Documentation Checklist for Injury Patients

Your chart is the backbone of your patient's injury claim and the proof that your bill is reasonable. Insurers read it line by line. These are the details that most often decide whether a record helps or hurts.

First visit

- [ ] Date, time and place of the incident
- [ ] How it happened, in the patient's own words (for example, rear-ended while stopped at a light)
- [ ] When symptoms started, and where
- [ ] Any care received before your visit (ER, urgent care, ambulance)
- [ ] Prior injuries or treatment to the same body parts, and the patient's condition just before the incident
- [ ] Job duties and daily activities, so later limits have a baseline

Every visit

- [ ] Pain level on a consistent scale, by body part
- [ ] Objective findings: range of motion measurements, orthopedic and neurological tests, palpation findings
- [ ] Progress or setbacks since the last visit
- [ ] Treatment performed, with CPT codes that match the note
- [ ] Functional limits: work, sleep, lifting, driving, childcare
- [ ] Home exercise or instructions given

> **ONE RULE FOR EVERYTHING**
>
> Write what you saw and measured, and record it the same way at every visit. Consistent, specific notes are what hold up. Never alter past entries; if you add information later, make a dated, signed late entry.

Plan and necessity

- [ ] Diagnoses with ICD-10 codes
- [ ] Treatment plan with frequency and expected duration
- [ ] Why the care is medically necessary
- [ ] Referrals out (imaging, orthopedics, pain management) and the reason
- [ ] Work restrictions or off-work notes, dated and specific

Gaps and missed visits

- [ ] Document every missed appointment and the reason given
- [ ] Explain any gap in care (cost, transportation, childcare, symptoms improved)

> **WHY GAPS MATTER**
>
> Adjusters often argue that a gap in treatment means the patient healed or was hurt by something else. A one-line explanation in the chart answers that argument.

Discharge

- [ ] Status at release or maximum medical improvement
- [ ] Remaining symptoms and permanent limits, if any
- [ ] Future care needs, with estimated cost where you can give one
- [ ] Your opinion on cause, stated plainly, only if you hold it

When records are requested

- [ ] Send the complete chart, imaging reports and an itemized bill (CPT codes, dates, charges, payments, balance) together
- [ ] Include a custodian of records declaration when one is requested
- [ ] Confirm a signed HIPAA authorization is on file before release

> **QUESTIONS? TALK TO US**
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