Stony Brook University Hospital

CONFIDENTIAL PEER REVIEW DOCUMENT
Procedural/Surgical Evaluation Form - FPPE

This form is to be completed by the evaluated and submitted to the Department Credentials Committee

Name of practitioner being reviewed: _____ **MRN:**_____ **Dates of Service:** _____

Name of evaluator conducting review: _____ **Review Type** □ **Prospective** □ **Concurrent** □ **Retrospective**

Privilege as Stated on Privilege Sheet: _____ **Procedure:** _____

Complications: _____

PLEASE ANSWER ALL OF THE FOLLOWING: If the answer to any of the following is "no", please attach an explanation

Yes	No	N/A	
			Was the indication for the procedure appropriate and documented?
	→		Was the practitioner's documentation appropriate and informative? If NO, Documentation was: □ Not present □ Not timed & dated □ Not adequate □ Illegible □ Not timely □ Not supportive of clinical course & treatment
			Was a complete, relevant, and timely H&P performed and documented. (documentation required prior to the procedure, if a surgery or procedure is being evaluated)?
			Was the use of diagnostic services (e.g., lab, x-ray, invasive diagnostic procedures) appropriate?
			Was the practitioner's proposed procedural technique appropriate?
			Were the practitioner's contingency plans appropriate?
			Was length of procedure appropriate?
			Was there documentation of site marking/time out?
			Did the pre-operative diagnosis coincide with postoperative findings?
			Was postoperative care adequate?
			Was the operative report complete, accurate, and timely?
			Were complications, if any, recognized and managed appropriately?
			Did the practitioner interact and communicate appropriately with the patient, family and staff?
			Was a complete, relevant, and timely H&P performed and documented. (documentation required prior to the procedure, if a surgery or procedure is being evaluated)?
→			Was there an adverse outcome? If YES, □ minor adverse outcome (complete recovery expected) □ major adverse outcome (complete recovery NOT expected) □ death
			OVERALL IMPRESSION OF CARE PROVIDED
	→		Were you comfortable with all aspects of care provided by the practitioner? If NO, attach comments
			Practitioner's skill & competence □ Acceptable □ Unacceptable □ Unable to evaluate

Basic Assessment	Satisfactory	Unsatisfactory	N/A	Basic Assessment	Satisfactory	Unsatisfactory	N/A
Basic medical knowledge				Communication skills			
Technical/Clinical skills				Professionalism			
Clinical judgment				Use of consults			
Interpersonal skills							5/09;6/22 4/23

Signature of evaluator: _____ **Date:** _____