## **Peer Assessment Committee**

**College of Physicians and Surgeons of New Brunswick** 



## **Offsite Assessment - Chart Review Form**

		N/A	A	U	S	Ν
1.	The date of each visit or consultation is clearly recorded.					
2.	The record is legible.					
3.	The patient's identity is evident on each component of the					
4.	file. There is a system in place to clearly show that test results come to the attention of the physician (i.e., initialled?)					
5.	A Cumulative Patient Profile (or equivalent summary sheet) relative to each patient is present.					
6.	Allergies are clearly documented.					
7.	The chief complaint is clearly stated.					
8.	An adequate description of symptoms is present.					
9.	Significant positive and negative physical findings are recorded.					
10	A diagnosis or provisional diagnosis is noted.					
11	. The treatment plan and /or treatment is noted.					

Definitions (for the purpose of this records review)

A "Always" U "Usually" 90% of files reviewed. 50-89% of files reviewed.

S "Sometimes"10-49% of files reviewed.N "Never"less than 10% of files reviewed.

**COMMENTS ON RECORDS:** 

From the files provided, assessors are requested to look for the specific disease entities relevant to the physician's field of practice.

Please include only the diseases that apply when submitting Patient Record Summary with this report. Please comment on any concerns which may arise.

COMMENTS ON MANAGEMENT OF SPECIFIC DISEASE ENTITIES:	

Recommendation from Chart Review:	Offsite: Onsite:
Assessor Signature	Date