Flip the Script: Changing Documentation Standards and Establishing Best Practices for Pharmacists in a Primary Care Setting

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Abstract
Documentation of clinical encounters continues to be a challenge to implement in practice and there is a lack of literature on documentation best practices in pharmacy. In order to inform documentation practices at an academic pharmacy clinic, a quality assurance (QA) initiative was implemented at the UBC Pharmacists Clinic (the Clinic). The goal of this QA initiative was to determine what facilitators and barriers to documentation existed for Clinic pharmacists and improve the efficiency of consultation note writing. Phase 1 conducted an online survey to assess each pharmacist's documentation practice at baseline. Phase 2 implemented new interventions that could advance these skills. There were five main interventions introduced: 1) revised consultation note templates, 2) a documentation "checklist", 3) a documentation "decision tree", 4) a clinical documentation guide and 5) a documentation peer-feedback workshop. During Phase 3, pharmacists re-answered the same survey questions 10 months later. This allowed for a direct comparison of documentation practices and skills before and after the interventions. After the interventions, pharmacists reduced the time to complete their notes by nearly 14 min. The revised note structure resulted in an increased uptake of template use from 37% to 100%. Furthermore, prior to the interventions, the majority of pharmacists ranked writing consultation notes as the most burdensome aspect of their daily workflow. Afterwards, the perceived level of burden reduced significantly. These findings can be used to inform how students are taught documentation and improve the quality of documentation by pharmacists in team-based or primary care settings.

Keywords: Documentation; Primary Care; Pharmacy Clinic; Pharmacist

Introduction

"I have made this letter longer than usual, only because I have not had the time to make it shorter." [Blaise Pascal 1623-1662 mathematician, physicist, philosopher]

Consultation notes are a critical component of communication between health care providers and a means for pharmacists to document and communicate their medication recommendations.[1,2,3,4] Unfortunately, documentation best practices in pharmacy practice have not been clearly established and information to support pharmacists in writing consultation notes is lacking. This is especially void in primary care or team-based settings where most consultation-based services are provided.[5]

Without understanding and adopting best practices for writing consultation notes, medication recommendations may end up unintentionally omitted by the reader (i.e. the prescriber), rendering ineffective use of pharmacists' time and poorer patient outcomes. This leads to question what factors may influence the uptake of recommendations written by pharmacists and whether a framework for documentation best practices in pharmacy can be established.

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Background

Documentation of patient care is standard of pharmacy practice and needs to be accurate, concise, and organized.[6,7,8] Consultation notes are documents that provide a detailed overview of the patient encounter, including subjective and objective history, the pharmacist's assessment, medication recommendations for the prescriber and the monitoring plan.[9,10] Consultation notes differ from chart notes in that they are usually more detailed, often written in a narrative style, and should provide action-oriented recommendations for the reader (i.e. start a new medication, change a dose, check blood work).[9,10] As pharmacists become increasingly integrated into team-based primary care, the need to document clearly and efficiently becomes imperative.[11,12]

Many health care professionals, including pharmacists, typically employ a "SOAP" or "DAP" format to their documentation, beginning with subjective and objective information, followed by the assessment, and finally the plan which outlines the key recommendations for implementation.[6,7] This format is used to teach clinical documentation to pharmacy students, and what many pharmacy licensing bodies recommend to ensure appropriate standards are met.[6,13,14] Despite this approach being used in pharmacy practice for many years, documentation of clinical encounters continues to be a challenge, with lack of time being cited as a common barrier in community and hospital settings.[1,15,16] Unfortunately, in the primary care setting, there is a clear shortage of literature or evidence regarding documentation best practices and there has been a lack of investigation into approaches that diverge from this traditional style.[5]

DOI: https://doi.org/10.24926/iip.v15i2.6147

Opportunity

The UBC Pharmacists Clinic (the Clinic) is an academic pharmacist-led clinic that offers patient consultations by appointment for comprehensive medication reviews. The services provided by pharmacists are consultation-based and not associated with a dispensing activity. Consultation notes following an initial visit are typically very detailed, multiple pages in length, and require significant time to complete. In February 2021, four Clinic pharmacists were interviewed about their documentation practices, as part of an initial quality assurance (QA) project on documentation. The interviews revealed that the time required to write consultation notes ranged from 45 to 120 minutes, which aligns with other literature where the median time to complete notes ranged from 60 to 120 min.[14]

Based on the above findings, a literature search was conducted to identify evidence-based or evidence-informed best practices for documentation in primary care pharmacy and to understand factors that improve the uptake of medication recommendations written by pharmacists. This included a comprehensive search of MEDLINE and EMBASE from inception to August 10, 2021 to identify suitable literature. The search strategy included key words such as "consultation note", "documentation", "impact", "primary care", "drug therapy problem*" and "physician* or doctor* or provider* or nurse* or team* or interprofessional or interdisciplinary or allied health." The complete search strategy is included in Appendix 1. In addition, the reference lists of relevant articles were screened, and documentation guidelines set out by each provincial pharmacy regulatory authority in Canada were reviewed in detail.

