

PRACTICE MONITOR REPORT

Licensee: _____ License # _____ Phone _____

Monitor: _____ License # _____ Phone _____

This report is for: Recordkeeping Prescribing Practices Procedures

Time Period of Report: _____ through _____ Date of Review: Total Number of Records Reviewed _____

For Records Monitoring

- | | YES | NO |
|---|--------------------------|--------------------------|
| ◆ An adequate description of the patient's presenting or subsequent complaint | <input type="checkbox"/> | <input type="checkbox"/> |
| ◆ The duration of the presenting or subsequent complaints | <input type="checkbox"/> | <input type="checkbox"/> |
| ◆ A description of factors which aggravate or relieve the complaints | <input type="checkbox"/> | <input type="checkbox"/> |
| ◆ A description of significant changes in the patient's complaint or in diagnosis | <input type="checkbox"/> | <input type="checkbox"/> |
| ◆ The veterinary diagnosis and a description of the treatments rendered | <input type="checkbox"/> | <input type="checkbox"/> |
| ◆ A complete and current medical history | <input type="checkbox"/> | <input type="checkbox"/> |
| ◆ A general systems review, as indicated by medical history or procedure | <input type="checkbox"/> | <input type="checkbox"/> |
| ◆ Appropriate radiographs included in the records | <input type="checkbox"/> | <input type="checkbox"/> |
| ◆ Evidence of improper care, treatments, diagnosis or substandard practice (If "YES", please give detailed explanation) | <input type="checkbox"/> | <input type="checkbox"/> |

All negative responses require a detailed explanation. Please use the back of this form and additional sheets as necessary, identifying patients by initials only.

For Prescription Monitoring

Do the records include

- | | YES | NO |
|--|--------------------------|--------------------------|
| ◆ Controlled substances dispensed, administered or ordered by prescription (If "YES", please list on a separate sheet) | <input type="checkbox"/> | <input type="checkbox"/> |
| ◆ Is the type, quantity and dosage of the drugs dispensed, administered or prescribed substantiated by diagnosis | <input type="checkbox"/> | <input type="checkbox"/> |
| ◆ A separate Controlled Substance Prescription Log | <input type="checkbox"/> | <input type="checkbox"/> |
| ◆ Compliance with the terms of the subsections of Board Rule VII | <input type="checkbox"/> | <input type="checkbox"/> |
| ◆ Are the prescription pads secure | <input type="checkbox"/> | <input type="checkbox"/> |
| ◆ Is there adequate documentation of anesthesia ordering/receipt/storage | <input type="checkbox"/> | <input type="checkbox"/> |

I certify that I have received and read a copy of the Rehabilitation Contract between PAS and the Licensee and I fully understand what is required.

Signature of Monitor

Date

Due Dates: _____

**Mail Original To: Peer Assistance Services, Inc.
2170 S. Parker Road, Suite 229
Denver, CO 80231
Phone: 303.369.0039 or 866.369.0039
Fax: 303.369.0982**