MEDICAL MANAGEMENT EVALUATION FORM
Facility Name:_____

Medical Staff Member **BEING EVALUATED**: _____

Date Privileges Started: _____ Evaluation to be Completed by: _____

	Anesthesia		Ophthalmology		Urology
	Critical Care Medicine		Orthopedics		Pathology
	Cardiovascular Surgery		Otolaryngology		Pediatric _____ subspecialty
	Dental Surgery		Plastic Surgery		
	General Surgery		Solid Organ Transplant		General Pediatrics
	Neurosurgery		Thoracic Surgery		Medical Imaging

Med. Rec. #: _____ Admission Diagnosis: _____

Date of Admission: _____ Date of Discharge: _____

TO BE COMPLETED BY THE MEDICAL STAFF MEMBER
WHO WILL EVALUATE THE MEDICAL MANAGEMENT

IN YOUR JUDGEMENT (for each of the following, if applicable)	**YES**	**NO**	**NOT APPLICABLE**
Was documentation timely? • Initial H & P completed within 24 hours of admission or prior to surgery • Consultation note • Review of laboratory tests or studies • Orders signed • Discharge summary completed			
Was documentation complete? • Required elements present in the H & P • Daily progress notes • Required elements present in discharge summary			
Was clinical care appropriate? - Safe - Timely - Effective - Patient Centered - Efficient - Equitable			
Did the practitioner practice within their scope of privileges granted?			
Does documentation support level of care and clinical course of treatment?			
Did patient/family receive appropriate education, instructions?			
If answer to any of the above is "NO", please explain:			

_____

_____

Other Comments: _____

attach copies of any continuous improvement reports used in support of your recommendation to continue privileges, i.e. procedure logs, correlation reports reviewed, proctoring forms, or FPPE assessments from their primary facility

Signature of Medical Staff Member PLEASE PRINT NAME
Performing Medical Management Evaluation

RETURN EVALUATION FORM TO THE MEDICAL STAFF OFFICE

#OperName#