HKCFP Exit Examination Practice Assessment Pre-Exit Review of Medical Records (PERM)

General Information

22 March 2024

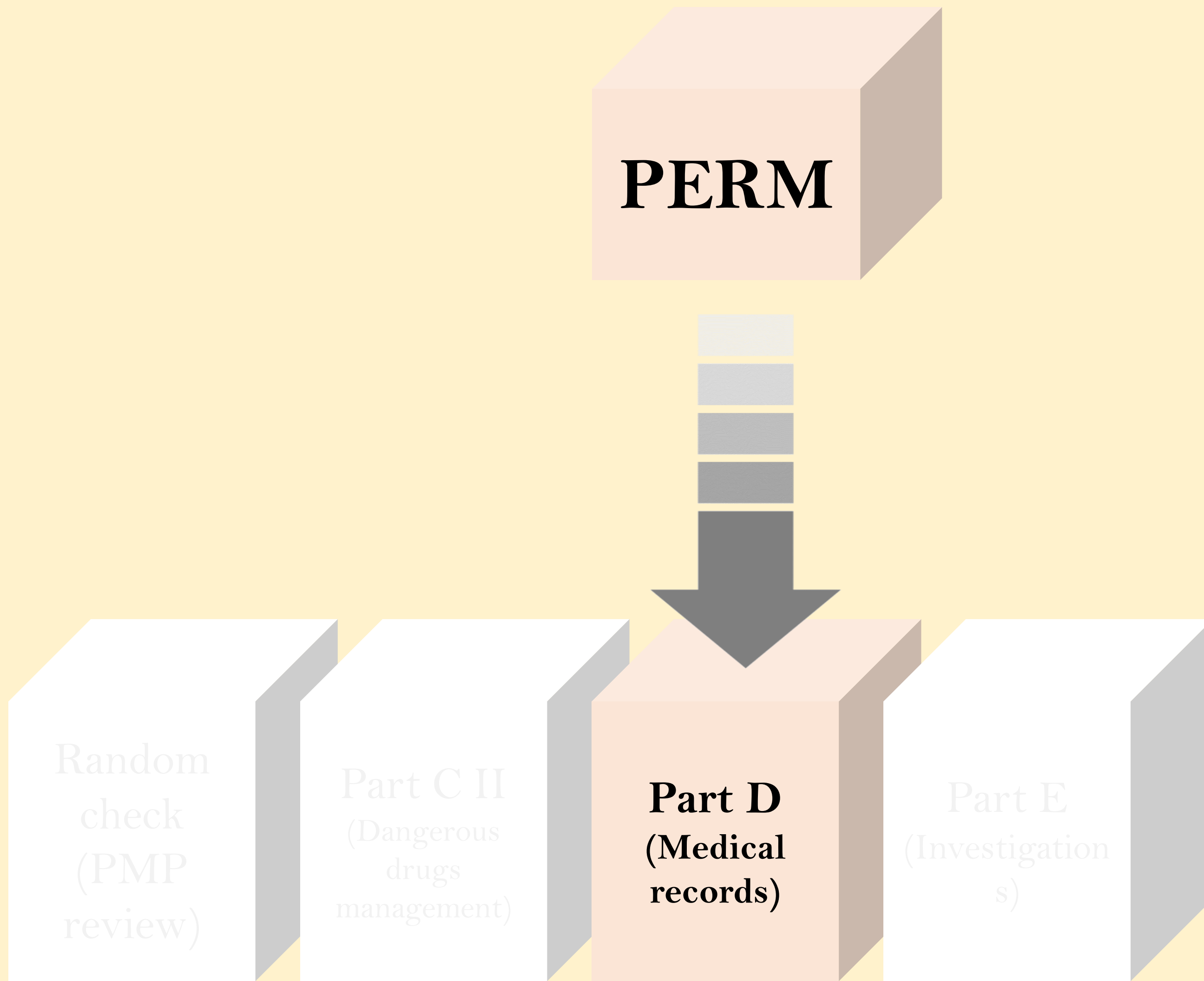
Practice Assessment consists of 4 Parts

Random check (PMP review)

Part C II
(Dangerous drugs management)

Part D
(Medical records)

Part E
(Investigations)



PERM: pre-exit review of medical records

Pre-Exit Review of Medical Records (PERM)

- ❖ Candidate preparation
- ❖ The Assessment
- ❖ PERM and Exit Examination

What
to
prepare

What
will be
assessed

Tips on
Good practice

Consensus
on marking

Candidate preparation

- 100 medical records
- 100-case log

100 medical records

1. Collect **medical records** of **100 different patients** that consulted you in a **six-week period** between **1st May to 31st August 2024**

Exclude:

- Medical examination , health assessment / screening

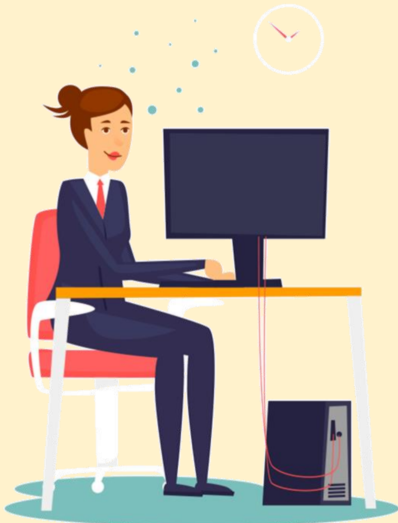
For example: the 100 Cases are collected between

- 1 May to 11 June 2023; or
- 19 June to 30 July 2023; or
- 21 July to 31 August 2023, etc.

100 medical records

2. The **format** of medical records in **PERM** can be:

on the computer screen



OR

paper

Print-out from computer system

or / with

Handwritten records

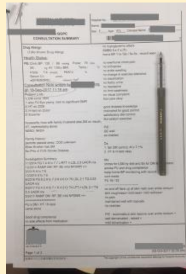
OR

A hybrid of both

However, please note

The **format** of medical records in **Exit Exam (PA)** :

paper



Print-out from computer system

or / with

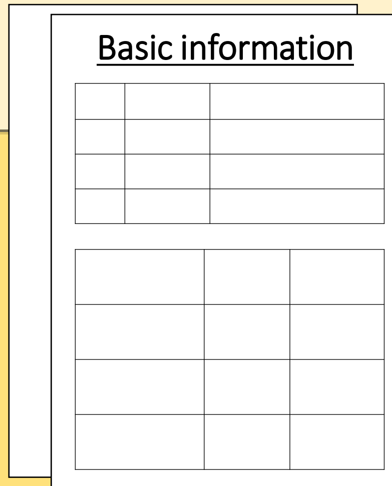
Handwritten records

AND

Readily retrievable and available upon Assessor's request

100 medical records

3. The content of each medical record for assessment should at least include:



i. Basic information

ii. Consultation notes

100 medical records

i. Basic information

On following areas

as appropriate and as applicable

- Allergy / Adverse drug reactions
- Current medication list
- Problem list (Current / Past health)
- Family history (with genogram as appropriate)
- Social history, occupation
- Height, weight, BMI/ growth chart, blood pressure
- Immunization
- Tobacco & alcohol use; physical activity

