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# The Atlantic Provinces Medical Peer Review



## PEER ASSESSMENT REPORT FAMILY MEDICINE/MEDICAL SPECIALTIES

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Please write legibly and forward completed form to the Peer Review office as quickly as possible.

(PLEASE USE BLACK INK)

APMPR# \_\_\_\_\_

Date of Assessment: \_\_\_\_\_

Assessor Name: \_\_\_\_\_

Assessor Signature: \_\_\_\_\_

## .1 Clinical Practice – New Presentations/Acute Condition Management

Please assess, based on the records, and through your interview with the physician, the appropriateness of the physician's actions in dealing with new patients or known patients presenting a new complaint or condition. New presentations will often involve the formulation of a diagnosis and recommendation(s) for treatment.

<b>New Presentations/Acute Condition Management</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
1. Chief complaint(s) is/are clearly stated, the duration of symptoms noted; functional inquiry is				
2. Physical examinations performed with positive/negative physical findings are				
3. In psychiatric illnesses, the presence of physical illness has been assessed to determine its influence, if any, on psychiatric symptoms.				
4. The family and past history (including significant negative observations, psychiatric illnesses, etc.) is maintained.				
5. Investigation of the complaint/condition is				
6. Requested lab tests, x-rays or other diagnostic investigations are clinically indicated and are				
7. The chief complaint, history, physical findings and investigations lead to an appropriate diagnosis or provisional diagnosis which is				
8. The treatment plan is				
9. Medications in type, dose and duration are				
10. Discussion regarding medication side-effects is				
11. Follow-up of acute conditions is				
12. Follow-up of abnormal test results is				
13. Requests for referrals are				
14. Emergency problems are dealt with quickly and in a manner which is				
<b>Section Recommendation</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
<b>New Presentations/Acute Condition Management</b>				

No concerns/suggestions:

Comments:

## .2 Clinical Practice – Management of Patients with Ongoing/Chronic Conditions

Please consider the evidence found in the records and, through your interview with the physician, the appropriateness of the physician's actions in dealing with patients with chronic conditions. Conditions will usually require long-term monitoring.

Management of Patients with Ongoing/Chronic Conditions	Appropriate	Appropriate with Suggestions	Concerns	N/A
1. The patient history is				
2. Physical examinations performed with positive/negative physical findings are				
3. Requested lab tests, x-rays and other investigations are clinically indicated and				
4. Co-morbidities are evaluated and considered in the treatment plan.				
5. Management/treatment plans are periodically reviewed and				
6. Long-term medications in type, dose and duration are				
7. All medications are periodically reviewed and monitored.				
8. Discussions regarding medication side-effects are				
9. Follow-up of patients suffering from chronic conditions is				
10. Follow-up of abnormal test results is				
11. Requests for referrals are				
12. Narcotic addiction screening is				
13. Narcotic addiction monitoring is				
14. Medication diversion (i.e., distribution of medications to other individuals) monitoring is				
15. Narcotic prescribing is				

### .2(a) Clinical Practice - Management of Specific Disease Entities

**Supplemental report forms, including clinical practice guidelines relevant to those diseases to be reviewed are attached. Please include only those that apply when submitting this report. It is important to note that these guidelines are meant to be of assistance to assessors in making observations. They should not be taken as standards of any of the Atlantic Provinces Licensing Authorities.**



### .3 Clinical Practice – Health Maintenance (as applicable)

Please consider the evidence found in the records and, through your interview with the physician, the appropriateness of the physician's actions in well care visits and preventive health maintenance. This includes patient visits for annual check-ups, screening, etc.

Health Maintenance	Appropriate	Appropriate with Suggestions	Concerns	N/A
1. Periodic discussion of health maintenance (e.g. regarding smoking, alcohol consumption, obesity, lifestyle etc.) is				
2. Periodic general assessments are performed.				
3. Use of age-related familial disease screening (e.g. mammography and colorectal) when indicated is				
4. Well baby visits are conducted (e.g. immunizations, growth monitoring, developmental milestones, etc.).				
5. Prenatal care is performed in a manner which is				
6. Adult immunizations are performed in a manner which is				
Section Recommendation	Appropriate	Appropriate with Suggestions	Concerns	N/A
Health Maintenance				

No concerns/suggestions:

**Comments:**

#### .4 Medical Records – Record Keeping & Patient Management Tools

<b>Record Keeping &amp; Patient Management Tools</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
1. The record system that allows for ready retrieval of an individual patient file is				
2. The mechanism that notifies the physician when consultant reports and/or laboratory reports have been received is				
3. The mechanism that ensures that all investigation, consultation and laboratory reports have been reviewed, with appropriate action taken (if required), is				
4. The record is organized.				
5. Documentation of the consultation record to the referring doctor is				
6. Patient Summary Sheet(s) (e.g. Cumulative Patient Profile) is/are				
7. In the event that more than one physician is making entries in the patient chart, each physician is identified.				
8. Growth charts are				
9. Antenatal Charts are				
10. Psychiatric forms are used.				
11. Allergies are clearly identified.				
12. Immunization records are				
13. Flow sheets for chronic conditions are				
14. Flow sheets for health maintenance are				
<b>Section Recommendation</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
<b>Record Keeping &amp; Patient Management Tools</b>				

**.4(a) Medical Records – Required Components of the Medical Record**

<b>Required Components of the Medical Record</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
1. The legibility of the record to the assessor is				
2. Documentation of the patient's name, sex, telephone number, address and date of birth is				
3. Documentation of the patient's Health Card number (if the patient has a Health card) is				
4. For a consultation, documentation of the name of the primary care physician and of any health professional who referred the patient is				
5. The date of each professional encounter with the patient is documented.				
6. The start and stop times for psychotherapy and counselling encounters are recorded.				
7. Patient histories are recorded.				
8. Functional inquiries are recorded.				
9. Diagnoses are recorded.				
10. Investigations are recorded.				
11. Results are recorded.				
12. Each treatment prescribed or administered by the physician (dose, duration, quantity) is recorded.				
13. Notation of professional advice given by the physician is recorded.				
14. Notation of particulars of any referral made by the physician is recorded.				
<b>Section Recommendation</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
<b>Required Components of the Medical Record</b>				

**.4(b) Medical Records – Required Electronic Medical Records Components (if used)**

<b>Required Components of the Electronic Medical Record</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
1. The system provides a visual display of the recorded information.				
2. The system provides a means of access to the record of each patient by the patient's name and, if the patient has a health number, by the health number.				
3. The system is capable of printing the recorded information promptly and is				
4. The system is capable of visually displaying and printing the recorded information for each patient in chronological order.				
5. Confidentiality is maintained.				
<b>Section Recommendation</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
<b>Required Components of the Electronic Medical Record</b>				

No concerns/suggestions about medical records:

**Comments:**

**Comments (cont.):**

## **.5 Patient Record Summary**

On the following page, please record the patient charts reviewed. Each note should include a patient identifier, such as initials or chart number and date of birth, **(please – no full names)**; the date of visit, the presenting problem and your comments. Include each chart, whether or not there are concerns or suggestions. If care is appropriate or exemplary, please ensure this is indicated in the “comments” section.

**Between 15 and 25 charts should be reviewed.** If this is **not possible**, please comment below:



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**.6 General Comments about this Assessment**