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: _____