YOUNGSTOWN COMMUNITY HEALTH CENTER

MEDICAL CHART REVIEW
FOR
INDIVIDUAL PROVIDERS

CHART #_____ **ADULT** **PEDS**

NAME OF PROVIDER_____

DATE OF REVIEW_____

NAME OF REVIEWER_____

 # ENCOUNTERS REVIEWED_____
PATIENT SEEN BY PROVIDER SINCE_____
AGE OF PATIENT AT TIME OF REVIEW_____

Indicators	Yes	Partial	No	N/A
1. Annual medical history complete?				
2. Are notes written legibly?				
3. Are notes written in SOAP format?				
4. Are return visits noted in the plan?				
5. Are notes signed?				
6. Are notes completed?				
7. Are problem lists completed?				
8. Are medication lists completed?				
9. Medical care follows protocols and generally accepted medical management?				

NOTES: