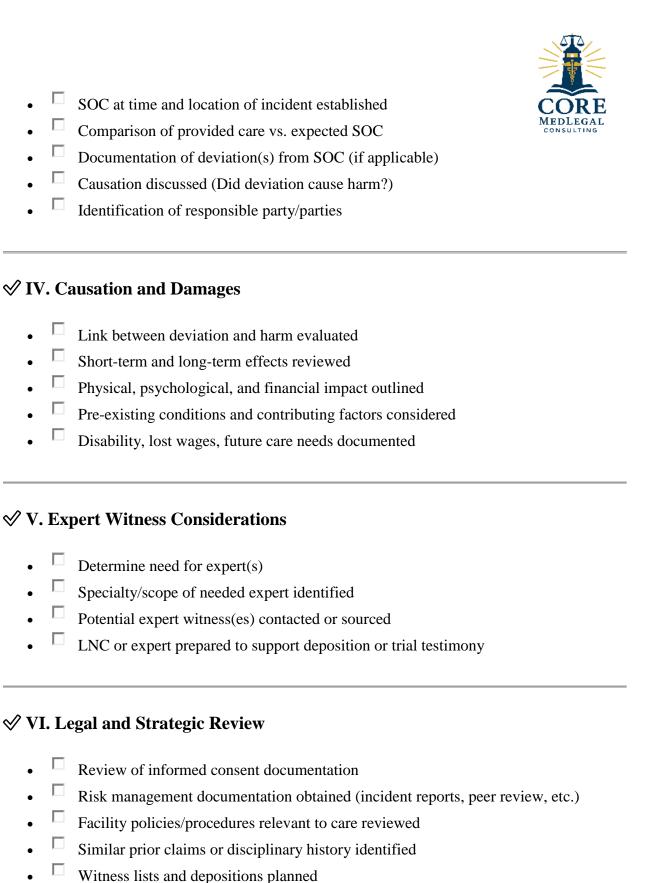




Prepared by: CORE MedLegal Consulting, LLC

	Client intake summary reviewed
	Date(s) of incident and care clearly identified
	Statute of limitations assessed
	Jurisdiction confirmed
	Alleged injury or harm defined
	Medical facility/provider(s) involved identified
	Prior medical history noted
	Records complete for initial review (hospital, clinics, EMS, etc.)
	HIPAA-compliant medical record authorization in place
M	edical Record Review  Records organized chronologically
M	Records organized chronologically
	Records organized chronologically  Medical chronology and timeline created
	Records organized chronologically  Medical chronology and timeline created  Key events and treatment milestones identified
	Records organized chronologically  Medical chronology and timeline created  Key events and treatment milestones identified  Initial presentation and complaints reviewed
	Records organized chronologically  Medical chronology and timeline created  Key events and treatment milestones identified  Initial presentation and complaints reviewed  Diagnostics (labs, imaging, pathology) analyzed
	Records organized chronologically Medical chronology and timeline created Key events and treatment milestones identified Initial presentation and complaints reviewed Diagnostics (labs, imaging, pathology) analyzed Procedures, surgeries, and interventions assessed
	Records organized chronologically Medical chronology and timeline created Key events and treatment milestones identified Initial presentation and complaints reviewed Diagnostics (labs, imaging, pathology) analyzed Procedures, surgeries, and interventions assessed Medication history and administration evaluated
	Records organized chronologically Medical chronology and timeline created Key events and treatment milestones identified Initial presentation and complaints reviewed Diagnostics (labs, imaging, pathology) analyzed Procedures, surgeries, and interventions assessed Medication history and administration evaluated Nursing and provider documentation assessed for consistency and accuracy
	Records organized chronologically Medical chronology and timeline created Key events and treatment milestones identified Initial presentation and complaints reviewed Diagnostics (labs, imaging, pathology) analyzed Procedures, surgeries, and interventions assessed

Relevant scope of practice and clinical guidelines identified





## $\mathscr{O}$ VII. Recommendations by LNC

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•		Case summary and medical chronology provided	
•		Identified strengths and weaknesses outlined	
•		Screening opinion for merit (plaintiff/defense)	
•		Recommendations for further record collection (e.g., pharmacy, rehab, I	PCP)
•		Summary report or expert support documentation prepared	