

**PATIENT RECORD QUALITY MANAGEMENT
CHECK LIST**

	DATE: _____		PROVIDER: _____									
	FACILITY: _____					OTHER: _____						
PATIENT NAME	DATE OF VISIT	SOCIAL INFO	CURRENT RX?	ALLERGIES NOTED?	IMMUNS REC?	P.E./OBJ FINDINGS	DX IMP	DX TESTS	RX	PT INST GIVEN	ED GIVEN	F/U VISIT
TOTAL AVERAGE GRADE Check=standard met 0= standard not met N/A= not applicable												
	COMMENTS: (OVERALL GRADE _____ %)											

Reviewer Sig _____ **Reviewed by Provider** _____

*After review, this form is to be forwarded to the clinic manager for review and retention