



# Atrium Health

February 6, 2017

RE: \_\_\_\_\_

**Applicant to: Atrium Health**

**Name of individual completing form:** \_\_\_\_\_

\*\*\*\*\*  
The above practitioner is applying to participate with Atrium Health. Letters of reference (LOR's) / Peer Reference Forms from partners within the same practice will be accepted if you attest that there is no financial conflict of interest. We also cannot accept LOR's / Peer Reference Forms from a relative.

**I attest that I have no financial Conflict of Interest nor am I a relative of the applicant.**

### PROFESSIONAL RELATIONSHIP

1. What is/was the applicant's specialty? \_\_\_\_\_
  2. Do you personally know the applicant? Yes \_\_\_\_\_ No \_\_\_\_\_
  3. How long have you known the applicant? \_\_\_\_\_
  4. Affiliation/Relationship with applicant: \_\_\_ Personal \_\_\_ Hospital \_\_\_ Practice \_\_\_ Previous Supervisor  
 \_\_\_ Supervising Physician \_\_\_ Referring Physician \_\_\_ Other (please specify) \_\_\_\_\_
- If training verification, please verify dates and completion if applicable. \_\_\_\_\_

### DISCIPLINARY ACTIONS

To your knowledge, have any of the following ever been, or are currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, voluntarily or involuntarily relinquished, or has the applicant ever withdrawn, or failed to proceed with an application for any of the following?

	Yes	No	Do Not Know
Medical/Clinical license in any state			
Other professional registration/license			
DEA/controlled substance registration			
Membership on any hospital medical staff			
Clinical privileges			
Prerogatives/rights on any medical staff			
Other institutional affiliation or status there at			
Professional society membership or fellowship/board certification			
Any other type of professional sanction			
Professional liability insurance			

If yes, to any of the above please give details: \_\_\_\_\_

\_\_\_\_\_



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Has the applicant exhibited any health or behavioral problems, which may affect his/her ability to provide quality patient care?

(Include signs of mental health, alcohol or substance abuse behavior).  Yes  No

If yes, please give details: \_\_\_\_\_

**GENERAL RATING – Please rate the applicant in the following categories:**

	Excellent	Good	Average	Marginal	Do Not Know
<b>1. Patient Care</b>					
• Provides compassionate, appropriate and effective care					
<b>2. Medical/Clinical Knowledge</b>					
• Basic clinical knowledge					
• Professional expertise/competence					
<b>3. Practice-Based Learning and Improvement</b>					
• Availability for and thoroughness in patient care					
• Adequacy of medical record documentation					
• Ability to safely perform within their scope of practice					
<b>4. Interpersonal &amp; Communication Skills (Patient, Families, Colleagues, Health Care Team)</b>					
• Ability to verbally communicate					
• Ability to work cooperatively with others					
• Rapport with patients					
• Ease of contacting the practitioner					
<b>5. Professionalism</b>					
• Clinical judgment					
• Sense of responsibility					
• Ethical and moral character					
• Overall professional performance					
<b>6. Systems-Based Practice</b>					
• Understands systems involved in care delivery					
• Core measures to improve care					
<b>7. Other</b>					
• Adherence to patient safety standards					



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RE: \_\_\_\_\_

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Name of individual completing form: \_\_\_\_\_

My recommendation concerning this practitioner's application is:

- Recommend highly without reservation
- Recommend as qualified and competent
- Recommend with some reservation (please explain below)
- Would not recommend (please explain below)

Comments: \_\_\_\_\_

This report is based on:

- Close, personal observations
- General impression
- Composition of evaluation by supervisors
- Other \_\_\_\_\_

## PRIVILEGES

Do you have any doubts about the applicant's qualifications for privileges in their practicing specialty or any physical or mental health conditions that could affect his/her ability to perform his/her job duties?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Signed by: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date completed: \_\_\_\_\_ Telephone :(    ) \_\_\_\_\_ - \_\_\_\_\_

## Core Privileges

Evaluate, diagnose, and provide primary mental healthcare and treatment using a variety of therapeutic and interpersonal techniques for patients within the age group of patients seen by the sponsoring physician(s) who are at risk for developing or presently have psychiatric disorders. The Allied Health Professional may not admit patients to the hospital.

NOTE: Psychiatry Core Privileges include: Assess and treat individual patients with disease states and non-disease-based etiologies using advanced theoretical and empirical knowledge of physiology, pathophysiology, and pharmacology, including determination of Axis I-V psychiatric diagnoses based on assessments, utilizing the most recent edition Diagnostic and Statistical Manual of Mental Disorders; clinically manage psychiatric disorders including but not limited to severe and persistent neurobiological disorders; complete comprehensive assessments, develop differential diagnoses, and formulate and implement treatment plans; conduct behavioral healthcare maintenance of the population served; conduct individual, group, and family psychotherapy; direct care as specified by medical staff-approved protocols; evaluate and manage psychobiological interventions; initiate referral to appropriate physician or other healthcare professional of problems that exceed the Allied Health Professionals scope of practice; make daily rounds on hospitalized patients with or at the direction of the collaborating/supervising physician; monitor and manage populations of patients with disease states and non-disease-based etiologies to improve and promote healthcare outcomes; obtain social and psychological admission history; utilize advanced practice skills to independently provide case management, including psychiatric rehabilitation and home care; and teaching, promotion, and prevention; obtain and record medical history and perform physician examinations; order diagnostic testing such as laboratory tests, X-rays, EKG, EEG, and CT scans, and order therapeutic modalities, including the prescribing as indicated of any medication which is FDA-approved for an Axis I or II psychiatric diagnosis, any medication which is FDA approved for, or routinely used for, treatment of side effects of medications used to treat Axis I or II psychiatric diagnoses; the prescribing as indicated of any medication used for treatment of an Axis I or II diagnosis when that medication does not have an FDA approved indication for that disorder, provided that such "off-label" use is common at the practice site and provided such use is reviewed during supervision with the primary supervising physician in the Quality Improvement Process; the prescribing as indicated of any non-psychotropic medication urgently needed on a temporary basis for non-psychiatric conditions, including 1) continuation or renewal at an established dose of a non-psychotropic medication that has been prescribed by another health care provider in order not to interrupt or prolong the interruption of a medication that is essential for the health and safety of the patient; and 2) initiation of medication treatment for an emergent or urgent medical condition until the patient can obtain appropriate non-psychiatric medical services; such prescriptions or orders of non-psychotropic medications will be limited to those amounts estimated to be necessary to allow the patient time to obtain appropriate non-psychiatric medical services and such use is to be reviewed during supervision with the primary supervising physician required as part of the Quality Improvement Process and perform an in person face-to-face evaluation for restraint use for violent or self-destructive behavior.