Ultimately, this literature review revealed that documentation requirements and expectations are somewhat defined in community and hospital pharmacy settings, and within these settings some guidelines are available.[6,7,17,18,19] However, beyond the recommendations from the 2006 IMPACT Project, best practices for documentation in team-based or primary care settings have not been well established and information to support the art of consultation note writing does not exist.[1,2]

Innovation

This project was framed as a QA initiative, to inform documentation practices at an academic pharmacy clinic. Challenges with documentation and the burden of time associated with writing consultation notes were anecdotally reported for many years. However, the Clinic had not previously taken inventory of documentation practices or assessed efficiencies and inefficiencies of documentation-related processes. This project was designed to investigate the quality and efficiency of documentation practices at baseline, and following specific interventions, to enhance these practices. Ultimately, the goal was to improve the efficiency of consultation note writing and determine what facilitators and barriers existed for the pharmacists.

Methods

The QA project was divided into three phrases and assembled a working group to support with the development and review of each intervention. Phase 1 conducted an online survey among Clinic pharmacists to assess each clinician's documentation practice at baseline. Responses from eight (8) pharmacists were collected at the Clinic in August 2022. The survey questions were developed de novo, based on existing processes and workflows, and given the lack of relevant questions in the literature. This approach allowed customization of the survey content to be specific to the Clinic's practice. Responses were anonymized and qualitative and quantitative statistics were then employed to interpret the data to observe general trends and patterns of the responses.

Phase 2 implemented new interventions that could improve documentation skills, namely the time required to complete consultation notes, the clarity and quality of medication recommendations and the perceived level of workload burden. There were four main interventions introduced (Table 1). These interventions culminated in a peer-feedback workshop, where clinicians exchanged consultation notes and provided 1:1 feedback using the documentation checklist. The main learning outcomes were shared in a group discussion.

During Phase 3, the same group of pharmacists re-answered the survey questions 10 months later in June 2023. Six (6) pharmacists at the Clinic participated in the survey. The follow-up survey used the same set of questions as the pre-survey conducted in August 2022, which allowed for a direct comparison of documentation practices before and after the interventions. Responses were anonymized and qualitative and quantitative statistics were used to analyze the results.

Results

This QA project was developed to address some of the issues pharmacists encounter with documentation. While the results of this QA project confirmed many of these challenges, it also highlighted areas that improved following the interventions.

A significant area of improvement was the time to write consultation notes (Figure 1). After the interventions, pharmacists reduced the time to complete their notes by nearly 14 min (from 48 to 34 minutes). In addition, the revised note structure resulted in an increased uptake of consultation note ("doctor letter") template use from 37% to 100% (Figure 2), thus creating more standardization in how recommendations are documented and communicated to the patient's primary care providers. Furthermore, prior to the interventions, most pharmacists ranked writing consultation notes as the most burdensome aspect of their daily workflow. Afterwards, the

DOI: https://doi.org/10.24926/iip.v15i2.6147

level of difficulty in writing consultation notes reduced significantly (Figure 3).

Implementation and Limitations

This QA project is one of the first initiatives to look at documentation practices among primary care pharmacists writing consultation notes. These findings can be used to inform how students are taught documentation, and the resources developed can be used by other healthcare professionals to help standardize their documentation. However, several limitations should be highlighted, primarily the small sample size. The number of pharmacists answering survey 1 (n=8) was more than survey 2 (n=6) and with such a small cohort at baseline, decreasing the number of responses by 2 likely had notable implications on the data. There was also very limited literature to guide and develop the survey questions and subsequent interventions. Lastly, because the project was designed for the purposes of internal QA, it may limit applicability to others. Yet, in the absence of robust guidelines, it provides a QA process that others can use, and templates that could be adapted to other outpatient practices settings.

