



# DHCS Medical Record Review (MRR) Checklist



Site Name: \_\_\_\_\_ Date: \_\_\_\_\_

Green rows are DHCS updates effective as of 7/1/2022.

Criteria	Status	Notes: include reason for "No" or "N/A"
<b>I. Format Criteria</b>		
I.A. Member identification is on each page	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
I.B. Individual personal biographical information is documented	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
I.C. Emergency contact is identified (document if patient refuses to give info)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
I.D. Medical records are maintained and organized	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Paper records and EHR charting consistent
I.E. Members are assigned and/or rendering primary care physician (PCP) is identified	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	This includes NPMPs
I.F. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
I.G. Person or entity providing medical interpretation is identified	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
I.H. Signed copy of the Notice of Privacy	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
<b>II. Documentation Criteria</b>		
II.A. Allergies are prominently noted	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
II.B. Chronic problems and/or significant conditions are listed [and updated]	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
II.C. Current continuous medications are listed [and updated]	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
II.D. Appropriate consents are present:		
II.D. Informed Consent for invasive procedures	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
II.E. Advance Health Care Directive Information is documented as <i>offered</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	18 years and older, includes emancipated youth
II.F. All entries are signed, dated (and for paper charts: legible)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	

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II.G. Errors are corrected according to legal medical documentation standards	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
<b>III. Coordination of Care Criteria</b>		
III.A. History of present illness or reason for visit is documented	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
III.B. Working diagnoses are consistent with findings	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
III.C. Treatment plans are consistent with diagnoses	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
III.D. Instruction for follow-up care is documented	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
III.E. Unresolved/continuing problems are addressed in subsequent visit(s)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
III.F. There is evidence of practitioner review of consult/referral reports and diagnostic test results	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
III.G. There is evidence of follow-up of specialty referrals made, and results/reports of diagnostic tests when appropriate	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Documentation of conversations and messages with patients and specialty
III.H. Missed primary care appointments and outreach efforts/ follow-up contacts are documented	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Documentation of conversations and messages with patients
<b>IV. Pediatric Preventive Criteria</b>	Document refusal of preventive care	See DHCS Standards/AAP site for rationale
IV.A. Initial Health Assessment (IHA) completed in 120 days - Includes H&P and IHEBA (Individual Health Education Behavioral Assessment)		
IV.A1. Comprehensive History and Physical	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.A2. Individual Health Education Behavioral Assessment (IHEBA)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	IHEBA: Staying Healthy Assessment (SHA) or Bright Futures
IV.B. Subsequent Comprehensive Health Assessment		
IV.B1. Comprehensive History and Physical exam completed at age-appropriate frequency	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Per AAP guidelines
IV.B2. Additional Periodic IHEBA (Staying Healthy Assessment or Bright Futures)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	For reestablished patients, SHAs completed
IV.C. Well-Child Visit		
IV.C1. Alcohol Misuse: Screening and Behavioral Counseling	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.C2. Anemia Screening	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Assess per AAP guidelines and serum Hgb at 12 months

IV.C3. Anthropometric Measurements	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Infant - 24months: Length/height, head circumference, WHO growth chart 2-21 months: Height/Weight, BMI, CDC growth chart
<b>IV. Pediatric Preventive Criteria - AAP &amp; USPSTF guidelines</b>	Document refusal of preventive care	See DHCS Standards/ AAP site for rationale
IV.C. Well-Child Visit		
IV.C4. Anticipatory Guidance	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.C5. Autism Spectrum Disorder Screening (18 and 24 months)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Use appropriate screening tools
IV.C6. Blood Lead Testing (assess and venous blood test at 12 and 24 months. Any time between and by 6 years old)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.C7. Blood Pressure Screening (starts at age 3)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.C8. Dental/Oral Assessment [document if member has dentist, establish "dental home" by age 12 months]	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Inspect mouth each health assessment- HEENT okay
IV.C8a) Fluoride Supplementation (Rx age 6 months-16 years if water supply has no fluoride) (new AAP guidance as of 6/21/22)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Check local water supply for fluoridation information
IV.C8b) Fluoride Varnish (PCP or dentist may apply every 3-6 months) (new AAP guidance as of 6/21/22)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Document if dentist provides this service
IV.C9. Depression Screening (screen 12-18 years old. Document: diagnosis, treatment and follow-up)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.C9a) Suicide-Risk Screening (new AAP guidance as of 6/21/22)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.C9b) Maternal Depression Screening (at 1-2-4-6 months child visits)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.C10. Developmental Disorder Screening	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Screen at 9th, 18th and 30th months (30 months okay at 24)
IV.C11. Developmental Surveillance	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Ask if there are development concerns/observations
IV.C12. Drug Use: Screening and Behavioral Counseling	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.C13. Dyslipidemia Screening [risk assess 2, 4, 6 and 8 years. Then annually after. Lipid panel between 9 and 11 years then 17 and 21 years old]	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	

