Hillcrest Educational Centers, Inc.
Residential Treatment Centers

Peer Review
Pediatrician

Privileged Member Name: ____________________________

Date of Review: ____________________________

Reviewer: ____________________________

Reviewer's Title: ____________________________

Reviewer's degree/licensure: ____________________________

The above named practitioner has applied for reappointment with H.E.C. Joint Commission requires a peer reference from a practitioner in the same discipline and this practitioner has given your name as a reference. ***Please respond to the following questions, sign and date, and return to the Human Resource Department no later than __/__/__.*** A release statement signed by the applicant is enclosed. Please be assured that we will protect the confidentiality of the information you provide to the full extent of the law.

In order to adequately review the performance of your peer, a detailed review of student charts is required. This review must include a representative sample of the students treated during the last two years. Please indicate below the charts reviewed and the dates in which that treatment occurred.

Student ID #______________ Treatment Dates: ___/___/___ to ___/___/___

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Student ID #______________ Treatment Dates: ___/___/___ to ___/___/___

Student ID #______________ Treatment Dates: ___/___/___ to ___/___/___

Student ID #______________ Treatment Dates: ___/___/___ to ___/___/___

Based upon your review of the charts listed above, please rate your peer's performance in the following areas:

1. Initial and annual evaluation is performed within HEC guidelines:
   - ○ **Meets Standard**
   - ○ **Fails to Meet Standard**
2. Provides comprehensive medical diagnostic assessments:
   - ○ **Meets Standard**
   - ○ **Fails to Meet Standard**

3. Provides ongoing diagnosis and treatment of medical conditions:	○ **Meets Standard** ○ **Fails to Meet Standard**
4. Involves student (and when appropriate student's family/guardian), in medical diagnoses, treatment, and pharmacological therapy as appropriate.	○ **Meets Standard** ○ **Fails to Meet Standard**
5. Refers student to outside health care providers in an appropriate and timely manner.	○ **Meets Standard** ○ **Fails to Meet Standard**

Core Competencies:

Student Care:
Are you aware of any problems with the practitioners practice, skills, and competence within the past two years? Yes___ No___ If yes, please specify.
____
____
__

Medical Knowledge:
In your opinion, is the practitioner employing accepted contemporary treatment methods to the students s/he treats? Yes ___ No ___ If no, please give a specific example.________________
____
_

Practice-Based Learning and Improvement:
Are you aware of the practitioner's use of evidence-based information in the treatment of students? Yes ___ No ____If no, please give a specific example.__________________________________
____

Interpersonal and Communication Skills:
Are you aware of any interpersonal and/or communication problems with students, colleagues, administration, nursing, and/or other ancillary staff? Yes___ No____ If yes, please explain with specifics. ____
____

Fitness for Practice:
Are you aware of any reasons that would prevent this individual from providing care for our students? Yes___* No___ * If yes, please explain with specifics.
____
____

In addition to the chart reviews indicated above, please indicate below other means in which would have the opportunity to evaluate your peers' performance: (check all that apply)

___ Experience with and/or observation of the privileged staff

___ Review of associated records and/or documents

___ Other (please specify)

Reviewer Signature: ____

Date of Review: ____/____/____

Thank you for taking the time to complete this peer review form. Your feedback is a critical component in ensuring that we provide the best care to our students.

Rev. 9/7/11