CHART REVIEW FORM – OFF SITE

Reviewer: _____ **Physician Reviewed:** _____

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

	PATIENT INITIALS/PHIN	GENDER	DOB (ddmmyyyy)	VISIT DATE (ddmmyyyy)	DIAGNOSIS, COMMENTS RE VISIT	CONCERNS (ATTACH COMMENT SHEET FOR YES)
1						
2						

	PATIENT INITIALS/PHIN	GENDER	DOB (ddmmyyyy)	VISIT DATE (ddmmyyyy)	DIAGNOSIS, COMMENTS RE VISIT	CONCERNS (ATTACH COMMENT SHEET FOR YES)
3						
4						
5						

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 standards of care: ☐ Yes ☐ No

Comments:

Practice improvement Recommendations:

Signature	Reviewer Name	Date