Oklahoma Department of Correction
Provider Peer Review Criteria

Date of Review: ________________ Provider Reviewed: __________________________________________________

Reason for Review:

- Biennial
- Professional concern
- Other ____________________________

OPT - 140142

Criteria:

1. Discipline specific assessment is thorough?
   - Yes  ❑  No  ❑  Comment: ____________________________________

2. Discipline specific assessment is completed within required timeframe?
   - Yes  ❑  No  ❑  Comment: ____________________________________

3. Discipline specific assessment includes current observations and recent behavior changes?
   - Yes  ❑  No  ❑  Comment: ____________________________________

4. Diagnosis is justified by history and current assessment?
   - Yes  ❑  No  ❑  Comment: ____________________________________

5. Treatment plan is consistent with diagnosis?
   - Yes  ❑  No  ❑  Comment: ____________________________________

6. Treatment plan is completed within required timeframe?
   - Yes  ❑  No  ❑  Comment: ____________________________________

7. Treatment plan includes measurable goals?
   - Yes  ❑  No  ❑  Comment: ____________________________________

8. Progress notes for provider (discipline) reviewed relate back to the problem(s) on the treatment plan?
   - Yes  ❑  No  ❑  Comment: ____________________________________

9. Progress notes for provider (discipline) reviewed are completed within required timeframes?
   - Yes  ❑  No  ❑  Comment: ____________________________________

10. Progress notes for provider (discipline) reviewed show changes in patient health/behavior/mental status?
    - Yes  ❑  No  ❑  Comment: ____________________________________

11. Frequency of contact is consistent with diagnosis and severity of symptoms?
    - Yes  ❑  No  ❑  Comment: ____________________________________

12. Treatment deadlines are consistently met?
    - Yes  ❑  No  ❑  Comment: ____________________________________

13. Requests for consults/lab testing/special treatments are justified by diagnosis/behavior?
    - Yes  ❑  No  ❑  Comment: ____________________________________

14. Requests for consults/lab testing/special treatments are requested timely and consistent with the immediacy of the problem?
    - Yes  ❑  No  ❑  Comment: ____________________________________

15. Medications are justified by diagnosis and severity of symptoms? Medication interactions and iatrogenic effects are considered and appropriate labs are monitored?
    - Yes  ❑  No  ❑  Comment: ____________________________________

16. Prescribing practices are consistent with peers, i.e., provider stays within the medical services formulary when prescribing? Polypharmacy prescribing is avoided when possible?
    - Yes  ❑  No  ❑  Comment: ____________________________________

17. Applicable current national guidelines are followed?
    - Yes  ❑  No  ❑  Comment: ____________________________________

Signature of Reviewer: ________________________________________ (R 11/20)