**Instructions for Peer Review of Medical Records:**

Please provide your feedback on whether the person consistently demonstrated (**Accomplished**), sometimes demonstrated (**Developing**, give examples of how it could be improved), or never demonstrated (**Not Done**) each of the following components of the medical record.

Remember, the more specific you can be with your comments, the more meaningful your feedback will be to your colleague!

**Logic:**

* The medical record clearly shows what the writer is thinking about the case at all times.
* Another person could immediately and seamlessly take over case management after reviewing the medical record.

**Master Problem List:**

* The Master Problem List is complete, including updated information as new data becomes available throughout case work-up.

**History:**

* Details of the presenting complaint are accurately recounted.
* There is a clear organization of the history (eg. use of different paragraphs as needed).
* Past medical history is included.
* Information pertaining to routine care (preventative health measures, nutrition, lifestyle or intended use, etc) is included in sufficient detail.

**Physical Examination:**

* Physical examination reports checking all body systems (even when there were no significant findings).
* Abnormal findings are reported using correct medical terminology and details (eg, when a mass is present, the location, texture, size, etc of the mass is described).

**Assessment – Initial:**

* Assessment includes degree of urgency as well as suspected body system(s) involved; localization of lesion(s) within the involved system.
* Each problem (or group of problems if appropriate) is discussed in terms of differential diagnoses.
* Discussion of differential diagnoses includes consideration of most likely vs less likely and justification.
* Diagnostic tests or treatments clearly reflect the differential diagnoses considered and are justified in terms of how the test(s) will help with further understanding of the case.

**Plans – Initial:**

* The diagnostic and treatment plans to move the case forward are included, and logically represent the conclusions of the case assessment.
* Plans are clearly listed, including specific details (route of administration, dose calculation, total volume, frequency, etc).
* Due consideration is given to possible complications that may arise either due to the tests/treatments or as a result of disease progression. Specific methods to monitor for such complications are included.
* Items for client education/discussion are listed including important details to include (eg: expected side effects of medication and how to react to that)

**Addendum (same-day entry with new data and assessment)**

* New data (results of tests, response to treatment, etc) are presented as an addendum.
* New data is assessed, including an updated problem list and an interpretation of how these results impact/modify the prior differential diagnoses; new differentials are included; new problems are discussed in terms of differential diagnoses and how to work them up further.
* A new diagnostic and/or treatment plan is presented that clearly reflects the new assessment.

**Medical Record Formatting:**

* The Medical Record includes owner and patient identification on each page.
* Every entry is dated, time-stamped and signed.
* Language used throughout record is professional.