Please note:
It is not mandatory to have full documentation on all the areas in every record

100 medical records

ii. Consultation notes

On following areas

as appropriate and as applicable

- Main reason(s) of consultation
- Clinical findings
- Diagnosis / working diagnosis
- Management
- Anticipatory care advice

Please note:

- **As appropriate and as applicable**
- **Not mandatory in every consultation**

Consultation note
Dr. Candidate
date: DD/MM/YYYY

Date of the consultation: to be stated in the **100-case log**

100 medical records

Also include the following whenever applicable:

Lab report

followed up in this consultation

Referral letter

issued in this consultation

the previous consultations' notes --- up to five

Consultation note
Dr. Colleague B

Consultation note
Candidate

Consultation note
Dr. Colleague A
date: DD/MM/YYYY

Consultation note
Dr. Candidate
date: DD/MM/YYYY

- Will not be marked directly

- Information in the previous consultation notes e.g. Blood pressure, BMI; chronic medications usage, control of medical condition(s) under your clinic's attention may help the Assessor to mark the consultation note

100-Case Log
(template)

A. Template for 100-Case Log

Serial no.	Patient record number	Patient initials	sex	age	diagnosis	Date of the consultation	Date of first attended the clinic
1							
2							
3							

100-Case Log

Table summary of the collected case in a standard format

Serial no.	Patient record number	Patient initials	sex	age	diagnosis	Date of the consultation	Date of first attended the clinic
1	3216	NFK	F	25	URTI	20 May 2022	18 OCT 2010
2	8839	LKF	F	46	DEPRESSION	20 May 2022	25 JUL 2011
3	292	KPW	M	87	DM, HT, HYPERLIPIDEMIA	21 May 2022	18 SEP 1999
4				1	URTI		
5				12	ALLERGIC RHINITIS		
6	4454	CHC	M	67	HT	21 May 2022	12 JAN 2011
…	…	….	…	…	…	….	….
100	2323	LKH	M	38	URTI	29 June 2022	24 OCT 2011

If the assessor choose to assess this record

This consultation notes would be selected for assessment

Confidentiality: Do not include patient's name, HKID

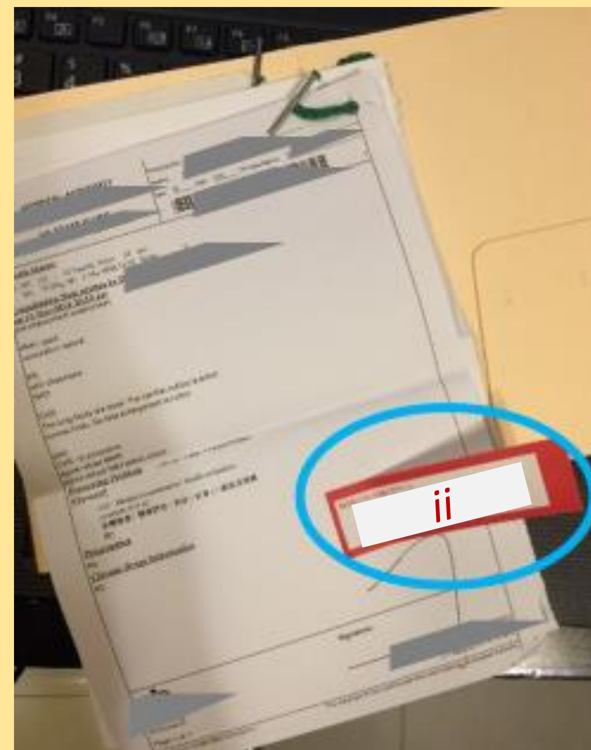
Suggestions on presenting PERM materials to assessor

100-Case Log

Case	Medical Record no.	Patient initials	Sex	Age	Diagnosis	Date of consultation	Date of first consultation in the clinic
1	[illegible]	LCL	F	72	Allergic dermatitis	2/5/2018	11/9/2001
2	[illegible]	CCL	M	80	URI	2/5/2018	12/9/2001
3	[illegible]	YHL	M	56	DM	4/5/2018	9/11/2011
4	[illegible]	LPH	M	54	DM, HT, high lipid, URI	2/5/2018	3/3/2015
5	[illegible]	TLF	F	57	GERD, blepharitis	4/5/2018	16/4/2015
6	[illegible]	HHP	F	59	HT	3/5/2018	10/12/2003
7	[illegible]	SYK	M	81	URI	5/5/2018	5/5/2018
8	[illegible]	YYC	F	88	URI, aphthous ulcer	5/5/2018	5/10/2001
9	[illegible]	CKT	M	63	HT with LVH, AR	5/5/2018	20/2/2004
10	[illegible]	LTW	M	58	HT	5/5/2018	15/8/2011
11	[illegible]	LKH	F	72	HT, high lipid	2/5/2018	26/2/2003
12	[illegible]	NLW	F	64	High lipid	2/5/2018	2/5/2018
13	[illegible]	YCP	F	51	HT with WC, IFG	3/5/2018	5/12/2013
14	[illegible]	CKF	M	74	HT, BPH, lipid, IFG	3/5/2018	21/4/2004
15	[illegible]	CKM	F	64	HT with LVH	3/5/2018	28/9/2001
16	[illegible]	LHY	M	82	HT, IFG, high lipid	5/5/2018	3/10/2001
17	[illegible]	LYK	F	49	HT, borderline TG, obesity	5/5/2018	25/11/2014
18	[illegible]	HTS	M	77	DM, high lipid, HT, AR	5/5/2018	19/9/2002
19	[illegible]	APY	F	55	URI	5/5/2018	24/10/2001
20	[illegible]	TYY	F	60	URI, OA Knee	3/5/2018	3/5/2018

EXAMPLE

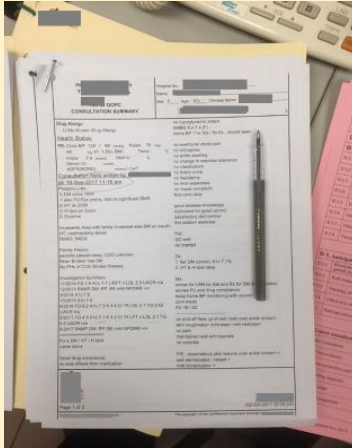
Medical records



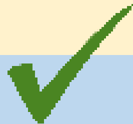
You can use paper flags to identify the relevant sections e.g. **ii. Consultation notes**

Areas to be assessed

0. Legibility

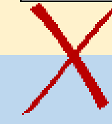


C/O:
RN 3/7
ST
Not much cough
No fever
......
P/E:
GC sat
Normal hydration
ENT: red throat, no pus
Chest clear, AE good bilat.
....;



legible→
Assessor proceed to mark the record

NOTE 1



Illegible →
the whole case will not be marked

0. Legibility

AR
Allergic Rhinitis?
Aortic Regurgitation?

