

Chart Audit Form

RESIDENT NAME: _____
 Year of Training: 1 2 3 4
 Evaluator Name: _____

Date of Review: _____
 Patient Record No.: _____

Type of Document Reviewed:

- Hospital
 History and Physical Exam
 Discharge Summary
 Progress Note
 Consultation
 Procedure Note

- Outpatient
 History and Physical Exam
 Progress Note
 Consultation
 Procedure Note

Other: _____

Please evaluate the sections that are relevant to the record you are reviewing. Cite specific examples of resident performance and include recommendations for improvement.

| ITEMS TO BE EVALUATED | | | | Comments |
|--|------------|-----------|-----------|-----------------|
| PATIENT CARE | YES | NO | | |
| Appropriate history for presenting problem documented | | | | |
| Appropriate physical exam documented | | | | |
| Accurate assessment | | | | |
| Developed diagnostic plan | | | | |
| Developed therapeutic plan | | | | |
| Follow-up plan documented | | | | |
| Procedures | | | | |
| o Indications clearly documented | | | | |
| o Written consent documented | | | | |
| o Procedure note present and complete | | | | |
| MEDICAL KNOWLEDGE | YES | NO | | Comments |
| Differential diagnosis documented | | | | |
| Interpretation of exam and laboratory data documented | | | | |
| Demonstrates investigatory and analytic thinking | | | | |
| Demonstrates knowledge appropriate to level of training | | | | |
| INTERPERSONAL AND COMMUNICATION | YES | NO | | Comments |
| Legible | | | | |
| Clear | | | | |
| Concise | | | | |
| Dated | | | | |
| Timed | | | | |
| Signed | | | | |
| Thorough and complete | | | | |
| Communicates well with referral source/primary care provider | | | | |
| Medication list current as of last visit | | | | |
| Problem list updated | | | | |
| Uses SOAP format | | | | |
| PROFESSIONALISM | YES | NO | | Comments |
| Timely completion of records | | | | |
| SYSTEMS BASED PRACTICE | YES | NO | NA | Comments |
| Provides documentation to enable appropriate billing | | | | |
| Uses appropriate ICD codes | | | | |
| Uses appropriate E & M codes | | | | |
| Made appropriate referral(s) | | | | |
| Provides cost-effective health care | | | | |
| Appropriate use of lab, x-ray, etc. | | | | |