CHART REVIEW FORM – OFF SITE

Reviewer: _____ **Physician Reviewed:** _____

Date: _____ **Location:** **Office** ☐ **Hospital** ☐ **Other** ☐ **– Specify:** _____

		VISIT DATE (dd/mm/yyyy)	COMMENTS RE VISIT	CONCERNS
1	**Patient Initials:** **PHIN #:** **Gender:** **Year of Birth:** **Diagnosis:**			
2	**Patient Initials:** **PHIN #:** **Gender:** **Year of Birth:** **Diagnosis:**			

		VISIT DATE (dd/mm/yyyy)	COMMENTS RE VISIT	CONCERNS
3	**Patient Initials:** **PHIN #:** **Gender:** **Year of Birth:** **Diagnosis:**			
4	**Patient Initials:** **PHIN #:** **Gender:** **Year of Birth:** **Diagnosis:**			
5	**Patient Initials:** **PHIN #:** **Gender:** **Year of Birth:** **Diagnosis:**			

OVERVIEW OF CHARTS

Please complete this section taking into account all charts reviewed.

	SATISFACTORY	NEEDS IMPROVEMENT	COMMENTS
Medical Record Keeping	☐	☐	
Chronic Disease Management	☐	☐	

OVERALL ASSESSMENT

Meets standard of care: ☐ Yes ☐ No

Comments:

Practice Improvement Recommendations:

Signature | Reviewer Name | Date