Use abbreviations sensibly

- Understood by local primary care doctor
- Avoid those easily causing confusion
- Can prepare a 'reference list of abbreviations' for Assessor
- Unnecessary to convert commonly used abbreviations to full forms; e.g.
  - Hx → History
  - C/O → Complaint of
  - P/E → Physical Examination
  - Ix → Investigation
  - CT → computerized tomography
  - US / USG → ultrasound scan / ultrasonogram
  - DEXA / DXA → dual-energy x-ray absorptiometry
  - Urine R/M …
  - LUTS …
  - BPH …

i. Basic information

- Allergy / Adverse drug reactions
- Current medication list
- Problem list (Current / Past health)
- Family history (with genogram as appropriate)
- Social history, occupation
- Height, weight, BMI/ growth chart, blood pressure
- Immunization
- Tobacco & alcohol use; physical activity

refers to the regular medications from your clinic

Genogram: not mandatory in every case

- As appropriate
- As applicable
- Dated
- Updated
- Consistent with other parts of the medical record

Please note:
It is not mandatory to have full documentation on all the areas in every medical record

i. Basic information

Use of templates / tables

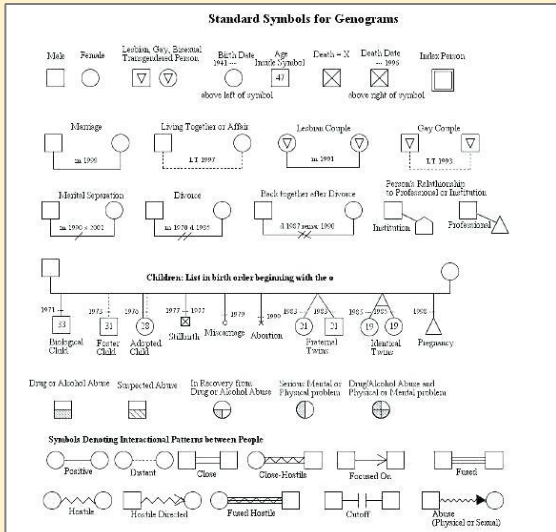
Basic information

- Preferred
- Should have significant ‘negatives’ e.g. Allergy: nil known

- **As appropriate and as applicable**
- **Not mandatory to full in all the blanks on the template in every medical record**
- **Inappropriate ‘blanks’ on the template/ table may be regard as missing information**

i. Basic information

Genogram



- At least (but not limited to) 2 generations
- Relevant & specific for the patient
- Show index patient
- Family members' health condition
  if deceased: cause & age of death
- Show members who are living together

No genogram in some cases could be acceptable, e.g.

- Communication difficulty (e.g. impaired cognition, hearing, speech, language barrier)
- Lack of appropriate informants
- Medical emergency encountered

ii. Consultation notes

- Main reason(s) of consultation

- State **clearly in the initial part** of the consultation notes; e.g.
  - *FU DM, HT, hypothyroidism*
  - *C/O: runny nose 2/7*
- **Avoid preceded by irrelevant past information**; **the main reason(s) of the consultation** may sink into the paragraphs of notes causing confusion / misunderstanding
- Keep any **'introductory information'** e.g. significant past / current medical information **concise and relevant**

ii. Consultation notes

- Clinical findings

- **Group the findings** under headings e.g. history, physical exam, diagnosis / impression, management, anticipatory care (AA) etc.

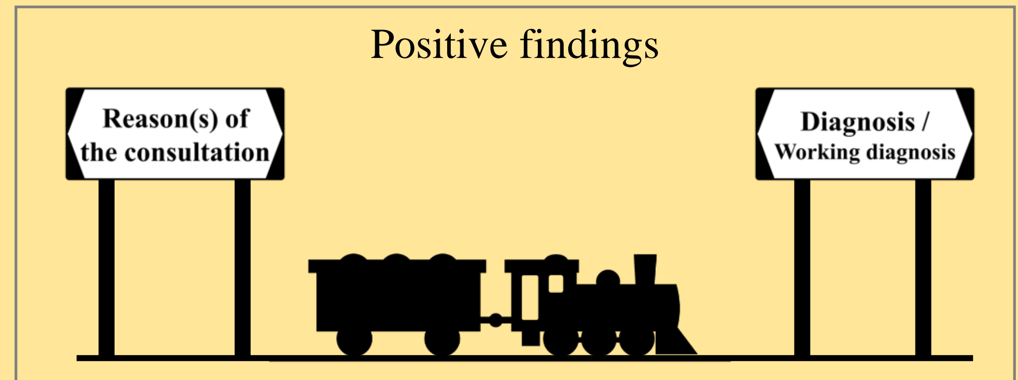
C/O
Runny nose 1/7
Watery,
Mild ST,
Not much cough
No fever
TOCC –ve
………
PE:
GC sat
Temp: ….
Hydration N
…….
Mx:
…….

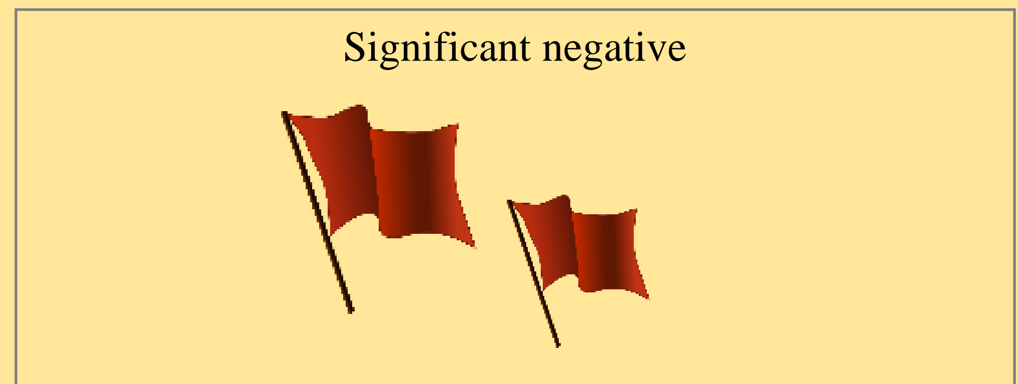
FU DM , HT
Good compliance to Rx
Tolerated
No hypoglycemia
Diet: usual care; but avoiding sweety fatty foods
Ex: nil regularly
………
PE:
GC sat
BP
Hstix 2hr pp …….
Mx:
… …. …
AA:
Discussed DEXA , patient not keen at present

ii. Consultation notes

- Clinical findings

- Record **positive** and **significant negative** clinical findings





ii. Consultation notes

- Clinical findings

- **Follow up significant issue(s) raised in previous visits as appropriate**
  e.g. overweight, smoking, elevated blood pressure

