressing, grooming, bowel and
  bladder management, toileting;
- instrumental activities of daily living (IADL) — preparing meals, doing housework,
  doing laundry, shopping, using the telephone and transportation, taking medications
  correctly and managing finances;
- mobility — doing necessary transfers, walking inside and outside, putting on a
  prosthesis or orthosis if necessary, moving around and using stairs;
- oral communication;
- higher mental functions — attention, orientation, concentration, judgement,
  memory and self-criticism.

When cognitive impairment is suspected or present, the Folstein's Mental State Test is
indicated (Appendix G). This test may be repeated, if necessary, and compared with
previous results obtained during the patient follow-up. The date must be noted on the
form each time.

For all patients experiencing a loss of autonomy, the physician should enter the desired
level of medical intervention in the record after discussing the matter with the patient or
his representative if he is no longer able to speak for himself.

The functional assessment may be done in collaboration with other health professionals.

---

8. The "Folstein's Mental State Test" form, presented in Appendix G, can be photocopied and entered in the record. It can also be downloa-
ded from the Web site of the Collège des médecins du Québec: www.cmq.org, under Physicians, keyword "Keeping of Records".

4.7 Home visits

The home visits record must reflect overall patient management rather than simply provide a list of ad hoc visits.

The notes entered in the record after home visits must respect the above-mentioned criteria for management and follow-up, as well as for loss of autonomy, where applicable.

To increase efficiency, the physician may, with the patient’s consent, leave certain documents at his bedside, such as the list of medications, but he must never leave the medical record at the patient’s home. Like all other medical records, the home visits record must be updated regularly.

When the desired level of medical intervention or the patient’s wish to be resuscitated or not have been discussed with the patient or the family, a letter may attest to what has been decided. Two copies of the letter can be made and signed by the patient if he is capable, or by his representative if he is unable to do so, and the physician. The first copy should be entered in the record and the second kept at the patient’s home. This approach is particularly helpful in emergency situations when the patient may be seen by another physician or by ambulance attendants who will have to make on-the-spot decisions.

When prescribing narcotics, the reason for the prescription and any dosage changes must be noted in the record. A register\textsuperscript{10} of medications and narcotics administered and taken from the physician’s kit must also be kept.

\textsuperscript{10} Parenteral benzodiazepines, controlled drugs and narcotics register.
### 4.8 Patient with mental health problems

Research and clinical experience increasingly highlight the relevance of a global systemic understanding of mental health problems that dynamically integrates the biological, psychological and social dimensions. This understanding must form the basis of professional practice, from the assessment and the treatment plan to follow-up, and be reflected in the contents of the medical record.

#### 4.8.1 Clinical assessment

As with all health problems, psychiatric diagnosis relies essentially on the collection of data, a history, a clinical assessment and an investigation. Each of these components comprises specific elements, which must be highlighted and entered in the record.

**a) Data collection**

Any information communicated by a third party, including family, close friends, police officers, ambulance attendants, school staff or information from the previous medical record.

**b) History**

Taking the patient’s reason for consulting as his starting point, the physician must clearly identify all the signs and symptoms during the interview using an interactive approach that allows him to formulate and verify his initial hypotheses: anxiety disorder, affective illness, psychotic disorder, addiction, adjustment disorder, personality disorder, organic disorder, etc.

The history must include:

- the patient’s identity (age, origin, language, creed, civil status, children);
- the description of the presenting complaint: onset of symptoms; description; impact; predisposing, precipitating and perpetuating factors; neurovegetative symptoms (sleep, appetite, libido);
- his occupation and sources of income;
- the relevant personal and family psychiatric, medical/surgical and legal histories;
- consumption habits (alcohol, drugs);
- allergies;
- medication;
- the impact of the disease on the person’s functioning.

The personal history is taken to collect longitudinal data: birth, development, education, family, adolescence, relationships, work. In an acute context, the absence of the person’s longitudinal history makes a diagnosis of personality disorder much less credible, whereas a history that describes the person’s typical reactions when he is destabilized, his main defense mechanisms, his usual mode of interpersonal communication as well as his ability to adapt to the various stages of his life can be used to support a diagnosis of personality disorder.