Implications

The results of this small-scale QA project demonstrate key interventions that can improve consultation note writing skills, specifically in terms of time. Based on the results of the surveys as well as feedback acquired during this process, the traditional format of the Clinic's consultation note template was permanently changed, to allow for the most important element, the recommendations, to be documented first. This aligns with suggestions from the 2006 IMPACT Project, encouraging pharmacists to highlight their recommendations first by using a summary box on the front page of the consultation note.[2]

Furthermore, as a result of this process, resources have also been developed that can support documentation best practices in a variety of different primary care settings. For example, the Documentation Checklist and Clinical Documentation Writing Guide was utilized by the Pharmacists in Primary Care Network (PCN) Quality Assurance Team to review the documentation of Primary Care Clinical Pharmacists (PCCPs) with positive feedback. Uptake from other programs and practices has also occurred.

Next Steps

Pharmacists are becoming increasingly integrated into primary care settings and team-based models of care.[11,12] This integration is expanding our role as medication consultants/drug therapy experts and heightening the need to establish documentation best practices to communicate recommendations effectively. Current literature reveals a lack of research and information on the topic of consultation note writing and the uptake of medication recommendations made by pharmacists.[5] The work done by the Clinic is a small step in developing an effective framework for documentation and builds on the recommendations from the 2006 IMPACT Project.[1,2]

In the absence of current research and guidelines on this topic, pharmacists should consider tailoring their documentation and consultation notes based on their area of practice. Within team-based care settings, establishing processes that optimize documentation should focus on ensuring every member of the team sends and receives information quickly and clearly. Pharmacists can engage in regular conversations with the interprofessional team to establish communication and documentation processes. Other helpful considerations to optimize pharmacist-to-physician communication include:

- Engaging in regular discussions with prescribers about how the documentation is helping their patient care
- Minimizing usage of pharmacy specific jargon and abbreviations
- Asking peers for feedback on written consultation notes
- Developing templates that work for each unique practice setting and
- Creating consistency so that the receiving individual knows where to look for specific information

Conclusion

Within and beyond pharmacy practice, variation in documentation will always exist. There will never be one "right" way to write consultation notes, and even the most articulate, systematic note may have recommendations that are not implemented or unintentionally omitted. While further research is needed, the benefits of standardizing and optimizing documentation by pharmacists are self-evident. Enhancing the way by which medication recommendations are communicated can profoundly increase the uptake of recommendations by prescribers, provide more time efficiency for pharmacists, and most importantly, yield better health outcomes for patients.

Acknowledgements:

We thank the team at UBC Pharmacists Clinic including: Dr. Jamie Yuen, Dr. Theresa Charrois, Barbara Gobis, and Anita Kapanen for their contributions to this project. In addition, we thank Vienna Cheng and Lauren Siemers for their contributions as student pharmacists.

Funding: N/A

Conflicts of Interest: N/A

Treatment of Human Subjects: N/A

Streaming Media: N/A

DOI: https://doi.org/10.24926/iip.v15i2.6147

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Table 1: Description of New Interventions Implemented During the Documentation QA Project

Intervention	Description
1. Revised Consultation Note ("Doctor Letter") template (Appendix 2 – Figure A)	A revised approach to the traditional documentation format whereby consultation notes first state the recommendation and rationale, followed by subjective and objective information. This differed from the previous template which followed the traditional SOAP format.
2. Documentation Checklist (Appendix 2 – Figure B)	A writing checklist to standardize expectations for documentation, which can be used to provide feedback or guide peer-review.
3. Documentation Decision Tee	A guide to help facilitate what type of note should be sent following different types of consultations specific to the Pharmacists Clinic (i.e. after an initial appointment vs. a follow-up appointment)
4. Pharmacist Clinical Documentation Guide – Tips and Tricks	A guide providing practical tips and examples to improve writing skills. This document is intended to support clinical documentation for pharmacists working in primary care/ambulatory care settings. It is not intended to be a comprehensive overview.
5. Peer-Review Documentation Workshop	An in-person workshop where Clinic pharmacists exchanged previously written consultation notes with another pharmacist, gave and received feedback, and shared top takeaways/lessons learned in a group discussion

DOI: https://doi.org/10.24926/iip.v15i2.6147

Figure 1: Time to write consultation note (minutes)