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IV.C14. Hearing Screening [pure tone audiometer]	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Audiometry: 4-20 years old, follow AAP, results charted
IV.C15. Hepatitis B Virus Screening [new AAP guidance 6/21/22]	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.C16. Hepatitis C Virus Screening	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.C17. HIV Infection Screening [assess starting at age 11 years old]	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	[Per USPSTF, test once between 15 and 18 years old]
IV.C18. Psychosocial/Behavioral Assessment [every well child visit] [new AAP guidance as of 6/21/22]	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Family centered, social determinants of health, etc.
IV.C19. Sexually Transmitted Infections (STIs) Screening and Counseling	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	High risk, 15-21 years. Address screening, prevention and treatment of sexually active pts.
IV.C20. Sudden Cardiac Arrest and Sudden Cardiac Death Screening [new AAP guidance 6/21/22]	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.C21. Tobacco Use Screening, Prevention and Cessation Services	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.C22. Tuberculosis Screening (assess for risk at each health assessment)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.C23. Vision Screening [documentation of PERRLA okay for below age 3 years]	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Visual acuity test starts at 4 years old, follow AAP, chart results
IV.D. Childhood Immunizations		
IV.D1. Given according to Advisory Committee on Immunization (ACIP) guidelines	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.D2. Vaccine administration documentation	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
IV.D3. Vaccine Information Statement (VIS) publication date documentation	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
<b>V. Adult Preventive Criteria - USPSTF guidelines</b>		Document refusal of preventive care
V.A. Initial Health Assessment (IHA) Includes H&P and IHEBA (Individual Health Education Behavioral Assessment)		
V.A1. Comprehensive History and Physical	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Includes dental; dental assessment in ROS, or seeing dentist

V.A2. Individual Health Education Behavioral Assessment (IHEBA)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	IHEBA i.e. Staying Healthy Assessment (SHA)
V.B. Periodic Health Evaluation according to most recent USPSTF Guidelines		
V.B1. Comprehensive history and PE completed at age-appropriate frequency	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
V.B2. Additional IHEBAs are offered every 3-5 years and reviewed annually	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	See DHCS instruction sheet
V.C. Adult Preventive Care Screenings		
V.C1. Abdominal Aneurysm Screening (one time ultrasonography)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Men ages 65-75 who have smoked 100+ cigarettes in their lifetime
<b>V. Adult Preventive Criteria</b>		Document refusal of preventive care
V.C2. Alcohol Misuse: Screening	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
V.C2a. Alcohol Misuse: Behavioral Counseling (if at risk or hazardous alcohol use)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
V.C3. Breast Cancer Screening	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
V.C4. Cervical Cancer Screening	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
V.C5. Colorectal Cancer Screening (starts age 45)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
V.C6. Depression Screening	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
V.C7. Diabetic Screening (35-70 years overweight or obese)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
V.C7a. Diabetic Comprehensive Care (if diagnosed with diabetes)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
V.C8. Drug Disorder Screening and Behavioral Counseling	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Use of SHA acceptable to start assessment
V.C9. Dyslipidemia Screening	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
V.C10. Folic Acid Supplementation (planning or capable of pregnancy, 12-49 years old)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Rx 0.4-0.8 mg
V.C11. Hepatitis B Screening	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
V.C12. Hepatitis C Screening [18-70 years old assessed for risk at each well visit]	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
V.C13. High Blood Pressure Screening	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
V.C14. HIV Screening (15-65 years old risk assess at each well visit)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Risk assess 15-65 years old. High risk: test
V.C15. Intimate Partner Violence Screening women of reproductive age (12-49 years old)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Use of SHA acceptable to start assessment

