DR. X OFF-SITE CHART REVIEW FORM

REVIEWER:

DATE:

PREAMBLE:

CHARTS REVIEWED:

PHIN #	Patient Initials	Year of Birth	Gender	Start/End Date of Visits
Diagnosis:				

Comments:

PHIN #	Patient Initials	Year of Birth	Gender	Start/End Date of Visits
Diagnosis:				

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PHIN #	Patient Initials	Year of Birth	Gender	Start/End Date of Visits
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Comments:

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Diagnosis:				

Comments:

PHIN #	Patient Initials	Year of Birth	Gender	Start/End Date of Visits
Diagnosis:				

Comments:

OVERVIEW OF CHARTS

Please complete this section taking into account all charts reviewed.

MEDICAL RECORD KEEPING: ☐ Satisfactory ☐ Needs Improvement

Comments:

MEDICAL MANAGEMENT: ☐ Satisfactory ☐ Needs Improvement

Comments:

OVERALL ASSESSMENT

STRENGTHS:

CONCERNS:

PRACTICE IMPROVEMENT RECOMMENDATIONS:

FOR INTERNAL USE ONLY: (Practice improvement recommendations to be categorized below)

SUGGESTED PRACTICE CHANGES:

REQUIRED PRACTICE CHANGES:

Signature	Reviewer Name	Date