---

11. This type of information may be redacted depending on the type of requests received for access to the record.
c) **Clinical assessment**

- **Mental examination**

A mental examination is carried out to objectivize the facts related in the history. The results of the mental examination must be entered in the record. Particular attention must be given to assessing dangerousness so that the risk of self-harm or harm to others can be determined and the requisite measures and level of monitoring identified.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Sub-criteria</th>
<th>Qualifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour</td>
<td>Appearance</td>
<td>Unkempt, neat</td>
</tr>
<tr>
<td></td>
<td>Hygiene</td>
<td>Poor</td>
</tr>
<tr>
<td></td>
<td>Dress</td>
<td>Neglected, stylish, flamboyant</td>
</tr>
<tr>
<td></td>
<td>Attitude</td>
<td>Apathetic, prostrate, guarded, cooperative</td>
</tr>
<tr>
<td></td>
<td>Psychomotor skills</td>
<td>Slowed, agitated</td>
</tr>
<tr>
<td>Affect and mood</td>
<td></td>
<td>Depressive, labile, exalted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sad, irritable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anxious, flat, incongruent</td>
</tr>
<tr>
<td>Thoughts</td>
<td>Rate of flow</td>
<td>Slowed or accelerated</td>
</tr>
<tr>
<td></td>
<td>Form</td>
<td>Concrete, undeveloped, disorganized, incoherent, tangential, flight of ideas</td>
</tr>
<tr>
<td></td>
<td>Content</td>
<td>Guilt, self-deprecation, disinterest, hopelessness, suicidal thoughts (means mentioned, specific plan), delusions, poverty, overvalued ideas, obsessions, hypochondria, intent to commit harm</td>
</tr>
<tr>
<td>Perceptions</td>
<td></td>
<td>Illusions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hallucinations (sensory modality affected)</td>
</tr>
<tr>
<td>Cognitive functions</td>
<td>Level of consciousness</td>
<td>Alert, drowsy</td>
</tr>
<tr>
<td></td>
<td>Attention-concentration</td>
<td>Attention deficit</td>
</tr>
<tr>
<td></td>
<td>Memory</td>
<td>Recent amnesia</td>
</tr>
<tr>
<td></td>
<td>Orientation</td>
<td>To place, time, person</td>
</tr>
<tr>
<td></td>
<td>Abstraction</td>
<td>Loose</td>
</tr>
<tr>
<td></td>
<td>Judgement</td>
<td>Disturbed, absence of self-criticism</td>
</tr>
<tr>
<td></td>
<td>Intelligence</td>
<td>Slow</td>
</tr>
<tr>
<td>Sensorium</td>
<td>Level of consciousness</td>
<td>Delirium, coma, stupor</td>
</tr>
</tbody>
</table>
- **Physical examination**

The cursory physical examination of the patient must focus on the signs likely to indicate the underlying organic cause of the illness. These signs must be carefully entered in the record if they are relevant or the physician must note where he referred the patient to for the physical examination if he does not do it himself.

d) **Investigation**

The medical consultations and requests for services made to other professionals (e.g., social work, psychology, occupational therapy), the different assessment tools used (e.g., the Hamilton Rating Scale for Anxiety and Depression, the Folstein test, the intellectual quotient test) and the complementary tests requested (e.g., ECG, thyroid work-up, drug screening) must be documented in the record. The attending physician is responsible for providing consultants with all the information he has that is relevant to the examination, investigation and treatment of the patient and must specify the degree of urgency (section 112 of the *Code of Ethics of Physicians*).

It is only after completing the steps outlined above that the physician will have an overview of the patient’s situation and be able to judge the relative weight of each of the elements in his diagnostic understanding.

e) **Diagnosis**

To make his diagnosis, the physician uses a recognized classification (ICD-10-CA or DSM). Although it is currently under review, the DSM-IV multiaxial diagnostic system is nonetheless valuable for its comprehensive approach (*see box*).

<table>
<thead>
<tr>
<th>Axis I</th>
<th>Main psychiatric diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis II</td>
<td>Personality disorders or mental retardation</td>
</tr>
<tr>
<td>Axis III</td>
<td>General medical conditions</td>
</tr>
<tr>
<td>Axis IV</td>
<td>Psychosocial and environmental problems</td>
</tr>
<tr>
<td>Axis V</td>
<td>Global assessment of functioning</td>
</tr>
</tbody>
</table>
4.8.2 Treatment plan

The treatment plan, derived directly from the clinical approach, focuses on four aspects that are clearly documented in the patient’s record.

