**[Facility Name]: Medical Coordinator Chart Review**

[Date]

To [Physician]

Fax: [Fax #]

Re: [Resident Name]

Allergies: [Allergies]

The review of health records by our Medical Coordinator, [Medical Coordinator], is an important component in monitoring the quality of medical care at [Facility].

☐ **No issues noted.** Thank-you for meeting our Medical ‘Standards of Care’, which require you to visit your patient at least once every 90 days.

☐ **The following issues were noted and require your attention:**

☐ Physician visit within 7 days of admission

☐ Admission history & physical

☐ Annual review

☐ Advance directive (requires annual review)

☐ Sign Allergy Form

☐ Routine visit/Physician Progress Notes every 90 days

☐ Annual lab work

**Recommendations:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Thank-you for your assistance in ensuring the highest quality of medical care for your patient at [Facility],

[Medical Coordinator] Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MRP Response:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Coordinator Medication Review**

Date

Admission Date

MRP

Last MRP Visit: [Date] With Chart Note: Y/N

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| **LABORATORY VALUES** | **LATEST VALUE** | **PREVIOUS VALUE** (as needed) |
| **Value** | **Date** | **Value** | **Date** |
| **Ferritin** (20 – 160 ug/L) |  |  |  |  |
| **Hemoglobin** F (120-150g/L); M (136-170 g/L) |  |  |  |  |
| **HCT** (0.35-0.45L/L) |  |  |  |  |
| **MCV - Mean Cell Volume** (82 – 98 fL) |  |  |  |  |
| **B12 - Vitamin B12** (150 – 600 pml/L) |  |  |  |  |
| **Na+ - Sodium** (135 – 145 mmol/L) |  |  |  |  |
| **K+ - Potassium** (3.5 – 5.0 mmol/L) |  |  |  |  |
| **eGFR – Estimated Glomerular Filtration Rate** (ml/min) |  |  |  |  |
| **SCr - Serum Creatinine** (60 – 100 umol/L)  |  |  |  |  |
| **HgA1c – Average Blood Glucose Levels** (%)On Diabetic Medications: Yes ☐ No ☐ |  |  |  |  |
| **INR - International Normalized Ratio** |  |  |  |  |
| **TSH** (0.34 – 5.6 mlU/L)On Thyroid Medications: Yes ☐ No ☐ |  |  |  |  |
| **Liver Function Tests** |  |  |  |  |
| **Other Applicable Lab Values:** |  |  |  |  |
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| **VITAL SIGNS** | **LATEST VALUE** | **PREVIOUS VALUE** |
| --- | --- | --- |
| **Value** | **Date** | **Value** | **Date** |
| **Blood Pressure (mmHg)** |  |  |  |  |
| **Pulse** |  |  |  |  |
| **Weight (kg)** |  |  |  |  |
| **Sp02** |  |  |  |  |

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| **FALLS** |
| **# of falls since last review** |  | **Dates** |  |

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| **MH** | **Has a Geriatric Psychiatrist** **seen in the last 6 months?** | ☐ Yes☐ No | **Psychiatrist:** |
| **Date:** |
| **MEDICATIONS** | **Any PRN’s that are being used frequently that could be ordered regularly?** | ☐ Yes ☐ No |  |
| **Any PRN’s that have not been used in the last 60 days that could be discontinued?** | ☐ Yes ☐ No |  |

**Completed by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notes:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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