MERCURY
PHARMACY SERVICES
A Guardian Pharmacy®

Medical Records Quality Assurance Form

Directions: Please describe the issue you would like addressed below. Be specific and include a copy of the MAR or physician order (this must be included).

Facility: _____ Date: _____

Facility staff member filling out this form: _____

Title: _____
(please print, title is required)

Name of patient: _____ DOB: _____

Detail description: _____

_____

_____

_____

Pharmacy response and follow-up: _____

_____

_____

_____

Medical records staff member: _____

Date received: _____

This form must be faxed to Mercury at 425.673.5230.