**Administrative aspects:**

- referral to a hospital centre for voluntary hospitalization or involuntary admission;
- ambulatory follow-up;
- liaison between the different levels of service (primary, secondary and tertiary);
- referral to another professional;
- leave from work;
- protective supervision;
- level of monitoring by family and friends;
- forms (RRQ, CSST, disability insurance).

**Biological aspects**

Pharmacotherapy (name of the medication, dosage, route of administration, duration and number of refills) as per the applicable protocols.

**Psychological aspects**

In psychotherapy practice, the reference model must be specified along with the therapeutic framework (helping relationship, support therapy, cognitive behavioural therapy, relaxation training and stress management, psychodynamic therapy, humanist therapy, crisis intervention, marriage and family therapies, motivational interviewing, etc.).

- frequency;
- duration;
- modalities;
- follow-up objectives.

**Social aspects**

- relationship;
- family;
- work;
- studies;
- respect for rights;
- justice.

Defining specific therapeutic objectives for each of these aspects promotes coordinated interdisciplinary work and facilitates successive reassessments during treatment.

Psychiatry practice in an institution must satisfy certain requirements, in particular with respect to note writing timeframes, which are not covered in this guide.
4.8.3 Mental health follow-up

When providing patient management, the physician must write up a progress note after each visit, as soon as he becomes aware of any new relevant information and after any telephone conversations with the patient or a health care provider.

At each visit, the physician writes up the patient’s subjective version of his situation, then carries out a systematic evaluation to assess for residual signs or possibilities of a relapse. He records information regarding compliance with treatment, the presence of side effects if drug therapy is being used, as well as blood pressure, pulse and body mass, if relevant. The reassessment carried out and the adjustments made to the treatment plan must be documented in the record. This approach helps ensure continuity of care both for the attending physician and the physician that may be called on to take over.

Psychotherapy follow-up

When providing psychotherapy follow-up, the physician determines and writes up precise objectives, which will become the criteria for assessing how the treatment is progressing. To mobilize the person’s resources and prevent a regression, it is often advisable to establish a specific framework and determine the duration of the psychotherapy at the outset. This information is entered in the record. A periodic review, specifying the number and length of sessions, can also be done to take stock and make any necessary adjustments. The use of a standardized scale, entered in the record, can make it easier to objectively assess developments in the patient’s state of health and his response to treatment.

4.9 Minor surgical procedure report

The consultation for a minor surgical procedure frequently takes place in a consultation office with or without an appointment. The acts required are often wound repair, abscess drainage, onychectomy, etc. A brief but comprehensive operative note must be written up for these procedures performed under local or topical anesthesia. At specialized medical centres, the notes and documents will necessarily be more detailed depending on the procedure performed. For more information on this topic, see the guide *Procédures et interventions en milieu extrahospitalier*, August 2011, page 20.

As with other types of consultations, the record relating to an in-office surgical procedure must contain:

- the medical observation, including the physical examination;
- the operative note;
- any anatomic pathology test requests;
- a document or note attesting to the patient’s free and informed consent, if considered pertinent.
The medical observation must include:

- a description of the symptomatology;
- a description of the lesion, including any positive findings and any relevant negative elements;
- the basic parameters, if appropriate;
- the diagnosis or, if it has not been established, a differential diagnosis.

The physician must write up or dictate the surgical protocol immediately after the procedure or within 24 hours. It must include any or all of the following elements, if relevant to the procedure performed:

- the diagnostic rationale for the surgery;
- the area disinfected and the product used;
- the type of anesthesia used (e.g., general, local, block);
- the anesthetic agent used, its concentration, the amount used;
- a brief description of the procedure: type of incision, material drained or excised (quantity), sutures (number, type, thread used);
- inspection if a wound contains a foreign body or if there is tendon, capsule or joint involvement;
- a list of any specimens sent to pathology;
- remarks as to whether the procedure was tolerated well or any complications that occurred;
- the type of dressing used with or without antibiotic;
- the medication administered if indicated;
- the medication prescribed;
- possible side effects or complications to watch for;
- the recommended follow-up;
- whom to consult if complications develop.

4.10 In-office surgical procedures performed under sedation/analgesia, regional anesthesia or general anesthesia

Consulting the two guides\(^{12}\) that address this subject is crucial for physicians who provide this type of care. The key record-keeping points are summarized below.

