San Mateo County Mental Health Services

PEER REVIEW FORM

Reviewee Name & Discipline:_____ Date:____/_____/_____
Unit/Agency:_____ Client #_____
Reviewer Name & Discipline:_____

I The following items are clearly addressed in this case presentation.

	YES	NO	Comments
A. Diagnosis	☐	☐	
B. Psychiatric History	☐	☐	
C. Medical History	☐	☐	
D. Family, Social, Educational, Vocational History	☐	☐	
E. Consumer/Family Strengths	☐	☐	
F. Client Plans	☐	☐	
G. Clinician Respects Consumer/Family Desires	☐	☐	
H. Clinician Maintains Collaborative Relationship with Team Members	☐	☐	
I. Clinician Uses System of Care Partners	☐	☐	
J. Clinician Involves Family in Treatment	☐	☐	
K. Clinician Demonstrates Cultural Sensitivity	☐	☐	

II Discussion

A. Clinician's strengths in working with this client/family:_____

_____

_____

B. Areas requiring improvement or attention: _____

_____

_____

C. Recommendations: _____

_____

_____

III To be completed by Unit Chief/Program Director

Signature _____ Date____/____/_____

Comments _____

_____

Original to Reviewee; Copy to Quality Improvement Manager