

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:

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Diagnosis:				

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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:

Signature

Reviewer Name

Date