- **ICE** (idea / concern / expectation) ,
  Elaborated psycho-social history:
  - may not be necessary in straightforward episodic physical / chronic follow up cases
  - important in certain situations e.g.
    - Psychological condition; e.g. insomnia, depression follow up
    - Diagnostic or management challenge e.g.
      - occurrence of a potentially sinister condition (e.g. suspected malignancy)
      - suboptimal chronic disease control
      - distressed patient / relatives
    - Volunteered by the patient / relatives

ii. Consultation notes

- Diagnosis / working diagnosis

- **Stated** in the consultation note

- For straightforward episodic / regular follow up cases: state the diagnosis usually sufficient
- Status of control in chronic disease e.g.
  - *HT, stable*
  - *DM suboptimal control*
  - *lipids on statin, at target (< 2.6)*
- 'Triple diagnosis': psycho-social status as appropriate; e.g.
  - *Dementia, care-taker (wife) stress*
  - *Depression, recently employed*
- In case cannot arrive at a diagnosis, give differential diagnoses (ddx) / working diagnosis / clinical impression:
  - *Dizziness; ddx: BPPV, vestibulitis*
  - *Weight loss: bowel pathology?, hyperthyroid*
  - *LUTS: BPH, Co-existing UTI?*

Exhaustive list of ddxs is not necessary

ii. Consultation notes

- Management

- Drug use or/ and non-pharmacological measures:
- Injudicious use of drugs e.g. inappropriate use of steroids, hypnotics, will be penalized

RAPRIOP

If follow up is required:
- 'planned': the interval should be appropriate to the nature of problem(s) to be reviewed
- 'FU p.r.n.', 'open FU': give appropriate advice e.g. *'return / seek medical attention if':*
  the tongue ulcer not improve in the next 2 weeks
  rash / vesicles develop on the region you feel the pain

Referral

If you expect the patient should be seen by a designated specialist with high priority / urgent basis, consider:
- follow up / contact the patient for confirmation
- remind patient such as *return / contact clinic if not seen by Breast Clinic within three weeks*

ii. Consultation notes

- Anticipatory care advice

- Anticipatory care advice (AA) is contemplated in:
  - straightforward episodic encounter,
  - stable regular follow up chronic medical condition
- AA may not be essential in certain situations, e.g. prolonged consultations due to
  - Patient raised multiple issues
  - Presence of sophisticated psycho-social issues
  - Diagnostic difficulties
  - Management difficulties
- One AA advice in one consultation should be sufficient
- Age and gender appropriate
- Document patient's response to the AA, e.g.
  - *Discussed bone density & DEXA; patient not keen, cost concern*
  - *Flu-shot today at clinic*
  - *PAP smear: due next year in FPA*

The Assessment

- Choose ten medical records from the 100-case log
- Mark the ten records
- Feedback to the candidate

Who can be PERM Assessor?

Candidate's Clinical Supervisor in Higher FM Training

OR

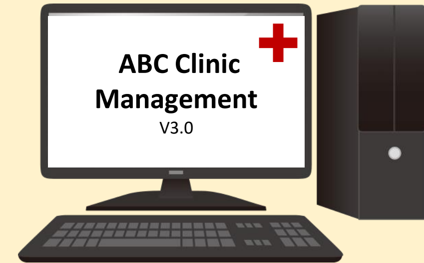
PA Examiner

Choose ten medical records from the 100-case log

Let's review these ten records

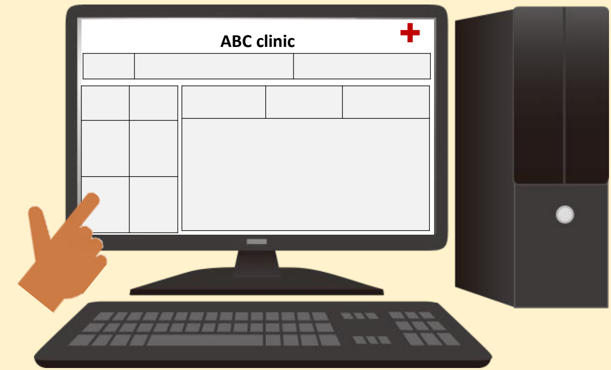
Assessor

Candidate



AND /OR

Explain the layout of the medical records to Assessor



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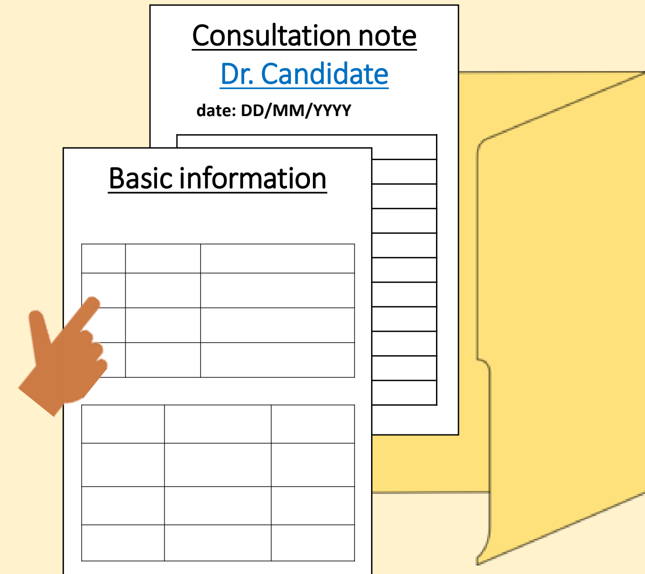
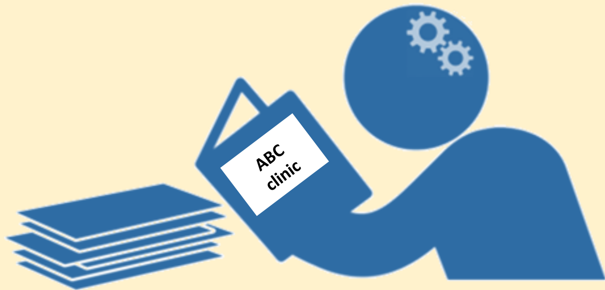
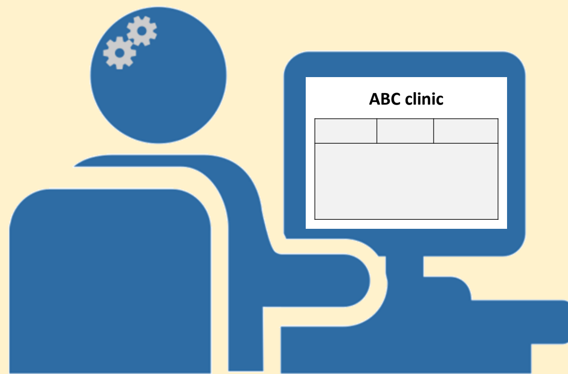
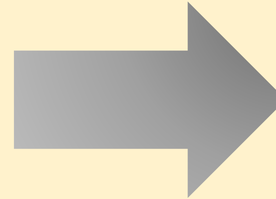


Assessor marks the ten medical records



AND /OR





PERM Assessment Form

PERM Assessment Form

The Hong Kong College of Family Physicians

香港家庭醫學學院

HKCFP

Pre-Exit Medical Record Review (PERM)

Candidate	
Practice name & address	(Working in the practice since____/____)

