

SOP Template: Pre-consultation Patient Information Review

This SOP details the process for **pre-consultation patient information review**, including the collection and verification of patient medical history, current medications, previous consultations, and relevant diagnostic results. The purpose is to ensure healthcare providers have comprehensive and accurate patient information prior to clinical consultations, facilitating informed decision-making, personalized care planning, and improved patient outcomes.

1. Scope

This SOP applies to all clinical and administrative staff involved in preparing patient information before consultations.

2. Responsibilities

- **Administrative Staff:** Compile and verify completeness of patient records.
- **Clinical Staff:** Review and confirm accuracy of clinical information.
- **Healthcare Provider:** Utilize reviewed information for effective clinical assessment.

3. Procedure

1. **Patient Record Retrieval**
 - Obtain the latest patient records through the EHR (Electronic Health Record) system or physical files.
 - Confirm patient's identity using two identifiers (e.g., name and date of birth).
2. **Medical History Review**
 - Check for comprehensive medical history including past illnesses, surgeries, and chronic conditions.
3. **Medication Verification**
 - List all current medications, dosages, and prescribing providers.
 - Confirm medication adherence and note recent changes.
4. **Previous Consultations**
 - Summarize findings and recommendations from prior visits.
5. **Diagnostic Results**
 - Collect relevant lab, imaging, and test results.
 - Note pending or abnormal results requiring attention.
6. **Documentation and Flagging**
 - Ensure all information is up-to-date in the patient's file.
 - Flag any missing or ambiguous information for follow-up.

4. Documentation

- All reviewed and updated information must be documented in the EHR system.
- Use standard templates and checklists where applicable.

5. Quality Control

- Conduct periodic audits of pre-consultation information reviews.
- Address gaps or delays in information retrieval promptly.

6. References

- Institutional policies on patient documentation and privacy.
- National healthcare information standards (e.g., HIPAA, GDPR).

7. Revision History

Version	Date	Author	Description
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1.0	2024-06-10	Medical QA Team	Initial release
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