In the case of surgical procedures performed under sedation/analgesia, regional anesthesia or general anesthesia, the medical record must contain the same information as for minor surgical procedures as well as the following elements.

The treatment plan must be detailed in the record and include:

- the type of complementary tests or consultations requested;
- the treatments prescribed or the options presented to the patient;
- an explanation of the side effects or all significant risks;
- the counselling provided to the patient, including the subject, the patient’s opinion and the objectives set;

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• the results of the complementary tests required for the patient’s condition;
• the reports of any relevant medical consultations;
• the follow-up suggested and the medication prescribed on discharge;
• whom to consult if complications develop.

The diagnoses must be formulated in the most precise terms possible using a recognized nomenclature.

For liposuction, the physician must include the intake/output record, including the fluids injected for tumescence and the fluids suctioned out. If more than one person is involved in the procedure, the name and role of each person should be noted.

With respect to anesthesia, the following information is essential:

• the upper respiratory tract assessment;
• the sedation/analgesia or anesthesia protocol;
• a note describing the patient’s condition after the procedure;
• a note describing the patient’s condition when he leaves.

4.11 Telephone calls

Any relevant telephone discussion with the patient should be documented in the record, whether it only concerns some information or a prescription for medications, and whether it takes place in the office or elsewhere. The telephone interview must be dated so that it can be filed chronologically in the record.

As far as possible, these interviews must be recorded in the medical progress notes. If self-adhesive sheets are used, they must be identified with the patient’s name so that they can be filed again easily should they fall out of the record.
5. Electronic records

A growing number of physicians use computer software to manage their medical records. The Collège des médecins du Québec authorizes its members to use electronic records, in whole or in part, provided that the provisions of the Regulation respecting records, places of practice and the cessation of practice by a physician with respect to the creation, keeping, retention and maintenance of medical records are respected:

- use a digital signature;
- use, for his records, a directory that is separate from any other;
- protect access to data, specifically by using a security key and user authentication;
- use document management software designed so that data already entered cannot be deleted, replaced or altered;
- use software that allows data to be printed;
- store an encrypted copy of the data at another location.

The digital signature can be the equivalent of a handwritten signature. It must allow its author to be identified and be recorded after the information collected has been entered in the record.

Lastly, the physician must be able to send, at the request of the patient or a third party, a copy of his record or certain elements contained therein.

The fact that a record is electronic does not automatically mean that it is well kept. The physician must apply the same rigorous standards to electronic record keeping to meet his regulatory obligations.

6. Writing a medical prescription

While writing a prescription is not in itself a component of record keeping, specific rules must be followed.

Furthermore, the millions of prescriptions written every year in Quebec, the ever-growing number of medications that are constantly being added to the therapeutic arsenal and the fact that certain medications have similar names or are written in a similar way substantially increase the risk of errors. Therefore, it is important that the physician write legible, complete prescriptions in order to optimize the quality of care provided to patients and to optimize interdisciplinary collaboration with pharmacist colleagues.
The practice guide *Les ordonnances faites par un médecin* addresses the various regulatory aspects concerning the writing of medical prescriptions, whether they are handwritten, verbal, sent by fax or email, and whether they are for narcotics or controlled drugs. It also deals with prescriptions that allow various health care professionals other than physicians to practice activities reserved to them, either exclusively or on a shared basis. All physicians concerned by these aspects are urged to read this document.

7. **Medical record self-evaluation**

In order to help physicians improve their medical record keeping, the Collège has created a medical record self-evaluation sheet.

Physicians are invited to use it as often as they wish (Appendix H).14

**Conclusion**

The medical record is the physician’s primary work tool. As such, it is the main reflection of his competence. It is worth backing up a job well done by keeping a complete, relevant record.

For patient management, the summary is the tool of choice in which the information is summarized and presented in a clear, concise and easily accessible manner.

Ultimately, improved record keeping will benefit both the patient and the physician whose objective is to provide the best possible quality care.

