Name: _____ ABPN ID #: _____

1. Clinical Module:

Date(s) of initial chart review: _____ _____

Category:

☐Diagnosis _____

☐Type of treatment _____

☐Treatment setting _____

☐Other _____

Published best practice or Practice Guideline used:

_____

Quality Measures Reviewed (minimum of 4) Use additional paper if necessary:

1. _____ 5. _____

2._____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Date(s) of follow-up chart review: _____ _____

Plan of Improvement and Result: (Use additional paper if necessary):

2. Feedback Module:

A. Patient feedback (Attach blank patient feedback form used)

Date(s) of feedback form distribution: _____ _____ _____ _____

Date(s) of follow-up feedback review: _____ _____ _____ _____

Plan of Improvement and Result: (Use additional paper if necessary):

B. Peer feedback (Attach blank peer feedback form used)

Date(s) of feedback form distribution: _____ _____ _____ _____

Date(s) of follow-up feedback review: _____ _____ _____ _____

Plan of Improvement and Result (Use additional paper if necessary):