JESSIE TRICE COMMUNITY HEALTH SYSTEM
Since 1967

Jessie Trice Community Health System – Medical Peer Review Form

Provider Reviewed: _____ Date: _____ Reviewed by: _____

Patient Initials and Chart #	Yes/No	Comments
Measure		
Was assessment and/or diagnosis appropriate?		
Was the physical examination appropriate for the problem or diagnosis?		
Were appropriate diagnostic tests and labs ordered?		
Were appropriate medications, dosages, and duration used and documented properly?		
Were chronic problems documented properly on problem list?		
Was patient's detailed self-management goals **documented along with progress toward meeting these goals?**		
What is the patient's self-management goal?		
Are health reminders up to date or ordered? Which are missing? Is there documentation supporting reason reminder not met?		
Patient engaged in medical care?		
Immunizations current?		
Does patient have CAD? Are they on aspirin or other appropriate med?		
Does patient have IVD? Are they on a statin?		
Care Status Post Hospitalization		
Hospitalized in past six months		
Appropriate documentation in the chart		
Discharge plans reconciled		
Medical History and Problem List consistent with Discharge Summary		
Care Involving External Specialists		
Patient involved in care with external specialists		
Appropriate documentation in the chart		
Medication list reconciled		
Chronic Disease Management: Diabetes Mellitus		
Hemoglobin A1c <9.0		
Most recent Hemoglobin A1c current (within 3 months)		
Monofilament Foot Exam		
Retinal screen/Exam		
Microalbumin		
Chronic Disease Management: HTN		
Blood pressure at appropriate target		
Tobacco cessation counseling		
Evidence of use of HTN Treatment Algorithm / appropriate medications		
Chronic Disease Management: COPD/Asthma		
Tobacco cessation counseling		
Spirometry and/or lung functions		
Patient on appropriate maintenance medication / long-term control		
Chronic Disease Management: Chronic Pain/Controlled Medication		
Controlled Substance Agreement		
Patient assessed in past 3 months		
Behavioral Health involved in the care		
Toxicology screen		
Weight loss/exercise counseling		

Recommendations for Care / Corrective Actions Taken:

_____

_____

Provider Signature: _____ Date: _____