

Outpatient Medical Record Peer Review Worksheet

Date: Reviewer: Month Reviewed:
 Clinic: Provider:

LEGEND: YES NO N/A

CRITERIA FOR PEER REVIEW		1	2	3	4	5	6	7	8	9	10	YES	NO	N/A	Total %
Identification Data:															
1	Is the history adequate (Past/Current/Family/Social HX:Tobacco, Alcohol, Drug/Living Conditions) and includes Chief Complaint?											0	0	0	#DIV/0!
2	Has pain been appropriately assessed and addressed? (if applicable)											0	0	0	#DIV/0!
3	Is the physical exam adequate?											0	0	0	#DIV/0!
4	Are vital signs recorded when appropriate?											0	0	0	#DIV/0!
5	Diagnostic tests/procedures:											0	0	0	#DIV/0!
	a. Were diagnostic tests/procedures appropriately ordered or done?											0	0	0	#DIV/0!
	b. If procedures were done, were they adequately documented? (if applicable)											0	0	0	#DIV/0!
	c. Were results of tests/procedures documented? (if applicable)											0	0	0	#DIV/0!
6	Is the assessment supported by the history, physical, diagnostic tests, and procedures/results?											0	0	0	#DIV/0!
7	Plan											0	0	0	#DIV/0!
	a. Is the plan appropriate?											0	0	0	#DIV/0!
	b. Does it include evidence of patient and/or family education?											0	0	0	#DIV/0!
	c. Does it include evidence of informed consent? (if applicable)											0	0	0	#DIV/0!
8	Adult Preventive and Chronic Care Flowsheet:											0	0	0	#DIV/0!
	a. Has it been updated within the past year?											0	0	0	#DIV/0!
	b. Are chronic medical diagnoses and/or conditions listed? (if applicable)											0	0	0	#DIV/0!
	c. Are surgical and invasive procedures listed? (if applicable)											0	0	0	#DIV/0!
9	Are the notes legible?											0	0	0	#DIV/0!
10	Referrals & Consults: Could you assume care of this patient with the information provided?											0	0	0	#DIV/0!
												COMPLIANCE TOTAL =		#DIV/0!	

"NO" Responses Require Comments: Other Constructive Feedback Welcome

Q #	COMMENT	CORRECTIVE ACTION
	All care was rendered very effectively.	