County of Los Angeles • Department of Health Services
Ambulatory Care Network

Attachment A-3

ONGOING PROFESSIONAL PRACTICE EVALUATION FORM
SPECIALTY CARE

PROVIDER NAME: _____ SPECIALTY _____

REVIEW PERIOD From: _____ To: _____

Complete each question below. If a section does not relate to the provider's scope of practice, leave it blank.

Chart	MRUN	Date of Visit	Reason for visit/Diagnosis
1			
2			
3			
4			
5			

CLINICAL PERFORMANCE

U = unsatisfactory N = needs improvement S = satisfactory E = excellent O = outstanding

In your review of the above medical records, do you find that the provider:		U	N	S	E	O
1	Documents enough to follow and substantiate clinical thought process					
2	Utilizes ancillary services appropriately (i.e., labs, radiology, referrals, etc.)					
3	Follows up prior orders/results appropriately					
4	Addresses specific conditions, and initiates appropriate work-up and treatment					
5	Uses good clinical judgment					
6	Procedures in clinic are performed appropriately					
7	Overall assessment of clinical performance					

COMMENTS

Chart #1	
Chart #2	
Chart #3	
Chart #4	
Chart #5	
Any additional comments	

	Summary Statement Required (Provide feedback on what was done well and recommendations for improvement)

Reviewer Name_____

Reviewer Signature _____ Date _____

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