|  |  |
| --- | --- |
| **Select Type of Review Requested:** | Choose an item. |
| **Requested Reviewer Specialty and Detail Any Specific Credential(s) Needed:** | |  | | --- | | Required | |
| **Name of Healthcare Provider Under Review:** | |  | | --- | | Required | |
| **Total Number of Episodes of Care for this Provider:** | |  | | --- | | Required | |
| **Is this an EPPE Review?** | Choose an item. |
| ***If YES, please SKIP to PAGE 2 “Facility Information” section.***  ***If NO, please complete all the information below for a comprehensive review.*** | |
| **Do you have any indication this case may result in a fair hearing?** | Choose an item. |
| **Is this review to be standard (30 days to complete) or expedited?** | Choose an item. |
| ***If expedited, by what date do you need CIMRO’s report?*** | Click or tap to enter a date. |

* **Complete this form for each episode of care unless the same questions apply to all.**
* **For additional information about our EPPE option, please contact peerreview@cimro.com.**

***REQUEST INFORMATION***

***QUESTIONS FOR THE REVIEWER***

**1. Was the standard of care met?**

**2.**

**3.**

**4.**

**5. Are additional concerns identified? If yes, please explain.**

**Do you want the reviewer to supply an overall rating of the care provided by the physician under review?** *(4 = Standard of care met; 3 = Standard of care met with some concerns; 2 = Standard of care NOT met with risk of negative outcome; 1 = Standard of care NOT met with known negative outcome)*

Choose an item.

***FACILITY INFORMATION***

|  |  |  |
| --- | --- | --- |
| **Name:** | |  | | --- | | Required | |
| **Address:** | |  | | --- | | Required | |
| **City/State/Zip:** | |  | | --- | | Required | |
| **Bed size:** | |  | | --- | | Required | |

***CONTACT INFORMATION***

**Primary Contact Person/Report Recipient (name and title):**

|  |  |  |
| --- | --- | --- |
| **Name/Title:** | |  | | --- | | Required | |
| **Phone:** | |  | | --- | | Required | |
| **Fax:** | |  | | --- | | Required | |
| **Email:** | |  | | --- | | Required | |

**Secondary Contact Person:**

|  |  |  |
| --- | --- | --- |
| **Name/Title:** | |  | | --- | | Required | |
| **Phone:** | |  | | --- | | Required | |
| **Fax:** | |  | | --- | | Required | |
| **Email:** | |  | | --- | | Required | |

**Should the report be sent to the secondary contact as well as the primary contact?** Choose an item.

***CHECKLIST***

* Questions are included with each episode of care unless they are the same for all episodes.
* If this is an EPPE review:
  + the records contain fewer than 100 pages;
  + the cases under review are NOT mortality or neurosurgery; and,
  + there are no known or strongly suspected quality concerns/issues.
* Electronic records are saved and named according to Review Preparation Instructions.
* I have notified [peerreview@cimro.com](mailto:peerreview@cimro.com) that the records are on their way.

**Record Includes:**

* Hospital cover sheet/face sheet
* H&P
* Discharge Summary
* ED notes, if applicable
* Physician orders, progress notes, and consultations
* Images for invasive procedures. Upload images to: <https://hub.nucleus.io/uploader/guest/EFRJo5SGKARkEmLgx?preview=true>

*This form asks for the patient’s email address. It does not matter what you enter there, as long as it is in the form of an email address.*

* Reports of labs, EKGs, radiology, pathology, etc.
* Procedure reports including surgeries, stress tests, echocardiograms, etc.
* Medication administration record\*
* Nurses’ notes/patient care notes\*
* Fetal strips/prenatal records/maternal records for OB cases\*
* Death summary/autopsy report\*

*\*May not be necessary for EPPEs*

***While CIMRO performs a cursory review of the records to check for completeness, please understand that completeness of records is the client’s responsibility.***