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14. The “Medical record self-evaluation sheet” presented in Appendix H, can be photocopied and used. It can also be downloaded from the Web site of the Collège des médecins du Québec: www.cmq.org, under Physicians, keyword “Keeping of Records”.
Appendices

A  Record summary ................................................................. 34
B  List of medications ........................................................... 35
C  Follow-up sheet — Type 1 or type 2 diabetes ...................... 36
D  Follow-up sheet — Cardiovascular diseases ....................... 37
E  Follow-up sheet — Anticoagulant therapy ......................... 38
F  Adult periodic health evaluation ......................................... 39
G  Folstein’s Mental State Test ................................................. 40
H  Medical record self-evaluation sheet ................................... 42
# Record summary

Name, first name:  

Sex:  

Date of birth:  

Health insurance no.:  

Telephone:  

Hospital record no.:  

<table>
<thead>
<tr>
<th>DATE</th>
<th>MEDICAL HISTORY</th>
<th>DATE</th>
<th>SURGICAL HISTORY</th>
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<tbody>
<tr>
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</tbody>
</table>

Weight:
Waist circumference or BMI:

**Major investigations**

Family history

Smoking

Alcohol

Allergies

Intolerance to medication

**Relevant elements**

Instruments used:  

Sphygmomanometer  

Glucometer  

Other

Reviewed on:  

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List of medications

Record no. ____________________________

Allergies ____________________________ Pill organizer [ ]
Name ________________________________
Intolerance to medication ____________________________ Pharmacist’s telephone no. ____________________________

<table>
<thead>
<tr>
<th>Medication</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
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</tbody>
</table>

Dosage
No. tabs. [ ]
Follow-up sheet - Type 1 or type 2 diabetes

Onset of the illness ________________________  Name ________________________

Risk factors:  
- Smoking [ ]
- Alcohol [ ]
- Sedentary lifestyle [ ]
- HT [ ]
- LVH [ ]
- Nephropathy [ ]
- CAD [ ]
- Heart failure [ ]
- TIA/CVA [ ]

Teaching at the Diabetes Day Centre [ ]: date: ____________________  Pneumococcal vaccine [ ]

<table>
<thead>
<tr>
<th>Test</th>
<th>Target Values*</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
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<tbody>
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<td>130/80</td>
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</tr>
<tr>
<td>Weight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>≤ 25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood glucose - fasting</td>
<td>4 to 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood glucose - PC</td>
<td>5 to 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>HbA1c q3 to 6 months</td>
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<td>Echocardiography</td>
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<td>Peripheral pulses</td>
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<td>Toe: vibration/monofilament</td>
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<td>Flu vaccine</td>
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<tr>
<td>DTaP vaccine (diptheria, tetanus,</td>
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</table>

*Target values to be reviewed based on the latest recommendations.
## Follow-up sheet - Cardiovascular diseases

**Onset of the illness**

**Name**

**Risk factors:**
- Smoking □
- Alcohol □
- Sedentary lifestyle □
- High-salt diet □
- Nephropathy □
- Angina □
- Infarction □
- Heart failure □
- TIA/CVA □
- LVH □
- Diabetes □

**Pneumococcal vaccine** □

<table>
<thead>
<tr>
<th>Test</th>
<th>Target Values</th>
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<th>Date:</th>
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<td>DTaP vaccine (diphteria, tetanus, pertussis)</td>
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Follow-up sheet - Anticoagulant therapy

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<th>Date</th>
<th>INR</th>
<th>Dose taken</th>
<th>Total dose per week</th>
<th>Missed dose</th>
<th>Dietary change</th>
<th>Medication change</th>
<th>Bleeding</th>
<th>Clinical approach Dose warfarin and next INR</th>
<th>Initials</th>
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**Comments:**

---

© Collège des médecins du Québec, 2013
# ADULT PERIODIC MEDICAL EXAMINATION

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<tr>
<th>Name:</th>
<th>Record no.:</th>
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## ASK

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<th>YEAR</th>
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<tr>
<td>Smoking</td>
<td>ALL</td>
</tr>
<tr>
<td>Diet</td>
<td></td>
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<tr>
<td>Physical activity</td>
<td></td>
</tr>
<tr>
<td>Domestic violence</td>
<td></td>
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<tr>
<td>BBST1 counselling</td>
<td></td>
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<tr>
<td>Alcohol abuse</td>
<td></td>
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<tr>
<td>Depression (if risk factors)</td>
<td></td>
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<td>Folic acid (young women)</td>
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<td>Osteoporosis risk factors</td>
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</tr>
<tr>
<td>Breasts (mammo, changes noted)</td>
<td>50+</td>
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<tr>
<td>Prostate (counselling, screening)</td>
<td>60+</td>
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<td>Fall or fracture</td>
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<tr>
<td>Cognitive impairment (if memory problems)</td>
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## ASSESS

