Mercy MEDICAL CENTER SIOUX CITY
A member of Mercy Health Network

Case Review Report:

Demographics:

Physician/Provider Name/Number: _____ Record #: _____
Admit Date: _____ Discharge Date:_____ Length of Stay _____
Diagnosis: _____ Level of Care: _____ Reason for review:_____

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1. Discharge diagnosis appropriate and substantiated in medical record. ___Yes ___No ___NA
2. Appropriate mediation therapy ordered and administered. ___Yes ___No ___NA
3. Appropriate procedures/diagnostic studies ordered. ___Yes ___No ___NA
4. Appropriate management of abnormal diagnostic studies. ___Yes ___No ___NA
5. Appropriate patient instruction documented. ___Yes ___No ___NA
6. Appropriate consultation/referral as clinically indicated. ___Yes ___No ___NA
7. Adequate documentation provided. ___Yes ___No ___NA
8. The level of care in this case was appropriate. ___Yes ___No ___NA
9. Did the care the patient received result in any adverse outcomes? ___Yes ___No ___NA

Reviewing Physician Comments:

_____
_____
_____
_____

Additional Peer Review Necessary: _____Yes _____No

Review time: _____ Initials/ID: _____ Date: _____

Physician Response:

_____
_____
_____
_____

Signature: _____ Date: _____

Medical Staff Action:

_____
_____
_____
_____

Date: _____

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