LNCScout

How-To

Medical Record Review Checklist

Step-by-step guide to organizing, reviewing, and using medical records in litigation

- Complete medical record request and collection checklist
- How to organize records for efficient LNC review
- Medical chronology development process
- Using medical records to evaluate case merit

Personal injury attorneys, medical malpractice attorneys, paralegals, and defense counsel who need legal nurse...

Medical Record Collection Checklist

What to Request — Complete Record Set

Hospital Records

- [ ] Admission and discharge summaries
- [ ] History and physical examination (H&P)
- [ ] Physician progress notes (all attending, consulting, resident)
- [ ] Nursing notes and assessments (shift-by-shift)
- [ ] Medication administration records (MAR)
- [ ] Laboratory results (all panels, cultures, pathology)
- [ ] Radiology / imaging reports (X-ray, CT, MRI, ultrasound)
- [ ] Operative reports (all procedures)
- [ ] Anesthesia records
- [ ] Consultation reports (all specialties)
- [ ] Respiratory therapy records
- [ ] Physical / occupational therapy notes
- [ ] Social work notes
- [ ] Dietary / nutrition notes
- [ ] Incident / occurrence reports (if obtainable)
- [ ] Informed consent documents

Physician / Office Records

- [ ] Office visit notes (all visits related to condition)

- [ ] Referral records
- [ ] Prescription records
- [ ] Test orders and results
- [ ] Correspondence with other providers
- [ ] Telephone encounter notes

Emergency Department Records

- [ ] Triage assessment
- [ ] ED physician notes
- [ ] Nursing notes
- [ ] EMS / ambulance run reports
- [ ] Cardiac monitoring strips (if applicable)

Specialized Records

- [ ] Physical therapy / rehabilitation records
- [ ] Mental health / psychiatric records
- [ ] Home health records
- [ ] Nursing home / long-term care facility records
- [ ] Pharmacy records (complete fill history)
- [ ] Durable medical equipment records
- [ ] Autopsy report (wrongful death cases)

> **Request "complete records" — not just "pertinent" records.**
>
> Incomplete records create gaps that weaken your case. Request ALL records from every provider for the relevant time period. Specify you want nursing notes, flow sheets, and MAR — facilities often omit these unless specifically requested.

Organizing Records for LNC Review

How to Organize Records Before Sending to Your LNC

Pre-Review Organization

- [ ] Paginate all records consecutively (Bates numbering preferred)
- [ ] Separate records by provider / facility
- [ ] Arrange within each provider in chronological order
- [ ] Remove duplicate pages (duplicate records inflate page count and cost)
- [ ] Create a cover sheet listing: patient name, DOB, all providers, date range, and total page count
- [ ] Note any missing records or gaps in treatment
- [ ] Provide a brief case summary (1-2 pages) with key medical issues and legal questions
- [ ] Deliver in searchable PDF format (not scanned images without OCR)

Record Organization Template

Provider	Facility	Date Range	Page Numbers	Notes
Dr. Smith (PCP)	ABC Medical Group	01/2023-12/2024	1-85	Complete office records
General Hospital	General Hospital	03/15/2024	86-350	Admission through discharge
Dr. Jones (Surgeon)	General Hospital	03/16/2024	351-410	Operative report + follow-ups
PT Associates	PT Associates	04/2024-08/2024	411-490	Rehab records

Searchable PDFs save money.

> If records are scanned images (not OCR'd), the LNC must read every page manually. Searchable PDFs allow keyword searching for medications, diagnoses, and provider names — reducing review time by 15-25%.

Medical Chronology Development

What a Quality Medical Chronology Looks Like

Chronology Format Standards

A professional medical chronology should include these columns at minimum:

Column	Description
Date / Time	Exact date and time of event (not just date)
Provider	Name and credential of treating provider
Facility	Location where care was rendered
Event / Intervention	What was done, ordered, or observed
Clinical Findings	Vital signs, lab values, assessment findings
Significance	Why this event matters to the case (LNC analysis)
Page Reference	Bates number or page number for source document

Chronology Quality Indicators

- [ ] Every entry has a specific source document reference (page/Bates number)
- [ ] Timeline is continuous — no unexplained gaps in treatment
- [ ] Significant findings are highlighted or flagged
- [ ] Standard of care deviations are identified with supporting rationale
- [ ] Medication administration is tracked (including timing relative to physician orders)
- [ ] Provider handoffs and communication are documented
- [ ] Nursing assessments are included (not just physician notes)

> **Beware "cut and paste" chronologies.**

> Some LNCs simply copy text from records into a timeline without analysis. A quality chronology adds clinical context, identifies significance, and flags deviations — it doesn't just reformat the chart.

