St. Clair County Community Mental Health

Prescriber Peer Review

Review Date: _____ Review Period: _____

Reviewer Name: _____ Prescriber Name: _____

Case Reviewed: _____ (please do not use names, only case #'s & initials)

Diagnosis: _____

CMH Medications: _____

_____

_____

Other Medications: _____

_____

_____

Individual's needs and preferences addressed? ☐ Yes ☐ No Comments: _____

Medications prescribed appropriately for diagnosis? ☐ Yes ☐ No Comments: _____

Efficacy of medication addressed? ☐ Yes ☐ No Comments: _____

Appropriate laboratory tests ordered? ☐ Yes ☐ No Comments: _____

Possible side-effects reviewed with individual? ☐ Yes ☐ No Comments: _____

Capacity to self-administer medication assessed? ☐ Yes ☐ No Comments: _____

Possible interactions between prescribed medications, OTC medications, alcohol, nicotine, and illicit drugs? ☐ Yes ☐ No Comments: _____

Collaboration with treatment team? ☐ Yes ☐ No Comments: _____

Collaboration with primary care physician? ☐ Yes ☐ No Comments: _____

Reviewers Comments: _____

_____

_____

Disposition:

☐ No quality of care and/or documentation problems.

☐ Medical Director discussed with prescriber.

Reviewed by Medical Director: _____ **Date:** _____