CHART REVIEW FORM

Auditor: _____ Physician Audited: _____

Date: _____ Location: Office ___x_ Hospital ____ Other – specify _____

	Patient Initials/PHIN	Gender	DOB	Visit Date	Diagnosis, comments re visit	Concerns (attach comment sheet for Yes)
1	AB	F	02/01/37	19/04/18	BP; DM; prev bronchitis. Foot exam? Immunizations? CVS? Consults? Resp?	Consults Colonoscopy
2	CD	F	15/04/37	23/04/18	CVS? Legs? Immunizations? Flow sheets?	
3	EF	F	28/11/34	19/03/18	AFIB; BP; CVS? HR? Legs? Good immunization, INR flowsheet	Allergies? CPX recently?
4	GH	F	31/01/79	19/03/18	Depression; hemorrhoids ?Follow up tests	Allergies? Meds in old list re IBS, migraines – not in problem list
5	IJ	F	12/08/60	23/04/18	Chronic pain Exam? Immunizations?	Ongoing rx for vesicare – no dx. Ongoing rx for zopiclone.

OVERVIEW OF CHARTS

Please complete this section taking into account all charts reviewed.

	Satisfactory	Needs Improvement	Comments
Medical Record Keeping	x		
Chronic Disease Management	x		

OVERALL ASSESSMENT

Meets standards of care: ❑x Yes ❑ No

Comments:

Chronic care – sees patients regularly. Good documentation of phone calls.

Practice improvement Recommendations:

Better documentation of immunizations.
Use of flow sheets?
Regular medication reviews.
Better documentation or regular performance of pertinent physical exams.

Signature | Auditor Name | Date