Assessor	
Date of assessment	
Signature	

Updated December 2021 1

PERM Assessment Form

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
0. Legibility										
i. Basic Information										

- Allergy / Adverse drug reactions
- Current medication list
- Problem list (Current / Past health)
- Family history (with genogram as appropriate)
- Social history, occupation
- Height, weight, BMI/ growth chart; blood pressure
- Immunization
- Tobacco & alcohol use; physical activity

Grade (please circle one)

A	Very good to Outstanding, mastery of most components and capability
C	Satisfactory to good in most components
E	Need to overcome some omissions / defects that have impact on patient care
N	Need attention to avoid unsafe practice

ii. Consultation notes										
Main reason(s) of consultation										
Clinical findings										
Diagnosis/ Working diagnosis										
Management										
Anticipatory care advice										

Grade (please circle one)

A	Very good to Outstanding, mastery of most components and capability
C	Satisfactory to good in most components
E	Need to overcome some omissions / defects that have impact on patient care
N	Need attention to avoid unsafe practice

Updated February 2023 3

Overall performance	
Grade (please circle one)	
A	Very good to Outstanding, mastery of most components and capability
C	Satisfactory to good in most components
E	Need to overcome some omissions / defects that have impact on patient care
N	Need attention to avoid unsafe practice

Feedback:

i. Basic Information

Updated February 2023 4

ii. Consultation notes

Overall / other comments

Please tick the area(s) need attention / improvement according to the overall performance:

Overall performance on Basic Information: area(s) need attention / improvement	If applicable, please ✓; higher priority ✓✓, etc.	remarks
• Insufficient positive / significant negative information		
• Inaccurate / inconsistent with other part(s) of the record		
• Information not updated		
• Documentation: length not appropriate OR unclear		
• Others:		

Overall performance on Consultation Notes: area(s) need attention / improvement	If applicable, please ✓; higher priority ✓✓, etc.	remarks
• Main reason(s) of consultation unclear		
• Insufficient documentation of clinical findings		
• Diagnosis/ Working diagnosis unclear		
• Suboptimal management		
• Lack of / inappropriate anticipatory care advice		
• Documentation: length not appropriate OR unclear		
• Others:		

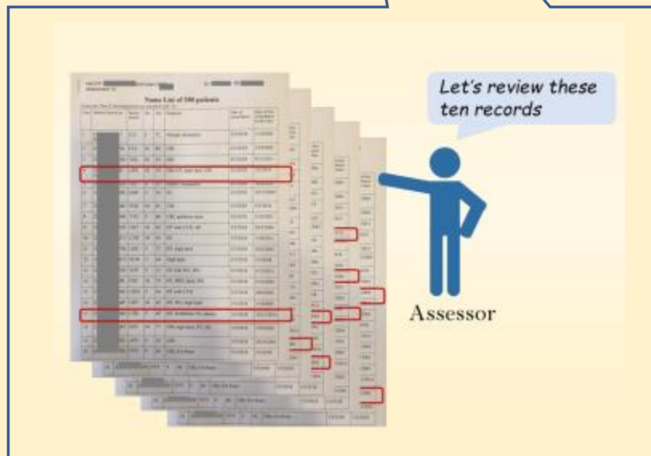
Assessor please sign on the front page

--- end ---

Enter the serial no.

Enter the serial numbers of the ten records chosen

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
	9	26	35	41	51	63	72	78	84	100
0. Legibility										



Legibility

PERM Assessment Form

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
	9	26	35	41	51	63	72	78	84	100
0. Legibility	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗

Check legibility of each records

legible→ Assessor proceed to mark the record

Illegible → the whole case would not be marked

Basic information

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
	9	26	35	41	51	63	72	78	84	100

i. Basic Information										
	• Allergy / Adverse drug reactions • Current medication list • Problem list (Current / Past health) • Family history (with genogram as appropriate) • Social history, occupation • Height, weight, BMI/ growth chart; blood pressure • Immunization • Tobacco & alcohol use; physical activity									

Grade (please circle one)	
A	Very good to Outstanding, mastery of most components and capability
C	Satisfactory to good in most components
E	Need to overcome some omissions / defects that have impact on patient care
N	Need attention to avoid unsafe practice

Basic information

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
	9	26	35	41	51	63	72	78	84	100

i. Basic Information										

- Allergy / Adverse drug reactions
- Current medication list
- Problem list (Current / Past health)
- Family history (with genogram as appropriate)
- Social history, occupation
- Height, weight, BMI/ growth chart; blood pressure
- Immunization
- Tobacco & alcohol use; physical activity

1. Assess the basic information of each record
2. Use the grid to jot notes or the key impression

Basic information

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
	9	26	35	41	51	63	72	78	84	100
i. Basic Information	✓✓	✓	✗	✓	✓	✓	✓✓	✗	No growth chart	✓
	• Allergy / Adverse drug reactions • Current medication list • Problem list (Current / Past health) • Family history (with genogram as appropriate)					• Social history, occupation • Height, weight, BMI/ growth chart; blood pressure • Immunization • Tobacco & alcohol use; physical activity				

- No rules in using the grid
- Help to recall when drafting feedback and grading the global performance
- May use other symbols preferred by assessor e.g. ++ , + , +/- , - etc.

Basic information

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
	9	26	35	41	51	63	72	78	84	100

i. Basic Information	✓✓	✓	✗	✓	✓	✓	✓✓	✗	No growth chart	✓

- Allergy / Adverse drug reactions
- Current medication list
- Problem list (Current / Past health)
- Family history (with genogram as appropriate)
- Social history, occupation
- Height, weight, BMI/ growth chart; blood pressure
- Immunization
- Tobacco & alcohol use; physical activity

Grade the global performance

Grade (please circle one)

Grade	Description
A	Very good to Outstanding, mastery of most components and capability
C (circled)	Satisfactory to good in most components
E	Need to overcome some omissions / defects that have impact on patient care
N	Need attention to avoid unsafe practice

Consultation Notes

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8	9	10
	9	26	35	41	51	63	72	78	84	100

ii. Consultation notes

Main reason(s) of consultation	✓									
Clinical findings	✓✓									
Diagnosis/ Working diagnosis	✓									
Management	✓✗									
Anticipatory care advice	✓									

Use the grid to jot the key impression of each case

e.g.