BEFORE **AFTER**

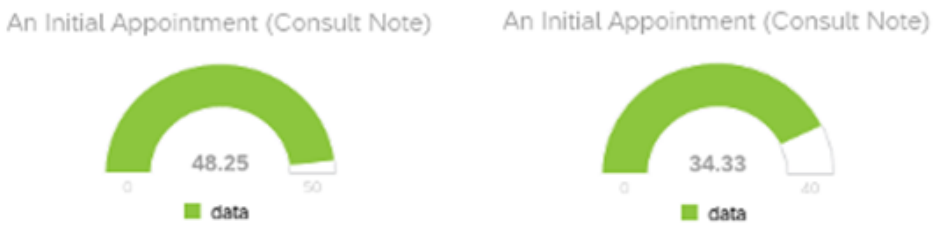
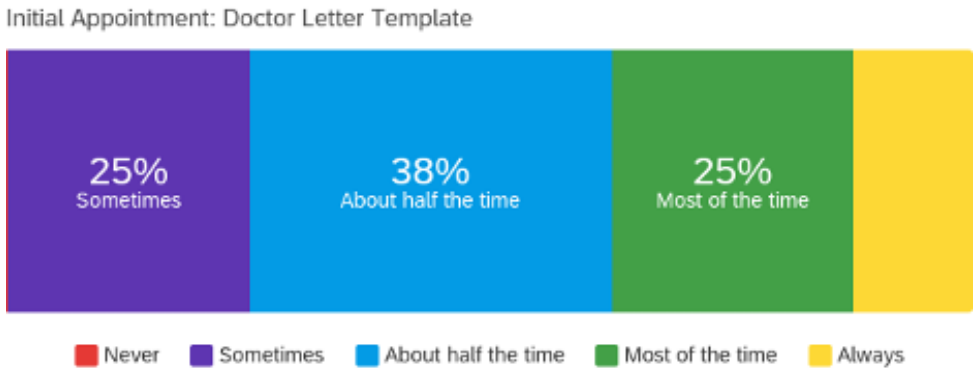


