**Nursing Medical Record Audit Form**

**Facility and Patient Details
Name of Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Documentation Audit**

| **Criteria** | **Completed** | **Not Completed** | **Comments** |
| --- | --- | --- | --- |
| **Patient Identification** | **☐ Yes** | **☐ No** |  |
| **Consent Forms** | **☐ Yes** | **☐ No** |  |
| **Medication Records** | **☐ Yes** | **☐ No** |  |
| **Nursing Progress Notes** | **☐ Yes** | **☐ No** |  |
| **Discharge Summary** | **☐ Yes** | **☐ No** |  |

**Overall Assessment
Does the medical record meet required standards? ☐ Yes ☐ No
If no, describe gaps: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Recommendations**

**Acknowledgment
☐ I certify that this audit has been completed accurately.**

**Auditor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**