Hillcrest Educational Centers, Inc.
Residential Treatment Centers

Peer Review
Psychiatrist

Privileged Member's Name: _____

Date of Review: _____

Reviewer: _____

Reviewer's Title: _____

Reviewer's degree/licensure: _____

The above named practitioner has applied for reappointment on the H.E.C. staff. The 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 ___/___/___

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

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:

6. Initial psychiatric history and evaluation is performed within HEC guidelines:
   - ☐ **Meets Standard**
   - ☐ **Fails to Meet Standard**

7. Demonstrates ability to identify age-specific bio-psychosocial needs, tasks and conflicts:
   - ☐ **Meets Standard**
   - ☐ **Fails to Meet Standard**

8. As a member of the treatment team, involves student (and when appropriate student's family/guardian), in problem identification, treatment planning, treatment and discharge planning incorporating age-specific needs, diagnostic specific tasks and conflicts of the student:
   - ☐ **Meets Standard**
   - ☐ **Fails to Meet Standard**
9. Demonstrates knowledge and practice of currently accepted psychopharmacology:
   - ☐ **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)

___ Clinical collaboration/consultation

___ 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. 4/12/11