Figure 2: Usage of the consultation note ("Doctor Letter") template
BEFORE



AFTER

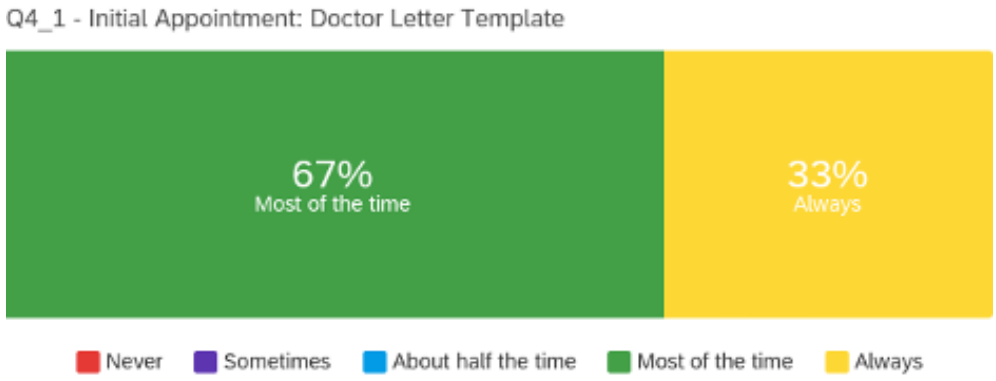


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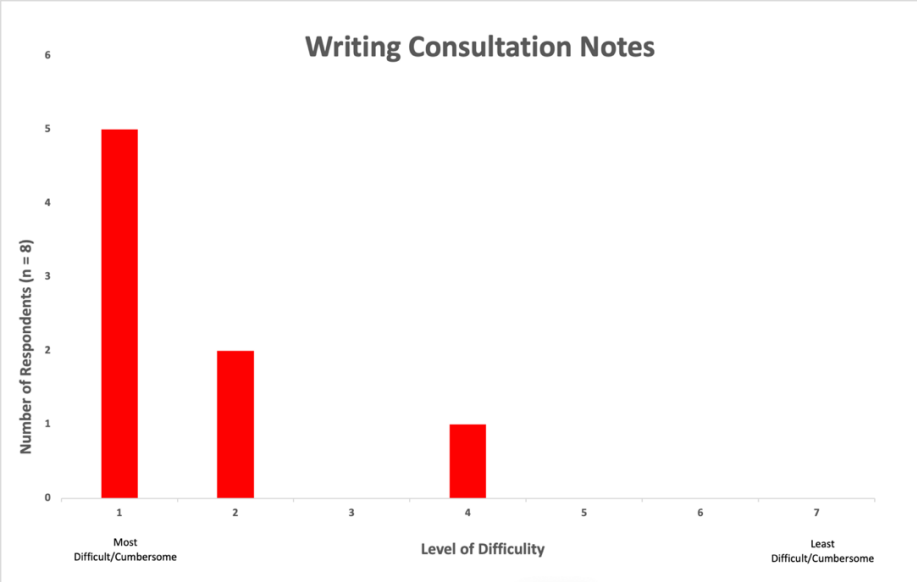
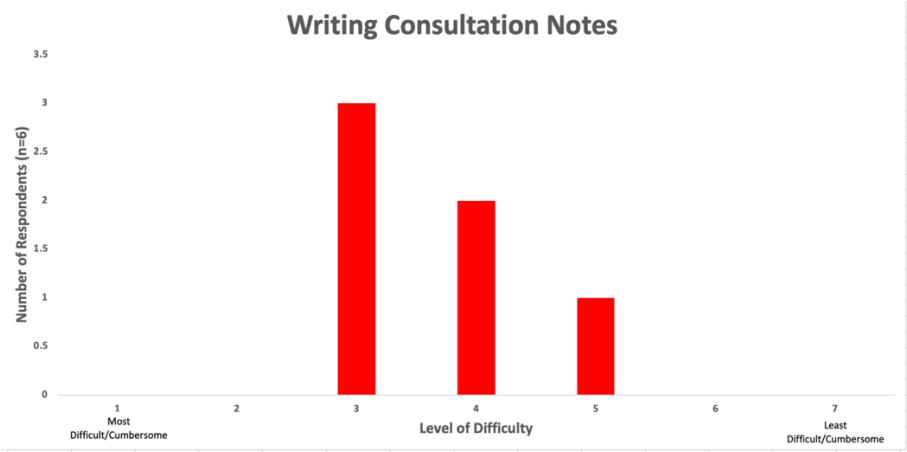
Figure 3: Perceived Level of Workload Burden/Difficulty Associated with Writing Consultation Notes

BEFORE



AFTER



DOI: https://doi.org/10.24926/iip.v15i2.6147

Appendix 1: Literature Search Strategy

Original Search Strategy:	Adapted Search Strategy:
(documentation or clinical note* or consult note* or soap note* or apso or dap or data assessment plan).mp. (pharmacy or pharmacist*).mp. 1 and 2 (clinical or ambulatory care or primary care or outpatient).mp. 3 and 4 (physician* or doctor* or provider* or nurse* or patient care team or interprofessional or health care team or healthcare team or interdisciplinary or allied health).mp. 5 and 6 (evaluat* or impact or assess* or measur* or outcome* or readability or effectiveness or value).mp. 7 and 8 Pharmacists/ Pharmacies/ pharmaceutical services/ or medication therapy management/ or pharmaceutical services, online/ from 7 keep 9 (pharmacy or pharmacist*).m_titl. 11 or 12 or 13 or 14 1 and 8 and 15	(writing or note* or soap or apso or dap or assessment or consult* or plan).mp. (pharmacy or pharmacist*).mp. 1 and 2 (clinical or outpatient or community or inpatient or community care).mp. 3 and 4 (physician* or doctor* or provider* or nurse* or team* or interprofessional or interdisciplinary or allied health).mp. 5 and 6 (evaluat* or impact or assess* or measur* or outcome* or readability or effectiveness or value or patient care or decision*).mp. 7 and 8 Pharmacists/ Pharmacies/ pharmaceutical services/ or medication therapy management/ or pharmaceutical services, online/ (pharmacy or pharmacist*).m_titl. 10 or 11 or 12 or 13 1 and 8 and 14 9 or 15 limit 16 to (english language and yr="2000 -Current") Pharmacy Service, Hospital/ or Community Pharmacy Services/ or Evidence-Based Pharmacy Practice/ or Pharmacy Research/ exp Medical Records/ (writing or charting or soap or consult* note* or care plan).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] 19 or 20 2 or 10 or 11 or 12 or 18 4 and 6 and 8 and 21 and 22 (drug related problem* or drp or dtp or drug therapy problem* or recommendation*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] 23 and 24 23 not 25 13 and 23

DOI: https://doi.org/10.24926/iip.v15i2.6147

Appendix 2– Interventions

Figure A: Revised Consultation Note ("Doctor Letter") Template

THE UNIVERSITY OF BRITISH COLUMBIA
Pharmacists Clinic
Faculty of Pharmaceutical Sciences

Second Floor, 2405 Wesbrook Mall
Vancouver, BC Canada V6T 1Z3
Phone 604 827 2584 Fax 866 229 3779
Email pharmacists.clinic@ubc.ca

Date

Dear Dr.