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<tr>
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<tbody>
<tr>
<td>Blood pressure</td>
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<tr>
<td>Weight</td>
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<tr>
<td>BMI and waist circumference</td>
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<td>Skin (assess for abnormalities)</td>
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<tr>
<td>Vision</td>
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<tr>
<td>Cervical cytology</td>
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## SCREENING

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<td>Lipid profile</td>
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<td>Blood glucose</td>
<td>40+</td>
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<td>Mammogram</td>
<td>50+</td>
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<tr>
<td>Colorectal cancer screening</td>
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<tr>
<td>Gonorrhea</td>
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<td>Syphilis</td>
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<td>Chlamydia</td>
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<tr>
<td>HIV</td>
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<tr>
<td>Hepatitis B and C</td>
<td>At-risk individuals</td>
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## IMMUNIZATION

<p>| | |</p>
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<tbody>
<tr>
<td>Measles-mumps-rubella</td>
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<tr>
<td>Varicella</td>
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<tr>
<td>Hepatitis A and B</td>
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<tr>
<td>Pneumococcal disease, herpes zoster</td>
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<tr>
<td>Influenza annually</td>
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<tr>
<td>DTaP then D2TS every 10 years</td>
<td>ALL</td>
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<tr>
<td>Human papilloma virus</td>
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<tr>
<td>Spirometry (symptomatic smokers)</td>
<td>40+</td>
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<tr>
<td>Bone mineral density test</td>
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<tr>
<td>Abdominal ultrasound (aortic aneurysm)</td>
<td>65+</td>
</tr>
</tbody>
</table>

Updated August 2014
### A) Orientation

**Ask the patient:**

1. What is the year, the month, the day, the day of the week?
   - 5
   - The season: Spring ☐ Summer ☐ Fall ☐ Winter ☐

2. Where are we?
   - Province
   - Country
   - City, town, village
   - Place (hospital, office, house, etc.)
   - Floor

### B) Registration

3. Pronounce one of the following groups of 3 words; take 1 second for each word:
   - shirt, blue, honesty
   - or
   - shoe, brown, modesty
   - or
   - sweater, white, charity

4. Then ask the patient to repeat the 3 words selected.

   Give 1 point for each correct answer on first attempt. Repeat until the patient learns all 3 words.

   Count and record number of attempts, for information purposes only.

### C) Attention and calculating (Check either test)

4. Ask the patient to begin with 100 and subtract by intervals of 7:
   - 100 – 7 = ( )
   - 93 – 7 = ( )
   - 86 – 7 = ( )
   - 79 – 7 = ( )
   - 72 – 7 = ( )
   - 65.

   OR 1 point for each correct answer.

5. Ask the patient to spell the word “WORLD” backwards. (DLROW): __ __ __ __ __ __

### D) Recall

5. Ask the patient to repeat the 3 words previously selected:
   - shirt, blue, honesty
   - or
   - shoe, brown, modesty
   - or
   - sweater, white, charity

### E) Language

6. Show the patient a pencil ( ) a watch ( ) and ask him what it is.
   - 2

7. Ask the patient to repeat the following sentence: “No ifs or buts.”
   - 1

8. Ask the subject to obey a 3-stage command: “Take this paper in your right or left hand, fold it in half and give it back to me.”
   - 3

**N.B.:** If the patient is right-handed, ask him to take the paper in his left hand and vice versa.

Be careful not to hold out your hand; avoid non-verbal indications.

---

Unvalidated adaptation of the "Mini-Mental State" by Folstein, M. F., Folstein, S.E., Mc Hugh, P.R. “Mini-Mental State: A practical method for grading the cognitive state of patients for the clinician”. Journal of Psychiatric Research, 1975, 12: 189-198, based on the work of the geriatric centre, Hôpital d’Youville, Sherbrooke, Québec.
E) Language (continued)

9- Ask the patient to read the following instruction and to do what it says:

10- Ask the subject to write a sentence:

(Subject, verb. Disregard mistake.)

F) Constructional praxis

11 - Ask the patient to copy the following drawing:

```
MAXIMUM SCORE: 30
PATIENT’S SCORE: ____________
```

*Interpretation of scores:*

While a score of less than 24 points in Folstein's Mental State Test indicates impairment of the cognitive functions, the test is not a means of diagnosing the cause of the impairment.

