

**Oklahoma Department of Correction
Peer Review Criteria for Dental Hygienist**

**Attachment D
OP-140142**

Date of Review: _____ **Provider Reviewed:** _____

Reason for Review:

- | | | |
|---|--|--|
| <input type="checkbox"/> Biennial | <input type="checkbox"/> Appropriateness of Care | <input type="checkbox"/> Adverse drug reaction |
| <input type="checkbox"/> Professional concern | <input type="checkbox"/> Critical Incident | <input type="checkbox"/> Utilization issues |
| <input type="checkbox"/> Other _____ | | |

Criteria:

1. Discipline specific assessment is thorough?
☐ Yes ☐ No Comment: _____
2. Discipline specific assessment is completed within required timeframe?
☐ Yes ☐ No Comment: _____
3. Treatment is consistent with clinical observations?
☐ Yes ☐ No Comment: _____
4. Treatment is completed within required timeframe?
☐ Yes ☐ No Comment: _____
5. Treatment includes measurable hygiene goals?
☐ Yes ☐ No Comment: _____
6. Progress notes for provider (discipline) reviewed relate back to the problem(s) on the treatment plan?
☐ Yes ☐ No Comment: _____
7. Progress notes for provider (discipline) reviewed are completed within required timeframes?
☐ Yes ☐ No Comment: _____
8. Progress notes for provider (discipline) reviewed show describe changes if necessary?
☐ Yes ☐ No Comment: _____
9. Frequency of contact is consistent with diagnosis and severity of symptoms?
☐ Yes ☐ No Comment: _____
10. Treatment deadlines are consistently met?
☐ Yes ☐ No Comment: _____
11. Requests for consults with dentist are requested when necessary?
☐ Yes ☐ No Comment: _____
12. Medications or hygiene aids are recommended to dentist when needed?
☐ Yes ☐ No Comment: _____
13. Applicable current national guidelines are followed?
☐ Yes ☐ No Comment: _____

Additional Comments:

Signature of Reviewer: _____ Date: _____

Signature of Provider Reviewed _____ Date: _____