My name is [ ] and I am a clinical pharmacist at the UBC Pharmacists Clinic. I had the pleasure of speaking with your patient [name/PHN] on [date] for a medication consultation. The appointment was conducted [via phone/via video/in-person]. The current medication list has been reconciled with the patient and PharmaNet and has been attached.

Chief Complaint:
Referral Source:

Recommendations for your consideration:

RECOMMENDATION(S)	RATIONALE

Supporting Information Obtained:

GOALS OF THERAPY:

ALLERGIES/INTOLERANCES:

MEDICATION MANAGEMENT: (i.e. adherence/compliance aids, medication coverage, patient preferences/beliefs)

SocHx: (i.e. occupation, caffeine, alcohol, tobacco, cannabis, illicit substances, exercise, diet)

MEDICATIONS (i.e. Rx, OTC, NHP, traditional medicines, samples, relevant past trials):

PMHx:

IMMUNIZATIONS: (i.e. COVID, flu, pneumonia, shingles, Td/Tdap)

SUBJECTIVE INFO: (consider relevant HPI, ROS)

RELEVANT LABS/MEASUREMENTS:

Patient recommendations/education provided:
1.
2.
3.

Follow up:

The patient have been advised to review the recommendations with you. I have offered to follow-up with the patient on [date] to [reason for follow]. I would appreciate a copy of any relevant consult notes that might be helpful in the care of this patient. Please feel free to contact me by phone, fax or email if you have any questions.

Sincerely, [name] | Clinical Pharmacist | UBC Pharmacists Clinic

DOI: https://doi.org/10.24926/iip.v15i2.6147

Figure B: Documentation CQC Checklist

DOCUMENTATION CQC CHECKLIST

Name: Date:
Peer Reviewer:

Documentation	Yes	N/A	Suggested Changes	Comments
1. Introduction				
Information is correct regarding: • Date • Physician's Name • Patient Name and identifier • Appointment modality • Appointment attendees	☐	☐	☐	
Referral Source (self/physician) is stated	☐	☐	☐	
Chief complaint is accurately described	☐	☐	☐	
2. Recommendation & Rationale				
Recommendation(s) are specific and clear enough that the action required is easily understood	☐	☐	☐	
Recommendation(s) are specific enough to be transcribed into a prescription	☐	☐	☐	
There is distinction between specific recommendation(s) vs. FYI only	☐	☐	☐	
Recommendation responsibility is clear (I.e., when and who will implement)	☐	☐	☐	
Rationale is clear, concise and trustworthy	☐	☐	☐	
Rationale contains all critical components (I.e, NESA, supporting evidence, patient/drug factors, alternatives)	☐	☐	☐	
The chief complaint/reason for referral is addressed or justification given if not addressed	☐	☐	☐	
If multiple recommendations, priority of implementation is clear	☐	☐	☐	

DOI: https://doi.org/10.24926/iip.v15i2.6147

If multiple recommendations, writer has taken into account feasibility of implementation	☐	☐	☐	
3. Supporting Information Obtained				
Subjective information documented directly relates to the assessment and plan	☐	☐	☐	
Comments in detail only on the condition(s) requiring intervention	☐	☐	☐	
Medications are documented with intention (I.e., to highlight discrepancies, to document past trials, or corresponding to the medical condition assessed)	☐	☐	☐	
Labs values reported are directly relevant to the recommendation(s) and listed chronologically	☐	☐	☐	
Goals of therapy are listed and patient preferences are represented	☐	☐	☐	
Assessment/rationale is expanded on if needed to further justify the plan	☐	☐	☐	
4. Follow- Up				
Reason for follow-up is described	☐	☐	☐	
Clearly describes when and why the pharmacist will follow-up or support in the monitoring plan	☐	☐	☐	
5. Language				
No use of pharmacy-specific jargon/abbreviations and incorrect terminology	☐	☐	☐	
Tone of note is professional, with proper grammar and spelling	☐	☐	☐	
6. Formatting				
Headings and subheadings are used effectively to categorize topics	☐	☐	☐	
Writing is appropriately **bolded**, *italicized*, underlined, to break up blocks of text	☐	☐	☐	
Narrative information or bullet points are used appropriately and effectively	☐	☐	☐	

Excessive white space has been deleted. Note is ideally max 2-3 pages.	☐	☐	☐	
7. Overall Assessment				
No duplicate information	☐	☐	☐	
No inconsistency/discrepancies	☐	☐	☐	
No confusing/questionable information	☐	☐	☐	
Generally good readability	☐	☐	☐	

General Comments:

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