

**CONFIDENTIAL PEER REVIEW DOCUMENT
Cognitive Diagnostic/Medical Evaluation Form**

This form is to be completed by the proctor and submitted to the Department Credentials Committee

Name of practitioner being reviewed: _____ MRN: _____ Dates of Service: _____

Name of proctor conducting review: _____ Review Type Prospective Concurrent Retrospective

Signature of Proctor: _____ Date: _____ Diagnosis: _____

Procedure: _____

Complications: _____

Yes	No	N/A	DIAGNOSTIC WORKUP				
			Was there adequate evidence to support the patient's admission?				
			Was the diagnosis correct?				
			Was the initial plan and level of care appropriate?				
			Was the practitioner's proposed use of diagnostic services (e.g., lab, x-ray, invasive procedures) appropriate?				
			Were the practitioner's initial orders appropriate?				
	→		Was the practitioner's documentation appropriate and informative? If NO, <input type="checkbox"/> Documentation not present <input type="checkbox"/> Documentation timed and dated <input type="checkbox"/> Documentation not adequate <input type="checkbox"/> Documentation illegible <input type="checkbox"/> Documentation does not substantiate clinical course & treatment <input type="checkbox"/> Documentation not timely				
Yes	No	N/A	PATIENT MANAGEMENT				
			Was the practitioner's drug and blood product use appropriate?				
			Was the practitioner's use of ancillary services (e.g. physical therapy, respiratory therapy, social service) appropriate?				
			Were complications anticipated, recognized promptly, and dealt with appropriately?				
			Was the patient's length of stay appropriate?				
			Was there evidence of daily rounds?				
Yes	No	N/A	PATIENT DISCHARGE				
			Was the patient discharged to an appropriate level of care?				
Yes	No	N/A	RELATIONSHIP WITH PATIENTS AND HOSPITAL EMPLOYEES				
			Did the practitioner interact and communicate well with patient, family and staff?				
			OUTCOME				
	→		Was there an adverse outcome? If YES, <input type="checkbox"/> minor adverse outcome (complete recovery expected) <input type="checkbox"/> major adverse outcome (complete recovery NOT expected) <input type="checkbox"/> death				
			OVERALL IMPRESSION OF CARE PROVIDED				
	→		Were you comfortable with all aspects of care provided by the practitioner? If NO, attach comments				
			Practitioner's skill & competence <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable <input type="checkbox"/> Unable to evaluate				
Basic Assessment	Satisfactory	Unsatisfactory	N/A	Basic Assessment	Satisfactory	Unsatisfactory	N/A
Basic medical knowledge				Communication skills			
Technical/Clinical skills				Professionalism			
Clinical judgment				Use of consults			
Interpersonal skills							