Date of Review: _______________ Provider Reviewed: ____________________________________________________________

Reason for Review:

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

Criteria (if related to assigned duties depending on facility):

1. Diagnosis is justified by history and current assessment?
   ☐ Yes ☐ No Comment: ____________________________________________________________

2. Treatment plan is consistent with diagnosis?
   ☐ Yes ☐ No Comment: ____________________________________________________________

3. Treatment plan is completed within required timeframe?
   ☐ Yes ☐ No Comment: ____________________________________________________________

4. Treatment plan includes measurable goals?
   ☐ Yes ☐ No Comment: ____________________________________________________________

5. Progress notes reflect changes in the inmate health/behavior/mental status and relate back to the problem(s) on the treatment plan?
   ☐ Yes ☐ No Comment: ____________________________________________________________

6. Conducts appropriate screening/evaluation/appraisal according to OP-140201 within the specified time frame?
   ☐ Yes ☐ No Comment: ____________________________________________________________

7. Documents appropriate assessment of inmates on antipsychotic medications for the treatment of major depression, bi-polar, and psychotic disorders as directed in OP-140201 at least monthly or more often according to severity of symptoms?
   ☐ Yes ☐ No Comment: ____________________________________________________________

8. Documents required segregated housing unit reviews and 30 day assessments?
   ☐ Yes ☐ No Comment: ____________________________________________________________

9. Demonstrates appropriate intervention services in response to crises?
   ☐ Yes ☐ No Comment: ____________________________________________________________

10. Updates mental health levels at least annually or as needed?
    ☐ Yes ☐ No Comment: ____________________________________________________________

11. Makes appropriate referrals to MHU/ICHU/HP when necessary?
    ☐ Yes ☐ No Comment: ____________________________________________________________

12. Makes appropriate referrals to psychiatry with supported documentation of symptoms?
    ☐ Yes ☐ No Comment: ____________________________________________________________

13. Treatment interventions adhere to accepted national professional standards?
    ☐ Yes ☐ No Comment: ____________________________________________________________

Signature of Reviewer: ________________________________________ (R 8/19)