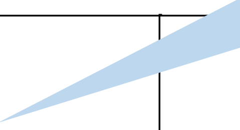
- for good performance: ✓✓
- for satisfactory performance: ✓
- for omissions / defects: ✓✗
- for issues with safety concerns: ✗
- Not applicable: NA

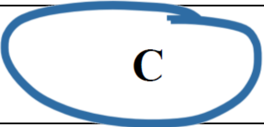
Consultation Notes

ii. Consultation notes

Main reason(s) of consultation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinical findings	✓✓	✓	✓	✓✓	✓	✓	✓✓	✓	✓	✗
Diagnosis/ Working diagnosis	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓
Management	✗	✓	✓	✓	✗	✓	✓	✓	✓✓	✓
Anticipatory care advice	✓	NA	✓	✓	✓	✓	✓	✓	✓	NA

Grade (please circle one)



A	Very good to Outstanding, mastery of most components and capability
C 	Satisfactory to good in most components
E	Need to overcome some omissions / defects that have impact on patient care
N	Need attention to avoid unsafe practice

Overall performance

Overall performance	
Grade (please circle one)	
A	Very good to Outstanding, mastery of most components and capability
C	Satisfactory to good in most components
E	Need to overcome some omissions / defects that have impact on patient care
N	Need attention to avoid unsafe practice

Please note

if any part(s) of PERM graded "N"

Grade (please circle one)	
A	Very good to Outstanding, mastery of most components and capability
C	Satisfactory to good in most components
E	Need to overcome some omissions / defects that have impact on patient care
N	Need attention to avoid unsafe practice

The PERM Report **will be rejected** by Specialty Board

Comparison of rating on medical records in PERM and Exit Exam

PERM		PA (Part D)		CSA (Record keeping)	
A	Very good to Outstanding, mastery of most components and capability	8.5 or above	Consistently demonstrates outstanding performance in all components; criterion performance. (outstanding)	8.5	Candidate can make an accurate and legible record with precise and concise details, and a relevant past medical / social history of an appropriate length
		8	Consistently demonstrates mastery of most components and capability in all. (Very Good)		
		7.5		7.5	Candidate can make an accurate and legible record with sufficient details, and a relevant past medical / social history for the consultation
C	Satisfactory to good in most components	7	Consistently demonstrates capability in most components to a professional standard. (Average to good) *(minor omissions / defects that can be tolerated)*		
		6.5		6.5	Candidate can make an accurate and legible record with adequate information for realizing the whole consultation without major omissions

Comparison of rating on medical records in PERM and Exit Exam

<table>
<tr><th colspan="2">PERM</th><th colspan="2">PA (Part D)</th><th colspan="2">CSA (Record keeping)</th></tr>
<tr><td rowspan="4">E</td><td rowspan="4">Need to overcome some omissions / defects that have impact on patient care</td><td>6</td><td rowspan="2">Demonstrates capability in some components to a satisfactory standard; but with omissions and/ or defects in other components that have impact on patient care. (such omissions/ defects were seen in two or more of the Cases assessed)</td><td></td><td></td></tr>
<tr><td>5.5</td><td>5.5</td><td>Candidate can make a legible record for the consultation but missing some major details</td></tr>
<tr><td>5</td><td rowspan="2">Demonstrates inadequacies in several components with major omissions or defects.</td><td></td><td></td></tr>
<tr><td>4.5</td><td>4.5</td><td>The record contains illegible information i.e. information overload, redundant or irrelevant information breakdown effective communication between medical professionals.</td></tr>
<tr><td>N</td><td>Need attention to avoid unsafe practice</td><td>4 or below</td><td>Demonstrates serious defects; clearly unacceptable standard overall.</td><td></td><td></td></tr>
</table>

Feedback to the candidate

Comment on
- Global performance
- Individual cases

The fact you noted
Your opinion as appropriate

Consolidate on:
- Good performance

make prioritized changes on:
- Area(s) need improvement
- Area(s) need attention
- Undesirable practice

Preferably to be conducted at earliest convenience after the marking
- Still having fresh memories on the cases
- Allow sufficient time for the candidate to consolidate and change

Feedback to the candidate

Assessor documents the Feedback

Summary of the feedback given to the candidate

Feedback:

i. **Basic Information**

ii. **Consultation notes**

Overall / other comments

Some examples

- *Case 64: Basic information (HAFM) form show "no HT", but in fact patient was HT on atenolol*
- *Case 100: No growth chart (age 3); irrelevant social history: non-smoker / drinker*

Updated February 2023 4

Feedback to the candidate

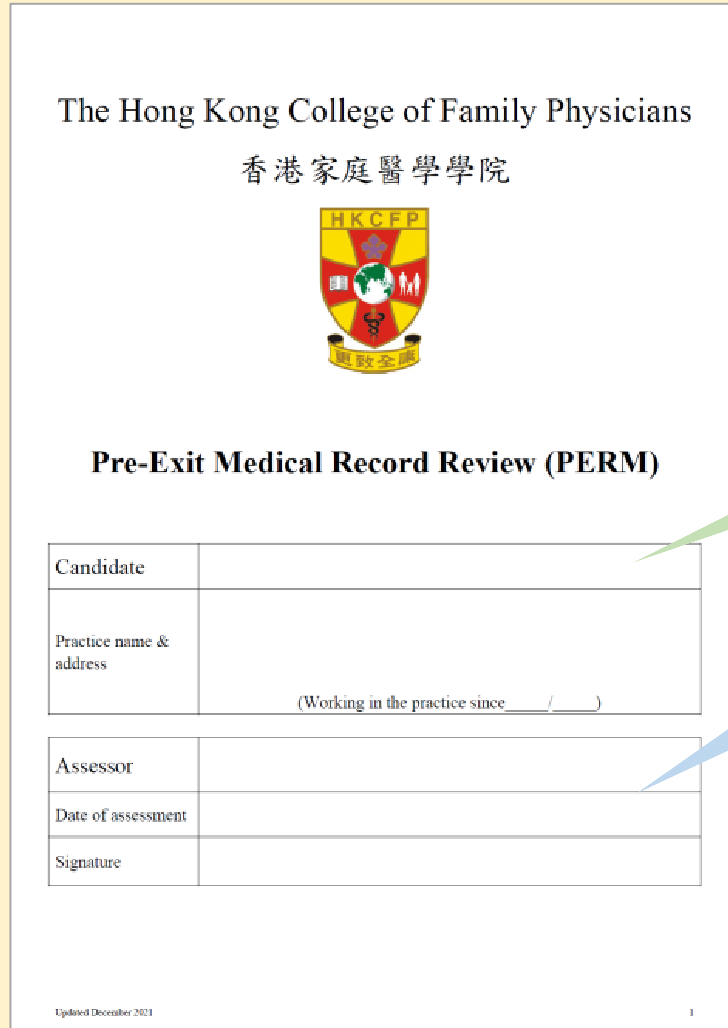
Assessor documents the Feedback

Please tick the area(s) need attention / improvement according to the overall performance:

Overall performance on Basic Information: area(s) need attention / improvement	If applicable, please ✓; higher priority ✓✓, etc.	remarks
• Insufficient positive / significant negative information		
• Inaccurate / inconsistent with other part(s) of the record		
• Information not updated		
• Documentation: length not appropriate OR unclear		
• Others:		

Overall performance on Consultation Notes: area(s) need attention / improvement	If applicable, please ✓; higher priority ✓✓, etc.	remarks
• Main reason(s) of consultation unclear		
• Insufficient documentation of clinical findings		
• Diagnosis/ Working diagnosis unclear		
• Suboptimal management	✓	
• Lack of / inappropriate anticipatory care advice		
• Documentation: length not appropriate OR unclear		
• Others:		

