17606.1
MEDICAL PEER OVERSIGHT

Patient: ________________________ Date of Birth:_______________________ Provider ID:_________________ Date of Service:____________________

Male ☐ Female ☐ Appt. Type: Scheduled ☐ Walk-in ☐ Established Patient? Yes ☐ No ☐
Problem List:____ Index Field #:__________________________________

Health Record Review

Is the following demographic in the medical record?

1. Current mailing address/ Phone #/ email address	
2. Web Enabled	
3. Allergies / adverse reactions are documented	
4. Documentations is legible	

Does the encounter entry contain the following information?

1. Reason for encounter (routine / walk-in)	
2. Chief complaint	
3. Patient & Center Rights & Responsibilities with Notice of Patient Privacy Rights (signed)	
4. Subjective/ Objective data related to complaint	
5. Current list of medications	
6. Assessment	
7. Plan of Care	
8. Plan of follow up	
9. Signature of provider	

Non-Physician Reviewer:__________________
Date:____________

The following information is in the medical record?

1. Subjective initial:	
a. Is subjective data adequate/ Pertinent History?	
b. Co-morbidities	
c. Compliance with treatment noted	
d. Effects of medication/ treatment noted	
2. Objective initial:	
a. Physical Exam	
b. Protocol specific objective data	
3. Assessment:	
a. Appropriate differential applies to give adequate diagnosis	
b. Were diagnostic test appropriate & necessary?	
c. Were abnormal test results addressed?	
d. Do progress notes acknowledge significant test results/findings?	
4. Plan of Care:	
a. Medications	
b. Diagnosis studies ordered	
c. Patient given recommendations on plan of care	
d. Protocol specific treatment	
e. Follow-up schedule	
f. Were medications appropriate & necessary?	
g. Was the documentation sufficient to justify plan of care?	

Physician Reviewer:______________________________
Date:______________

PEER REVIEW FINDINGS

(Comment on management and outcomes for patient, key issues/concerns and general positive and negative impressions)

Compliance with accepted standard of care (check one) Yes ☐ Reservations ☐ No ☐

Physician Reviewer ____________________________________ Date: __/__/____

REVIEWED PROVIDER RESPONSE

Comments:

Provider ________________________________ Date:__/__/____
(Use attachments as necessary)

MEDICAL DIRECTOR REVIEW AND RECOMMENDATIONS

Summary and Findings (Comment on management and outcomes, key issues/ concerns and general impression.)

Compliance with accepted standard of care (check one) Yes ☐ Reservations ☐ No ☐
If “no” or “reservations” state recommendations for improvement or corrective action:

Medical Director___________________________________ Date:__/__/____

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