CENEVIA
HEALTH BUSINESS SERVICES

FAX

To: Reference Name	From: Intake Coordinator
Phone:	Date:
Fax:	5 Pages (including cover sheet)
Re: Practitioner's Name	Peer Reference Inquiry

Thanks for your help!

To Whom It May Concern,

Cenevia is attempting to finish the credentials verification on the above practitioner within the next few days. Your assistance in completing this information form will be most appreciated. This is of an URGENT nature.

Please fax your response as soon as possible to (804) 237-7698 or email to ccnvintake@ccnva.com.

If you have any questions or concerns, please call us at (804) 237-7686 x 1214

Thanks,

Intake Coordinator

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Date: _____

RE: _____
(Practitioner's Name)

Dear: _____
(Reference Name)

Cenevia verifies professional references as a part of our initial credentialing process. Your name has been provided by _____(**enter practitioner's name here)** as a professional reference on his/her initial credentialing application. In accordance with Cenevia guidelines, this information must be current within the last year.

Enclosed is a copy of a release and immunity statement. This statement constitutes consent to this inquiry and to your response and releases you from liability if certain conditions of good faith and reasonableness are observed in reporting the information.

Cenevia is requesting that you complete the "Professional Reference Form" provided. **Your prompt reply is greatly appreciated. Within the next day or so, please fax to (804) 237-7698 to prevent subsequent requests.**. You may also email your response to ccnvintake@ccnva.com. If you have questions or require assistance, please feel free to call our intake coordinator at 804-237-7686, ext. 1214.

Respectfully,

Intake Coordinator

3831 Westerre Parkway, Henrico, VA 23233, Suite 1
Phone: 804-237-7686 ext. 1214 **Office Fax:** 804-237-7698 **Email:** ccnvintake@ccnva.com

Website: www.cenevia.health

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Reference given for _____
Reference provided by _____

Length of time with applicant _____
Describe why you are qualified to provide a reference for this person._____
(Example: Peer, Supervisor, Academic colleague or professor, etc.)
Nature of observation (hospital, office, etc.) _____
List the estimated number of clinical procedures you have observed the applicant perform:_____
What type of procedure and how many?_____
How many times have you observed the applicant render episodes of care?_____

Please rate the following: Excellent; Good; Average; BA (below average); NI (no information); N/A (not applicable)

Medical knowledge	**Excellent**	**Good**	**Average**	**BA**	**NI**	**N/A**
• Basic Medical / Clinical Knowledge	_____	_____	_____	____	_____	_____
• Knowledge in specialty	_____	_____	_____	____	_____	_____

Clinical judgment	**Excellent**	**Good**	**Average**	**BA**	**NI**	**N/A**
• Basic clinical judgment	_____	_____	_____	____	_____	_____
• Availability and thoroughness of patient care	_____	_____	_____	____	_____	_____
• Appropriate and timely use consultants	_____	_____	_____	____	_____	_____
• Quality/appropriateness of patient care outcomes	_____	_____	_____	____	_____	_____
• Appropriateness of resource use (e.g., admissions, procedures, LOS, tests)	_____	_____	_____	____	_____	_____
• Clinical pertinence and completeness of Medical record documentation	_____	_____	_____	____	_____	_____

Communication Skills	**Excellent**	**Good**	**Average**	**BA**	**NI**	**N/A**
• Overall communication skills	_____	_____	_____	____	_____	_____
• Verbal and written fluency in English	_____	_____	_____	____	_____	_____
• Clarity/legibility of records	_____	_____	_____	____	_____	_____
• Responsiveness of patient needs	_____	_____	_____	____	_____	_____

Interpersonal Skills	**Excellent**	**Good**	**Average**	**BA**	**NI**	**N/A**
• Ability to work with members of healthcare team	_____	_____	_____	____	_____	_____
• Rapport with patients	_____	_____	_____	____	_____	_____
• Rapport with families	_____	_____	_____	____	_____	_____
• Rapport with hospital staff	_____	_____	_____	____	_____	_____

Professionalism	**Excellent**	**Good**	**Average**	**BA**	**NI**	**N/A**
• Timely documentation of medical record	_____	_____	_____	____	_____	_____
• Participation in MSO activities	_____	_____	_____	____	_____	_____
• Participation in CME	_____	_____	_____	____	_____	_____
• Maintenance of patient confidentiality	_____	_____	_____	____	_____	_____
• Fulfillment of clinical ED call assignments	_____	_____	_____	____	_____	_____
• Demonstration of ethical standards in treatment	_____	_____	_____	____	_____	_____

Credentialing Dept, 3831 Westerre Parkway, Suite 1, Richmond, VA. 23233
Phone: 804-237-7686 ext. 1214 **Office Fax:** 804-237-7698

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Do you have any basis upon which to doubt his/her personal integrity, honesty or medical ethics?
☐ Yes ☐ No. *If yes, please provide an explanation on a separate sheet of paper.*

Describe any strengths and/or weaknesses with regard to his/her manner of practice and adherence to relevant ethical standards:

Are you aware of any current physical, mental, emotional, or behavioral issues that the applicant has that have affected or could potentially affect his/her ability to exercise all or any of the privileges requested or to perform the duties of medical staff appointment? ☐ Yes ☐ No *If yes, please provide explanation on a separate sheet of paper.*

To your knowledge has the practitioner ever had his/her hospital privileges denied, reduced, suspended, or terminated? ☐ Yes ☐ No

If "yes" please check the box that applies *and provide an explanation on a separate sheet of paper:*
☐ Denied ☐ Reduced ☐ Suspended ☐ Terminated

Is there any relevant information that we should have asked that we did not ask? If so, please provide it below:

Recommendation:

☐ Recommended without reservations

☐ Recommended with the following reservations:

☐ Do not recommend *If you check the box indicating the practitioner not be recommended, you must provide an explanation below.*

Comments:

_____ _____
Signature Date

_____ _____
Printed Name Current Position

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