Case Merit Evaluation Framework

Using Medical Records to Evaluate Case Merit

Four-Element Framework

1. Standard of Care

- [ ] Identify the applicable standard of care for the clinical situation
- [ ] Reference clinical practice guidelines, protocols, and published standards
- [ ] Consider the provider's specialty and the resources available at the facility

2. Breach

- [ ] Compare actual care to the standard of care
- [ ] Identify specific deviations documented in the records
- [ ] Note timing issues (delays in assessment, treatment, escalation)
- [ ] Document communication failures (between providers, shifts, departments)

3. Causation

- [ ] Establish timeline between the breach and the injury
- [ ] Rule out alternative causes for the patient outcome
- [ ] Assess whether timely appropriate care would have changed the outcome

4. Damages

- [ ] Document the nature and extent of injury
- [ ] Identify additional treatments, hospitalizations, or procedures caused by the breach
- [ ] Assess functional limitations and quality-of-life impact

- [ ] Identify ongoing or future care needs

Merit Assessment Rating

Rating	Description	Recommendation
Strong	Clear breach, strong causation link, significant damages	Proceed with case; retain testifying expert
Moderate	Breach identified but causation or damages debatable	Obtain expert medical review before proceeding
Weak	Standard of care met, or causation link unclear	Consider declining; bad outcome ≠ negligence
No Merit	No identifiable breach of standard of care	Decline case

A good LNC saves you money on bad cases.

A $2,000-$5,000 case screening identifies weak cases BEFORE you invest $50,000-$100,000 in discovery, experts, and depositions. The ROI on early screening is extraordinary.

Common Medical Record Issues

What to Watch For in Medical Records

Two-column layout: Issue -> Significance

Issue	Significance
Late entries or addenda	May indicate after-the-fact documentation to cover care gaps
Altered or whited-out records	Potential spoliation; request original records from facility
Gaps in nursing assessments	Suggests monitoring failures; critical in deteriorating patients
Boilerplate / template charting	"Copy-paste" documentation may not reflect actual patient condition
Missing informed consent	Patient may not have been advised of risks/alternatives
Conflicting provider notes	Multiple providers documenting different findings at the same time
Delayed physician orders	Significant time between nursing assessment and physician response
Missing medication administration times	Cannot verify timing of critical medications
No code sheet / resuscitation record	Critical documentation missing from code events
Pharmacy override records	Staff bypassing safety systems to administer medications

Preserve original records immediately.

If you suspect record alteration, send a preservation letter to the facility demanding original records (including metadata for electronic records). EHR audit trails can reveal post-event modifications.

Medical Record Review Engagement Timeline

From Record Collection to Case Merit Report

Phase	Duration	Action
Record collection	2-6 weeks	Request from all providers; follow up on slow facilities
Record organization	1-2 weeks	Paginate, de-duplicate, index by provider
LNC review and chronology	2-4 weeks	Depends on page count and complexity
Preliminary findings call	1 day	LNC discusses initial impressions with attorney
Merit assessment report	1-2 weeks	Written analysis of standard of care, breach, causation, damages
Expert physician review	2-4 weeks	If LNC screening shows merit, medical expert confirms/ expands
Decision point	1 week	Accept, decline, or request additional investigation

Total timeline: 8-16 weeks from record request to case merit decision.

The biggest bottleneck is record collection — facilities can take 2-6 weeks to produce. Send requests on day one and follow up aggressively.

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1. **Printability matters.** Attorneys print these. Avoid large solid color areas on interior pages (waste ink). Reserve full-bleed backgrounds for cover and back cover only. 2. **Tables are the star.** These guides live or die on their reference tables. Make tables scannable, well-spaced, and easy to read at 100% zoom on screen AND when printed on letter paper. 3. **Checklist pages should be func

Find LNCs at lncscout.com