V.C16. Lung Cancer Screening (55-80 years old)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	20 pack smoking history and currently smoke or quit within past 15 years
V.C17. Obesity Screening (document weight and BMI) and Counseling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
V.C18. Osteoporosis Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
V.C19. Sexually Transmitted Infection (STI) Screening and Counseling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
V.C20. Skin Cancer Behavioral Counseling (6 months to 24 years old)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
V.C21. Tobacco Use Screening, Counseling and Intervention	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
V.C22. Tuberculosis Screening (upon enrollment and periodic physical exams)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
V.D. Adult Immunizations				
V.D1. Given according to ACIP guidelines	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
V.D2. Vaccine administration documentation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
V.D3. Vaccine Information Statement (VIS) publication date documentation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
<b>VI. OB/CPSP Preventive Criteria – ACOG guidelines</b>				Document refusal of preventive care
VI.A. Initial Comprehensive Prenatal Assessment (ICA)				
VI.A1. Initial prenatal visit completed within 4 weeks of entry to prenatal care	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.A2. Obstetrical and Medical History	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.A3. Physical Exam (includes breast, pelvic exam and calculation of EDD)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.A4. Dental Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.A5. Health weight gain and behavioral counseling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.A6. Lab tests				
VI.A6a. Bacteriuria Screening (12-16 weeks gestation or 1 <sup>st</sup> pre-natal visit if later)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.A6b. Rh Incompatibility Screening (24-28 weeks)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.A6c. Diabetes Screening (GDM – after 24 weeks)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.A6d. Hepatitis B Virus Screening (1 <sup>st</sup> trimester or prenatal visit)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.A6e. Hepatitis C Virus Screening (1 <sup>st</sup> prenatal visit)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.A6f. Chlamydia Infection Screening (under 25 years old and older with increased risk)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	

<b>VI. OB/CPSP Preventive Criteria</b>			
VI.A6. Lab tests			
VI.A6g. Syphilis Infection Screening (1 <sup>st</sup> prenatal visit. High risk test again at 28 weeks)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.A6h. Gonorrhea Infection Screening (under 25 years old and older with increased risk)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.A6i. Human Immunodeficiency Virus (HIV) Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
<b>VI.B. First Trimester Comprehensive Assessment</b>			
VI.B1. Individualized Care Plan (ICP) (developed based on each trimester assessment and during the 12 months post-pregnancy period. Update each trimester and as needed)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.B2. Nutrition Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.B3. Psychosocial Assessment			
VI.B3a. Maternal Mental Health Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.B3b. Social Needs Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.B3c. Substance Use Disorder Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.B4. Breastfeeding and other Health Education Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.B5. Preeclampsia Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.B6. Intimate Partner Violence Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
<b>VI.C. Second Trimester Comprehensive Re-Assessment</b>			
VI.C1. Individualized Care Plan updated and follow-up	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.C2. Nutrition Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.C3. Psychosocial Assessment			
VI.C3a. Maternal Mental Health Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.C3b. Social Needs Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.C3c. Substance Use Disorder Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.C4. Breastfeeding and other Health Education Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.C5. Preeclampsia Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.C5a. Low Dose Aspirin (preventive medication after 12 weeks gestation for those at high risk for preeclampsia; see VI.C5)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.C6. Intimate Partner Violence Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
VI.C7. Diabetes Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
<b>VI.D. Third Trimester Comprehensive Re-Assessment</b>			
VI.D1. Individualized Care Plan updated and follow-up	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>

VI.D2. Nutrition Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.D3. Psychosocial Assessment				
VI.D3a. Maternal Mental Health Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.D3b. Social Needs Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.D3c. Substance Use Disorder Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.D4. Breastfeeding and other Health Education Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.D5. Preeclampsia Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.D5a. Low Dose Aspirin (preventive medication after 12 weeks gestation for those at high risk; see VI.D5)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.D6. Intimate Partner Violence Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.D7. Diabetic Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.D8. Screening for Strep B				
VI.D9. Screening for Syphilis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.D10. TDAP Immunization	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.E. Prenatal care visit periodicity according to most recent ACOG standards	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
<b>VI.D. Third Trimester Comprehensive Re-Assessment</b>				
VI.F. Influenza Vaccine (during any trimester)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.G. COVID Vaccine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.H. Referral to WIC and Assessment of Infant Feeding Status	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.I. HIV-related services <i>offered</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.J. AFP/Genetic Screening <i>offered</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.K. Family Planning Evaluation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.L. Comprehensive Postpartum Assessment				
VI.L1. Individualized Care Plan	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.L2. Nutrition Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.L3. Psychosocial Assessment				
VI.L3a. Maternal Mental Health/Postpartum Depression Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.L3b. Social Needs Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.L3c. Substance Use Disorder Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.L4. Breastfeeding and other Health Education Assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
VI.L5. Comprehensive Physical Exam	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	

Rationale for criteria listed can be reviewed in the 2022 DHCS Medical Record Review Standards  
AAP Periodicity Schedule: <https://bit.ly/2YZe41u>

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