Oklahoma Department of Correction
Peer Review Criteria for Dentist

Attachment C
OP-140142

Date of Review: _______________ **Provider Reviewed:** ____

Reason for Review:

❑ Biennial ❑ Appropriateness of Care ❑ Adverse drug reaction
❑ Professional concern ❑ Critical Incident ❑ Utilization issues
❑ Other ____

Criteria:

1. Sick calls with complaints of acute pain/swelling were evaluated in a timely manner?

   ❑ Yes ❑ No Comment: ____

2. Clinical observations were documented during the encounter of sick call?

   ❑ Yes ❑ No Comment: ____

3. Diagnosis is justified by history, x-rays, and current assessment?

   ❑ Yes ❑ No Comment: ____

4. Treatment is consistent with x-rays and clinical observation?

   ❑ Yes ❑ No Comment: ____

5. Consent and/or waivers were signed if necessary for surgical procedures?

   ❑ Yes ❑ No Comment: ____

6. Post- op instructions and follow up appointments provided when necessary?

   ❑ Yes ❑ No Comment: ____

7. Progress notes for dental provider reviewed relate back to the initial request?

   ❑ Yes ❑ No Comment: ____

8. Progress notes for dental provider were completed in a timely manner?

   ❑ Yes ❑ No Comment: ____

9. Progress notes for treatment provided reflects priority of dental care?

   ❑ Yes ❑ No Comment: ____

10. Follow-up appointments consistent with diagnosis and severity of symptoms?

    ❑ Yes ❑ No Comment: ____

11. Referrals for specialty consults are consistent with diagnosis?

    ❑ Yes ❑ No Comment: ____

12. Referrals for special treatments are timely with the immediacy of the problem?

    ❑ Yes ❑ No Comment: ____

13. Medications are justified by diagnosis and severity of symptoms?

    ❑ Yes ❑ No Comment: ____

14. Prescribing practices are consistent with peers, i.e., provider stays within the medical services formulary when prescribing?

    ❑ Yes ❑ No Comment: ____

15. Applicable current national guidelines are followed?

    ❑ Yes ❑ No Comment: ____

PEER REVIEW FOR DENTIST

Additional Comments:

Signature of Reviewer: ____ Date: _____________

Signature of Provider Reviewed ____ Date: ____________________

(12/24)