Peer Assistance Services

DENTIST PEER ASSISTANCE PROGRAM
Practice Monitor Report

Date: _____ Month submitted for: _____

Licensee Name: _____ Telephone Number: _____

Address: _____
Street City State Zip

Name of Monitor: _____ Telephone Number: _____

License #: _____

Address: _____
Street City State Zip

E-Mail Address: _____

Time Period of Report Covered From: _____ through _____

Date(s) of Review: _____ Number of Records Reviewed: _____
(Minimum of 10 records required, if not stated in Stipulation)

This is report # _____ of _____ reports required.
(Number of Report begin submitted) *(Total number of requires required, i.e. 2 years monthly reports equals 24 reports.)*

This report is for: *(circle)* Record Keeping Prescribing Practices Dental Procedures Fiscal Activities

Physical Facility

S-Satisfactory or above; NI=Needs Improvement; U=Unacceptable; N/A=Not applicable	S	NI	U	N/A
1. General appearance, cleanliness, and orderliness of reception and business areas, operatories, sterilization area, and lab.				
2. Presence of adequate/appropriate sterilization equipment, such as autoclave, dry heat, or vaporclave and is biologically monitored on a weekly basis.				
3. Presence of effective tuberculocidal surface disinfectant.				
4. Presence of current X-Ray inspection certification sticker.				
5. Evidence of attempts to comply with OSHA (gloves, masks, MSDS book, Etc.)				
6. Presence of basic emergency kit.				
Observations and Comments: *Please print or type. All Needs Improvement or Unacceptable responses require a detailed explanation.*				

Staff Management

S-Satisfactory or above; NI=Needs Improvement; U=Unacceptable; N/A=Not applicable	S	NI	U	N/A
1. Is the staff aware of the licensee's situation? *(Purpose of question is to avoid inadvertent disclosure)*				
2. Does the staff work together to ensure a smoothly run practice?				
3. Does the staff appear to support the practitioner?				

Reports may be submitted via:

Email: reports@peerassist.org

Fax: Last name A-L 720.213.1007
Last Name M-Z 720.213.0002

Mail: Peer Assistance Services
2170 S. Parker Road, Suite 229
Denver, CO 80231

In Person: Peer Assistance Services, Inc.
2170 S. Parker Road, Suite 229
Denver, CO 80231

or

Peer Assistance Services, Inc.
200 Grand Avenue, Suite 270
Grand Junction, CO 81501

Revised 4/24/2013
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Licensee Name: _____

4. Does the licensee or any staff member keep odd hours? Chronic tardiness or absence? Early arrivals or late departures? Frequent bathroom breaks?				
5. Is any staff member asked to pick up prescriptions for patients?				
6. Does the licensee or any staff member exhibit mood swings, slurred speech, excitability, hand tremor, sweating, or nitrous mask imprint?				
7. Are there unusually frequent nitrous deliveries or leaks?				
8. Are the licensee and staff trained in CPR and currently certified?				
Observations and Comments: *Please print or type. All Needs Improvement or Unacceptable responses require a detailed explanation.*				

Fiscal Activity

S-Satisfactory or above; NI=Needs Improvement; U=Unacceptable; N/A=Not applicable	**S**	**NI**	**U**	**N/A**
1. Are billings, payments, petty cash, accounts receivable, insurance claims handled properly?				
2. Do supply accounts show payments to pharmacies for office samples?				
3. Do statements from mail order dental supply houses show controlled substances are ordered?				
Observations and Comments: *Please print or type. All Needs Improvement or Unacceptable responses require a detailed explanation.*				

Dental Procedures

S-Satisfactory or above; NI=Needs Improvement; U=Unacceptable; N/A=Not applicable				
Appropriate sterilization and disinfection techniques:	**S**	**NI**	**U**	**N/A**
1. Are handpieces and instruments heat sterilized between patients?				
2. Is an adequate surface disinfectant technique used between patients?				
3. Are the operatories properly set-up (draped)?				
Radiographic or clinical check of techniques and quality:	**S**	**NI**	**U**	**N/A**
1. Diagnosis and treatment planning.				
2. Crown/bridge quality				
3. Direct restorations				
4. Endodontic treatment				
5. Extraction/other surgery				
6. Orthodontics				
Observations and Comments: *Please print or type. All Needs Improvement or Unacceptable responses require a detailed explanation.*				

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Licensee Name: _____

Prescribing Practices

S-Satisfactory or above; NI=Needs Improvement; U=Unacceptable; N/A=Not applicable	S	NI	U	N/A
1. Is there appropriate handling of emergency phone requests for pain medication?				
2. Is there evidence of prescribing medications without seeing the patient?				
3. Is there evidence of prescribing for self, family or staff?				
4. Does the practitioner ever fill or pick up patient's prescriptions?				
5. Are prescriptions for controlled and uncontrolled substances noted in patient records?				
6. Are treatment dosages, quantities, and regimes appropriate?				
7. Are prescriptions written so they are difficult to alter?				
8. Are prescription pads secure and out of sight?				
9. Is there adequate documentation of nitrous oxide ordering, receipt, and storage?				
10. If DEA privileges are intact, is DEA registration current?				
11. If DEA privileges are suspended, is there evidence that controlled substances are kept in office or prescribed?				
12. If DEA privileges are intact, and the contract does not prohibit the dentist from keeping other controlled substances inventory on site check Controlled Substance Prescription Log for medications administered and/or dispensed from inventory.				
Observations and Comments: *Please print or type. All Needs Improvement or Unacceptable responses require a detailed explanation.*				

Record Keeping

S-Satisfactory or above; NI=Needs Improvement; U=Unacceptable; N/A=Not applicable	S	NI	U	N/A
1. Doe the record entries reviewed follow a consistent and logical order in all or most charges reviewed?				
Do the records include:	**S**	**NI**	**U**	**N/A**
2. An adequate description of the patient's presenting or subsequent complaints, including duration, of aggravation factors and significant changes?				
3. Examination results?				
4. The dental diagnosis?				
5. A description of the treatments rendered?				
6. A complete and current medical history with detailed history of problems identified?				
7. Appropriate follow-up to problems identified in #6?				
8. Appropriate radiographs?				
9. Prescriptions?				
10. Informed consent forms appropriately and properly completed?				
11. Post-op instructions, recall or other follow-up?				
Observations and Comments: *Please print or type. All Needs Improvement or Unacceptable responses require a detailed explanation.*				

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The Stipulation required the following areas be reviewed:

Based on the Stipulation requirements, I determined that the following specific areas be addressed by Respondent:

Overall Review:

All Needs Improvement (NI) or Unacceptable (U) responses require a detailed explanation. Please print or type any information that was not included in the comment spaces, using an additional sheet of paper if necessary. You must identify patients and records by initials only.

Identify here the files reviewed by the patient's initials:

Signature of Monitor: _____ Date: _____

Signature of Licensee: _____ Date: _____

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