**DR. X OFF-SITE CHART REVIEW FORM**

**REVIEWER:**

**DATE:**

**PREAMBLE:** Initial Quality Improvement Program chart review.

**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: |  |

Comments:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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: |  |

Comments:

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

Comments:

|  |  |
| --- | --- |
| **Level of Concern** | **Definition** |
| No/Minimal ConcernsReasonable care provided | No/minimal concerns, care provided is reasonable and adequate. |
| Opportunities for Improvement | Suggested changes or improvements to practice for self-directed implementation. |
| Further CPSM Action Required | Major practice changes needed and CPSM follow-up required. |

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| **OVERALL ASSESSMENT**Please complete this section taking into account all charts reviewed. | **No/Minimal Concerns** **Reasonable** **care provided** | **Opportunities for Improvement** | **Further CPSM Action Required** |
| **Medical Record Keeping** | [ ]  | [ ]  | [ ]  |
| Comments: |
| **Medical Management** | [ ]  | [ ]  | [ ]  |
| Comments: |
| **Strengths** |
| Comments: |
| **Opportunities for Improvement** |
| Comments: |

|  |
| --- |
| **REQUIRED CHANGES** |
| **Further CPSM Action Required** |
| Comments: |
| **Patient Safety Concerns** [ ]  |

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|  |  |  |  |  |

 Signature Reviewer Name Date