Completing PERM Report



The Hong Kong College of Family Physicians

香港家庭醫學學院

Pre-Exit Medical Record Review (PERM)

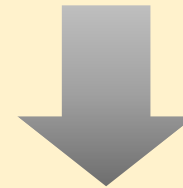
Candidate	
Practice name & address	(Working in the practice since____/____)

Assessor	
Date of assessment	
Signature	

Updated December 2021 1

Candidate's information

Assessor's signature



PERM Report

The ten medical records assessed in PERM must be kept till 31st March next year

These records may be reviewed by delegates of Specialty Board for:

- suspected misconduct in PERM when necessary; OR
- quality assurance as agreed by the candidates and assessors

Some observations, comments and recommendations from previous PA (Part D Medical Records)

Overall performance on D2 (Basic information): area(s) need attention / improvement	If applicable please ✓; higher priority ✓✓, etc.	remarks
• Insufficient positive / significant negative information		
• Inaccurate / inconsistent with other part(s) of the record		
• Information not updated		
• Documentation: length not appropriate OR unclear		
• Others:		

Overall performance on D3 (Consultation notes): area(s) need attention / improvement	If applicable please ✓; higher priority ✓✓, etc.	remarks
• Main reason(s) of consultation unclear		
• Insufficient documentation of clinical findings		
• Diagnosis/ Working diagnosis unclear		
• Suboptimal management		
• Lack of / inappropriate anticipatory care advice		
• Documentation: length not appropriate OR unclear		
• Others:		

Part D (Medical Records)
General

issue noted:	Comments / recommendations
Submitted duplicate cases in the case-log	• To be avoided • In Exit Exam: risk of penalty & disqualifications

Part D (Medical Records)
Documentation: length not appropriate OR unclear

issue noted:	Comments / recommendations
Long consultation notes, even simple URTI , document almost each wording or standard wording from textbook, which is not necessary	
Annual blood result documentation only need the most updated one, candidate also put down those few years ago.	

Part D (Medical Records), D2 (Basic Information)
Insufficient positive / signifiant negative information

issue noted:	Comments / recommendations
"Other allergy" section left blank on the basic information templates	• Enter 'nil' , 'nil known'
Genogram: there was no age and health information for those alive; although age and cause of death of the deceased family members are recorded	• In case of time constraint, focus on information of closely blood-related, spouse, living together (i.e. members surrounding the patient). Put down the significant positives, 'in good health', etc.
No immunization record for child cases	

Part D (Medical Records), D2 (Basic Information)
Inaccurate / inconsistent with other part(s) of the record

issue noted:	Comments / recommendations
Housewife; given sick leave for IOD	
Notes mentioned that patient lives with husband, but marital status being 'unknown' in the basic information of the record	
In the basic information: ' X ' for contraception on one page, but mentioned condom on another page.	

Part D (Medical Records), D2 (Basic Information)
Information not updated

issue noted:	Comments / recommendations
Wife passed away → reason?	
Mother passed away → reason?	

Part D (Medical Records), D3 (Consultation notes)
Main reason(s) of consultation unclear

issue noted:	Comments / recommendations

Part D (Medical Records), D3 (Consultation notes)
Insufficient documentation of clinical findings

issue noted:	Comments / recommendations
ENT referral made; but not a single word on ENT symptoms found in the record	
Topical urea cream prescribed; indication not found in record	
Patient has ECG; routine care? or ordered for any symptoms? Not documented in history and the referral letter.	
eGFR is more relevant thant Creatinine level in monitoring of renal function	
ddx costochondritis but not mentioned any local chest tenderness	
ddx anorexia nervosa but no related symptoms documented	

Part D (Medical Records), D3 (Consultation notes)
Insufficient documentation of clinical findings

issue noted:	Comments / recommendations
Dizziness for 3 month on and off, genogram: husband mental health issues; 2 children need to take care of. Need to explore psychological aspect	
Dx cataract but visual blurring last 10 mins each time, not typical symptoms of cataract. Other causes e.g. dry eyes? Can test red reflex in PE	
Known depression FU PSY. Dx acute stress disorder without any traumatic event encountered. Did not assess suicidal risk.	
Hx of fever / stomach pain → Dx mesenteric adenitis. Location of pain not typical. The Dx can only be made after imaging	

Part D (Medical Records), D3 (Consultation notes)
Diagnosis/ Working diagnosis unclear

issue noted:	Comments / recommendations
• Case A - Syncope 2nd time with few months should need further work up rather than just treatment GI symptoms. DDx may include TIA epilepsy • Case B – sub-mandibular mass may need further work up. e.g. sputum culture, imaging • Overall impression: little attempt to arrive provision dx / ddx; problems are then mostly referred out. Can discuss more with patient and suggest more for options	
Can consider other DDx in kids with prolonged cough e.g. allergic rhinitis; not followed up	
Diagnosed ‘post-herpetic neuralgia for persisted pain ~ 1/52 after the onset of rash	
Central chest pain for few weeks; CXR few months ago NAD, ECG no acute changes, dx atypical chest pain without further workup. Symptoms at night and patient on NSAID recently → GERD?	

Part D (Medical Records), D3 (Consultation notes)
Suboptimal management

issue noted:	Comments / recommendations
Tramadol and pholcodine; both opioid types, risk of respiratory suppression	
F/61 FU for neck pain, numbness UL The consultation notes (done in 9/17) typed: MRI neck (9/17): C3/4; C4/5; C5/6; C6/7 mild spinal stenosis with compressing cord…C3/4 mild increase T2 intensity suggestive of early compressive myelopathy. Ortho pending 12/ 2018 -- should attempt to advance the orthopedic appointment Mx: Referred to Physiotherapy -- potential unsafe Mx	
HT newly on drug; no regular FU was arranged, instead advised patient to self book IVAS. Also there is a DM RAMP podiatrist appointment for patient in the record, it is not sure if patient in having DM or not.	
Why 10-year-old child epistaxis given neomycin cream?	
Fasting Hstix 8.3 – 10.4, A1c 8.5%, hx too brief, better to have more hx on lifestyle and any symptoms of poor DM control. Mx just stepped up metformin from 500 mg BD to 750 mg BD, not likely to bring significant improvement	

Part D (Medical Records), D3 (Consultation notes)
Suboptimal management

issue noted:	Comments / recommendations
LDL 3.4, CKD, should switch (treatment) for LDL target < 2.6	
On Hytrin 6 mg , can warn side effects on Mx	
M46, BP 162/84, BP not rechecked. No recommendation for FU high BP. BP also high in the last consultation in March 2023.	
F/87, PR bleed, change of bowel habit, weight loss, only refer patient to surgeon, did not consider other ddx such as bld test / CXR / urine test	
CVS risk 14.4%, LDL 3.0, commented 'suboptimal control' and increased Crestor dose. Aim LDL < 3.4 sufficient if medium CVS risks.	
Hytrin increase from 1 mg to 5 mg daily: too aggressive, may trigger postural hypotension	