Patient's number of years of schooling: ________________

Estimate the patient's level of sensorium: □ alert □ somnolent

If the patient cannot be tested, specify: _________________________________

State any conditions that may have influenced your estimation. _________________________________

Date ____________________________

_____________________________ Signature
Medical record self-evaluation

Medical record self-evaluation is an excellent way for the physician to identify strengths and weaknesses in his record keeping. To help the physician carry out this exercise, the Collège des médecins du Québec has drawn up a list of clear criteria to evaluate medical record-keeping practices during professional inspection visits to practicing physicians.

<table>
<thead>
<tr>
<th>RECORD-KEEPING CRITERIA</th>
<th>PRESENT</th>
<th>NEEDS IMPROVEMENT</th>
<th>N/A</th>
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<tr>
<td>1. Record classification system</td>
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<tr>
<td>2. Complete patient identification for each component of the record</td>
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<tr>
<td>3. Elements are filed by category and in chronological order</td>
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<tr>
<td>4. Legibility is satisfactory</td>
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<tr>
<td>5. The following elements are entered in the record</td>
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<tr>
<td>a) Complete, updated summary</td>
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<tr>
<td>b) List of medications</td>
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<tr>
<td>c) Date of each consultation</td>
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<tr>
<td>d) Reason for the consultation</td>
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<tr>
<td>e) Family or personal history</td>
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<tr>
<td>f) Description and duration of the symptoms noted in the history</td>
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<tr>
<td>g) Physical examination noted with the relevant positive and negative findings</td>
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<tr>
<td>h) Basic parameters (vital signs)</td>
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<tr>
<td>i) Main or differential diagnosis</td>
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<td>j) Complementary test requests</td>
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<tr>
<td>k) Consultation requests</td>
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<tr>
<td>l) Prescriptions for medications, including dosages</td>
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<td>m) Other treatments</td>
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<tr>
<td>n) Surgical protocols</td>
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<tr>
<td>o) Follow-up visits</td>
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<tr>
<td>p) For follow-up of a specific clientele:</td>
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<tr>
<td>- periodic health evaluation</td>
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<td>- lifestyle habits counselling</td>
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<td>- periodic medication review</td>
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<td>q) Signature</td>
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<tr>
<td>6. Documents to be entered in the record</td>
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<tr>
<td>a) System in place to ensure follow-up of abnormal complementary test results</td>
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<td>b) Summary of hospitalizations or consultation reports</td>
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<td>c) Copy of medical certificates</td>
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<tr>
<td>d) Copy of legal authorizations</td>
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</table>
Editorial Board members

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*Administrator, Board of Directors*  
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<table>
<thead>
<tr>
<th>Acronym</th>
<th>French</th>
<th>English</th>
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</thead>
<tbody>
<tr>
<td>CHSGS</td>
<td>Centre hospitalier de soins généraux et spécialisés</td>
<td>General and specialized care hospital centre</td>
</tr>
<tr>
<td>CHU</td>
<td>Centre hospitalier universitaire</td>
<td>University hospital centre</td>
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<tr>
<td>CLSC</td>
<td>Centre local de services communautaires</td>
<td>Local community services centre</td>
</tr>
<tr>
<td>CPASS</td>
<td>Centre de pédagogie appliquée aux sciences de la santé</td>
<td>Centre for health sciences education</td>
</tr>
<tr>
<td>CSSS</td>
<td>Centre de santé et de services sociaux</td>
<td>Health and social services centre</td>
</tr>
<tr>
<td>CSST</td>
<td>Commission de la santé et de la sécurité du travail</td>
<td>Occupational health and safety commission</td>
</tr>
<tr>
<td>RAMQ</td>
<td>Régie de l’assurance maladie du Québec</td>
<td>Quebec health insurance board</td>
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<tr>
<td>RRQ</td>
<td>Régie des rentes du Québec</td>
<td>Quebec pension board</td>
</tr>
<tr>
<td>SAAQ</td>
<td>Société de l’assurance automobile du Québec</td>
<td>Quebec automobile insurance board</td>
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This document advocates professional practice that integrates the latest medical information at the time of publication. However, new scientific knowledge may advance understanding of the medical context described in this document.

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Note: In this document, the masculine gender is used without prejudice and solely to facilitate reading.