

DENTIST PEER ASSISTANCE PROGRAM

Initial Practice Monitor Report

Licensee _____ Telephone Number _____

Address _____
Street City ZIP

Monitor _____ Telephone Number _____

Address _____
Street City ZIP

This report should be submitted with the **first Practice Monitor Report** submitted by the monitor.

Orientation

	Yes	No
The licensee and I reviewed together the Final Agency Order (FAO), Stipulation and Order, or the Dentist Rehabilitation Contract. We also reviewed the Report of Investigation if the licensee is on a FAO or Stipulation.	<input type="checkbox"/>	<input type="checkbox"/>
The licensee and I developed together the dimensions of the monitor program and identified individual responsibilities to my satisfaction.	<input type="checkbox"/>	<input type="checkbox"/>
The licensee and I scheduled regular monitoring appointments at the frequency required.	<input type="checkbox"/>	<input type="checkbox"/>
The licensee and I agreed upon a fee for service and signed the Fee for Service Agreement.	<input type="checkbox"/>	<input type="checkbox"/>
I conducted an initial evaluation of the licensee's performance and areas of competency and weakness.	<input type="checkbox"/>	<input type="checkbox"/>
The licensee and I agreed upon problem areas including those identified in the FAO, Stipulation, or Rehabilitation Contract and developed a plan to monitor the areas.	<input type="checkbox"/>	<input type="checkbox"/>

I certify that I have received and read a copy of the Final Agency Order, Stipulation and Order, or Rehabilitation Contract and I fully understand what is required for monitoring the licensee.

Signature of Monitor _____ Date _____

Signature of Licensee _____ Date _____

Attach this form to the front of the Practice Monitor Report and submit both reports.

DENTIST PEER ASSISTANCE PROGRAM

Peer Assistance Services, Inc.
 2170 South Parker Road, Suite 229
 Denver, Colorado 80231
TEL 303.369.0039 FAX 303.369.0982
Practice Monitor Report

Licensee Name _____ Telephone Number _____

Address _____
Street City ZIP

Monitor Name _____ Telephone Number _____

Address _____
Street City ZIP

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 # (number of report submitted) _____ of _____ reports required (total number of reports required, i.e. 2 years monthly reports equal 24 reports).

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

Physical Facility

<i>S=Satisfactory or above, NI=Needs improvement, U=Unacceptable, N/A=Not applicable</i>	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 & Comments. Please print or type. All Needs Improvement or Unsatisfactory responses require a detailed explanation.				

Staff Management

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

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Staff Management continued

1. Are the licensee and staff trained in CPR and currently certified?				
Observations & Comments. Please print or type. All Needs Improvement or Unsatisfactory responses require a detailed explanation.				

Fiscal Activity

<i>S=Satisfactory or above, NI=Needs improvement, U=Unacceptable, N/A=Not applicable</i>	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 & Comments. Please print or type. All Needs Improvement or Unsatisfactory responses require a detailed explanation.				

Dental Procedures

<i>S=Satisfactory or above, NI=Needs improvement, U=Unacceptable, N/A=Not applicable</i>	S	NI	U	N/A
Appropriate sterilization and disinfection techniques				
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				
1. Diagnosis and treatment planning				
2. Crown/bridge quality				
3. Direct restorations				
4. Endodontic treatment				
5. Extraction/other surgery				
6. Orthodontics				
Other evidence of improper care, treatments, diagnosis or substandard practice? If yes, please describe. Please print or type. All Needs Improvement or Unsatisfactory responses require a detailed explanation.				

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Prescribing Practices

<i>S=Satisfactory or above, NI=Needs improvement, U=Unacceptable, N/A=Not applicable</i>	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 & Comments. Please print or type. All Needs Improvement or Unsatisfactory responses require a detailed explanation.				

Record-keeping

<i>S=Satisfactory or above, NI=Needs improvement, U=Unacceptable, N/A=Not applicable</i>	S	NI	U	N/A
1. Do the record entries reviewed follow a consistent and logical order in all or most charts reviewed?				
Do the records include:				
2. An adequate description of the patient's presenting or subsequent complaints, including duration, of aggravating 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 & Comments. Please print or type. All Needs Improvement or Unsatisfactory responses require a detailed explanation.				

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The Stipulation **requires** 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 or Unsatisfactory 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 _____

