Medical Review & Quality Improvement

Medical Record # _____	Area for Improvement: ☐ Registration ☐ Triage ☐ Clinic
Treatment Date: _____	Volunteer Names: _____
Location: _____	_____

Review Findings

☐ Missed injury or diagnosis ☐ Technical/procedural opportunity ☐ Patient management opportunity ☐ Equipment Failure or unavailability ☐ Drug unavailability ☐ Personnel unavailability	☐ Inadequate documentation ☐ Inadequate notification/communication ☐ Failure to follow established policy ☐ Other opportunity _____

Comments: _____

Reviewer Signature: _____ Date: _____

Volunteer Response

☐ None (explain in comments) ☐ Documentation Corrected / Amended ☐ Formal Audit recommended	☐ Update to Policy/Procedure recommended (describe in comments) ☐ Training Program recommended (describe in comments) ☐ Other (describe in comments)

Comments: _____

Volunteer Signature: _____ Date: _____

Outcome

☐ No impact on patient outcome ☐ Minimal impact: *contributed to or resulted in temporary harm to the patient and required intervention* ☐ Moderate impact: *contributed to or resulted in temporary harm to the patient and required transfer to hospital*	☐ Major impact: *contributed to near death event or required intensive medical care* ☐ Severe impact: *contributed to patient's death* ☐ Impact cannot be determined

Comments: _____

Administrator Signature (if applicable) _____ Date: _____

Nursing Director Signature (if applicable) _____ Date: _____

Medical Director Signature (if applicable) _____ Date: _____