

Appendix A

Sample Addendum Policy

Making Addendums within the Health Record

PURPOSE: The purpose of the health record is to provide a basis for planning patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the instances in which an addendum is necessary to support the integrity of the health record.

POLICY: Providers documenting within the EHR must avoid indiscriminate use of addendums as a means of documentation. All attempts to correctly identify patients and their medical conditions should be made prior to documenting within the record.

DEFINITION: Addendums are significant clinical corrections or changes in information to a signed report or direct entry documentation. (INSERT APPLICABLE STATE LAW AS REFERENCE)

PROCEDURE:

PROVIDER:

1. If the provider determines that additional information is appropriate, the provider is responsible for ensuring the total content of their documentation.
2. The provider should complete an addendum which includes the following information:
 - a. Patient name
 - b. Date of service
 - c. Account number
 - d. Medical record number
 - e. Original report that the addendum is to be attached to
 - f. Date, time, and signature of the addendum

DEPARTMENT (INSERT DEPARTMENT NAME):

1. Review each addendum for appropriateness prior to attaching it to the original report
2. Attach to original report
3. Ensure the addendum has a separate date, time, and signature line

See Also:

Amendment Policy

Correction Policy

Deletion/Retraction Policy