

Alliance Ambulatory Infusion Center

Collaborative Chart Review

Clinic Site: _____

Date: _____

Patient Name: _____

Nurse Practitioner: _____

Audit Criteria:

____ **Assessment Complete**

____ **Orders have been co-signed by NP**

____ **Follow established protocol of the RSV/Synagis Clinic**

____ **Allergies are documented**

____ **Documentation is legible**

Notes:

Physician Signature: _____ **Date:** _____

Nurse Practitioner Signature: _____ **Date:** _____