Part D (Medical Records), D3 (Consultation notes)
Lack of / inappropriate anticipatory care advice

issue noted:	Comments / recommendations

PERM
and
Exit Exam

PERM report

- Decide how many medical records need to be prepared in Part D of PA
- Part of the PA Document to be submitted at Exit Exam application

Candidate

The Hong Kong College of Family Physicians

香港家庭醫學學院

Pre-Exit Medical Record Review (PERM)

Candidate	
Practice name & address	(Working in the practice since____/____)

Assessor	
Date of assessment	
Signature	

PERM Report ✓

AND

A. Template for 100-Case Log

Serial no.	Patient record number	Patient initials	sex	age	diagnosis	Date of the consultation	Date of first attended the clinic
1							
2							
3							

100-case log ✓

To be submitted with

the Exit Examination Application

(deadline: 1st working day of November)

Candidate

PERM Report

The Hong Kong College of Family Physicians

香港家庭醫學學院

Pre-Exit Medical Record Review (PERM)

Candidate	
Practice name & address	(Working in the practice since____/____)

Assessor	
Date of assessment	
Signature	

AND

100-case log

A. Template for 100-Case Log

Serial no.	Patient record number	Patient initials	sex	age	diagnosis	Date of the consultation	Date of first attended the clinic
1							
2							
3							

Collect **100 medical records for Part D** (Medical Record)

and separately,

10 medical records for

Part E (Investigations)

in the usual six-week **case collection period** (usually from middle of Sep to end of Oct) for Exit Examination

Please refer to the Pre-Exit Examination Workshop for candidates in August every year

Candidate

The Hong Kong College of Family Physicians

香港家庭醫學學院

Pre-Exit Medical Record Review (PERM)

PERM Report

A. Template for 100-Case Log

Serial no.	Patient record number	Patient initials	sex	age	diagnosis	Date of the consultation	Date of first attended the clinic
1							
2							
3							

100-case log

Same as the requirement of Exit Examination before 2022

Collect **300 medical records for Part D** (Medical Record) in the usual six-week case collection period (usually from middle of Sep to end of Oct) for Exit Examination

From 2026 PERM will be mandatory and may be enhanced

Process of PA

1. Prepare for the examination
2. Submit required PA Document at Exam Application
3. Examiners will visit the candidate on a designated **exam date** to conduct PA –which consist of:

   Random check (on PMP)

   Part CII (Dangerous drugs management)

   Part D (Medical records)

   Part E (Investigations)
4. Results announcement
5. Post Examination evaluation

PA Document

*Please refers to the **PERM Workshop**:*

Cases collection: A 6-week period between 1st May & 31st August

PERM report

One copy

*Please refers to the **Preparatory Workshop***

*PMP visit: any day between 1st May to 30th October**

PMP report

One copy

Attachment 1 to Attachment 11

Four copies (A4 size)

*Please refers to the **Pre-Exit Workshop***

*Cases Collection: 16th September to 30th October**

Attachment 12
Part D
(Medical Records)

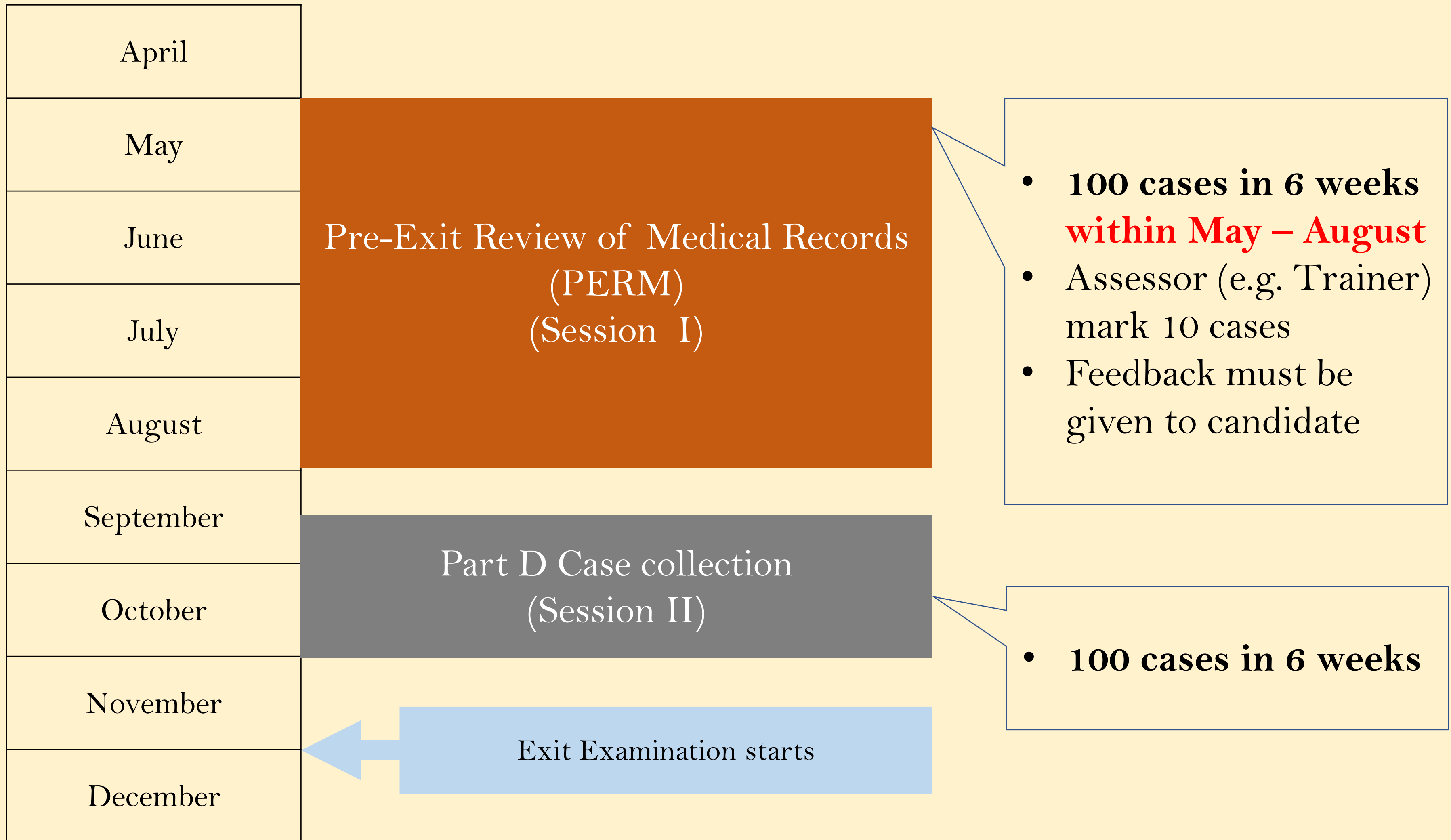
Four copies (A4 size)

Attachment 13
Part E
(investigations)

Four copies (A4 size)

**tentative*

Part D: timeline



Enquiry

Specialty Board secretary:

alkyyu@hkcfp.org.hk

Tel: 2871 8899 (Alky or John)