**Peer Review Part I**

**PRELIMINARY OFFICE ASSESSMENT—General Information**

CHIROPRACTOR’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHIROPRACTOR’S DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OFFICE NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Incorporated: Yes No

 If yes, name of Incorporation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

College/Program of Graduation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Graduation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Years in Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chiropractic Specialties Completed (with year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Practice: Solo \_\_\_\_\_\_\_\_ Associate \_\_\_\_\_\_\_ Partner \_\_\_\_\_\_\_\_\_

Membership Category with the NBCA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have there been any changes in your membership category in the past 12 months: Yes No

If Yes, please detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of practice hours per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of patient visits per week (avg. of last 12 weeks): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average time of patient visit (subsequent): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your files, both on computer and hard copies, protected (password and/or locked)? Yes No

Do you have more than one office? Yes No

X-ray facilities: Yes No

 If Yes, date of last inspection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please send proof of inspection)

\*\* In order to be valid, the inspection must be completed within the two years prior to the Peer Review Inspection. Mr. André Robichaud of Shediac is our official X-ray inspector.

The following questions relate to your primary office.

List other professionals in office (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office size (approx. sq. ft.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of treatment rooms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of support staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Modalities (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fees: How much do you charge for the following services (adult):

 Initial Patient Examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 X-ray \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Subsequent treatment/office visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Modalities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any secondary therapies in your practice? Yes No

If yes, please list the forms of treatment being used (i.e. trigger point therapy, nutritional, exercise, etc)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Peer Review Part II**

**PRELIMINARY OFFICE ASSESSMENT—Forms**

Blank copies of the following (if used) are to be provided with the Assessment.

* First visit/Initial contact forms
* Case history forms
* Examination forms
* Treatment forms (e.g. SOAP notes)
* Diet/nutritional forms
* Office stationary (letterhead, notepaper, business cards, appointment cards, etc.)
* Informed consent form
* Information release form
* Financial policy
* Copies of any other material used for patients

**Instrumentation:** Please complete the following table. Please include any/all equipment used in patient care.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Equipment  | Age/Date Purchased | Condition  | How often youUse equipment | Frequency of Maintenance |
| Chiropractic Table 1 |  |  |  |  |
| Chiropractic Table 2 |  |  |  |  |
| Xray unit |  |  |  |  |
| Ultrasound |  |  |  |  |
| IFC/TENS |  |  |  |  |
| Massage Unit |  |  |  |  |
| Office Furniture |  |  |  |  |
| Other |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Peer Review Part III**

**GENERAL OFFICE ASSESSMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Equipment  | Available | Not Available | Comments |
| Gown/Shorts |  |  |  |
| Stethoscope |  |  |  |
| Blood Pressure Cuff |  |  |  |
| Otoscope |  |  |  |
| Ophthalmoscope |  |  |  |
| Tuning Fork |  |  |  |
| Reflex Hammer |  |  |  |
| Sharp/Dull Testing |  |  |  |
| Other |  |  |  |
|  |  |  |  |

**To be completed by Assessors**

**Inspect the condition of the following piece of equipment and check the appropriate box;**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| EQUIPMENT | EXCELLENT | GOOD | AVERAGE | POOR |
| Chiropractic table |  |  |  |  |
| X-ray unit |  |  |  |  |
| Ultrasound |  |  |  |  |
| Massage Unit |  |  |  |  |
| Office Furniture;(desk, chairs, décor, etc) |  |  |  |  |
| Other |  |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RECORD KEEPING**

Instructions for the team members: Ask the chiropractor to show you his/her filing cabinet, then, the team members should choose six files at random.

Does the patient’s file include the following information? **Yes (Y) No (N**)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| File Number | 1 | 2 | 3 | 4 | 5 | 6 |
|  Name |  |  |  |  |  |  |
| Age |  |  |  |  |  |  |
| Gender |  |  |  |  |  |  |
| Address |  |  |  |  |  |  |
| Occupation & Employer |  |  |  |  |  |  |
| Referring Practitioner/ Or Referring Person |  |  |  |  |  |  |
| Emergency Contact |  |  |  |  |  |  |
| Case History |  |  |  |  |  |  |
| Examination |  |  |  |  |  |  |
| Imaging Findings (x-rays) |  |  |  |  |  |  |
| Diagnosis |  |  |  |  |  |  |
| Treatment Plan |  |  |  |  |  |  |
| Consent Form |  |  |  |  |  |  |

**The following categories have to be evaluated next:**

1. Progress notes: Progress notes shall be recorded and dated at each patient visit or communication.
2. Method of Recording: Notes must be recorded in ink or other permanently retrievable method.
3. Use of abbreviations and terminology: Recorded abbreviations and terminology should be internally consistent and a key for these abbreviations must be available.

The team members have to evaluate each item according to the following systems:

Excellent 4

Good 3

Fair 2

Poor 1

Inadequate 0

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | File #1 | File #2 | File #3 | File #4 | File #5 | File #6 |
| PROGRESS NOTES |  |  |  |  |  |  |
| METHODS OF RECORDING |  |  |  |  |  |  |
| ABBREVIATIONS |  |  |  |  |  |  |

**COMMENTS:**

Describe your general opinion of the office (both interior and exterior). Do you consider the office to be clean, does it need repairs, etc… \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Inspection: Day\_\_\_\_ Month \_\_\_\_ Year \_\_\_\_

Name of Doctor being inspected: Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and signature of NBCA Peer Review inspection team:

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NB: The member could not be present for his/her inspection for the following reason:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Signature of Peer Review Committee members:

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Day \_\_\_\_ Month \_\_\_\_ Year \_\_\_\_