Before you begin 1 of 4

Case selection can be random or selected by the candidate or assessor to address any specific concerns, competencies, patient profile, etc. Assessors should review the chart note prior to meeting with the candidate. Assessors will guide candidates in revealing their thought processes during the clinical encounter, using probing questions.

Chart Review

Date of patient visit:

2024-11-25

Setting of the patient visit:

- [ ] Office
- [ ] ER
- [ ] Hospital Out-patient
- [ ] Hospital In-patient
- [ ] UPCC/urgent care
- [ ] Other

If Other, please explain where below:

Click on one of the listed Domains of Care below as your focus for this assessment:

- [ ] Care of the Adults
- [ ] Care of the Elderly
- [ ] Care of the Child & Adolescent
- [ ] Vulnerable & Underserved Population
- [ ] Behavioural Medicine/Mental Health
- [ ] Maternity/Gynecology/Newborn
- [ ] Procedural Skills
- [ ] Palliative Care

Note indicates whether patient care was provided in person or via telemedicine.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

Clear information 2 of 4

Is the information presented in a clear manner? Are there any concerns about comprehension and written communication?

Note is organized (e.g. easy to find relevant information, has clear sections (history/subjective; examination/objective; impression/assessment; management; plan).

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

Pertinent positives and negatives from history and exam are included in the note.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

History review 3 of 4

Is the main reason for the visit clearly identified? Have ongoing medical problems and major health risks been listed? Are all relevant past medical and family history stated?

History is synthesized and clear.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

Assessment of case linked to data recorded.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

Plan reflects assessment.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

Medications given/changed are documented appropriately and existing medications reviewed.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

Plan includes direction for future care, including follow-up and next steps in investigation or management.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

Note is legible and signed.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

Avoids confusing acronyms or abbreviations.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

Corrections/changes are clearly indicated and dated.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

Results of investigations are documented, including follow-up action.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

New information about patient is updated on flow sheets.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

Critical thinking process is seen in this note.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

Another physician would be able to know what the next steps for the patient were if asked to assume care of this patient.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

Goal 4 of 4

Recall the overall goal, can you follow the intellectual footprint of this encounter?

It is possible to see clearly from this note why the patient came to see the physician, what was done and why, and what follow-up plan has been made.

- [ ] Yes
- [ ] No
- [ ] N/A

Comments:

Assessor Comments:

Assessment of competence on this case

- [ ] Competence Demonstrated
- [ ] Competence Partially Demonstrated
- [ ] Competence Not Demonstrated

Acknowledgement:

- [ ] I acknowledge that this assessment is true and accurate.