

Confidential Professional Reference Questionnaire- Pshchologist/Therapist

Name of reference: _____

Professional evaluation concerning: [Applicant's full name, including any other name(s) used]

Release of Information:

I am applying to work as an Independent Contractor with California Telepsychiatrists and/or American Telepsychiatrists (CTAT). By signing this release, I am voluntarily requesting that you respond to reference requests from any staff member from CTAT and from any prospective sub-contracting agency CTAT may require in order to evaluate my suitability as an Independent Contractor doing telepsychiatry. I authorize you to disclose to said entities any employment-related information that you, in your sole discretion and judgment, may determine is appropriate to disclose, including any personal comments, evaluations, or assessments that may have about my performance or behavior as an employee, volunteer, peer, and as to my personal character and characteristics.

In exchange for your agreement disclose the above information pursuant to my request, I agree to release and discharge you and your company and your successors, employees, officers, and directors for all claims, liabilities, and causes of action, know or unknown, fixed or contingent, that arise from or that are in any manner connected to your disclosure of employment-related and personal information to CTAT and any of its affiliates. This release includes, but is not limited to, claims of defamation, libel, slander, negligence, or interference with contract or profession.

I acknowledge that I have carefully read and fully understand the provisions of this release. I further acknowledge that I was given the opportunity to consult with an attorney or any other individual of my choosing before signing this release and that I have decided to sign this release voluntarily and without coercion or duress by any person.

This release sets forth the entire agreement between you and me, and I acknowledge that I have not relied upon any representation or statement, written or oral, not set forth in this document.

Signed by Independent Contractor Applicant: _____

Date: _____

Dear (Name of Reference) _____, please complete the following reference form and mail it in the enclosed, stamped envelope addressed to Dr. John Schaeffer, California Telepsychiatrists, 3308 El Camino Ave, Suite 300-136, Sacramento, CA 95821.

Applicant's Specialty/subspecialty: _____

Your answers are completely confidential and will not in any way be shared with the applicant.

Section I: Your present professional position: _____

My responses are based on (check all appropriate responses)

direct observation. review of accumulated information and reports about the practitioner's performance.

I know the applicant (check the most accurate response)

very well. well. casually. personally. professionally.

I do not personally know the applicant. (If checked, please skip the remaining questions in this section (Reference's relationship with the applicant) and go directly to Section III (Professional knowledge, skills, and attitude.)

Please answer the following questions based on your personal knowledge and direct observations. Your candor is greatly appreciated.

Section II: REFERENCE'S RELATIONSHIP WITH THE APPLICANT

1. How long have you known the applicant? _____

2. During what time period did you have the opportunity to directly observe the applicant's work?

3. In what setting(s) did you observe the applicant (e.g., academic, clinic, hospital, residency program, etc.)?

4. Was the applicant active in your organization? ___ Yes ___ No

How frequently did you observe the applicant? ___ Daily ___ Weekly ___ Monthly ___ Infrequently

Comment:

5. Was your observation done in connection with any official professional title or position?

___ Yes ___ No

If so, please indicate title and organization:

What was the applicant's title or position?

6. Were you previously, are you now, or are you about to become related to the applicant as family or through a professional partnership or financial association? ___ Yes ___ No

If yes, please explain:

Section III: PROFESSIONAL KNOWLEDGE, SKILLS, AND ATTITUDE

If you do not have adequate knowledge to answer a particular question, please indicate Unable to evaluate (UE)

1. Please rate the following as Excellent, Good, Average, Below average, or Unable to evaluate:

	Excellent	Good	Average	Below Average	Unable to Evaluate
Clinical Knowledge					
Basic clinical knowledge					
Knowledge in specialty					
Technical and clinical skills					
Clinical Judgment					
Basic clinical judgment					
Availability and thoroughness of client care					
Appropriate and timely use of consultants					
Quality/appropriateness of client care outcomes					
Appropriateness of resource use (e.g., admissions, procedures, length of stay, tests, etc.)					
Clinical pertinence and completeness of record documentation					
Communication Skills					
Overall communication skills					
Verbal and written fluency in English					
Clarity/legibility of records					
Responsiveness to client needs					
Interpersonal Skills					
Ability to work with members of healthcare team					
Rapport with clients					
Rapport with families					
Rapport with hospital staff					
Professionalism					
Timely documentation of client record					
Participation in staff organization activities (e.g., committees, leadership positions, etc.)					
Participation in continuing education					
Demonstration of ethical standards in treatment					
Maintenance of client confidentiality					
Response to clinical emergencies					
Technical Skills					
Ability to operate a personal computer with minimal IT support					
Ability to problem solve technical difficulties with minimal frustration					
Ability to type quickly and efficiently					
Expertise with therapy via Skype or other televideoconferencing means					
On-camera demeanor and personal presentation					
Ability to multi-task					
Ability to work independently					

2. Have you ever observed or been informed of any physical, mental, emotional, or behavioral issues the applicant has or had that could potentially affect his/her ability to exercise all or any of his/her clinical responsibilities?

Yes No No information

If yes, please explain: _____

3. To the best of your knowledge, have any of the following ever been denied, challenged, investigated, terminated, reduced, not renewed, limited, withdrawn from or resignation submitted, suspended, revoked, modified, placed on probation, relinquished, or voluntarily surrendered, or do you have knowledge of any such actions that are pending?

- license or registration Yes No No information
- clinical privileges Yes No No information
- hospital appointment Yes No No information
- affiliation with any healthcare organization Yes No No information
- professional status Yes No No information
- employment arrangement with any healthcare facility Yes No No information
- employment arrangement with a physician group Yes No No information

Please explain and Yes answers: _____

4. Do you know of any malpractice action instituted or in process against the applicant?

Yes No No information

If yes, please explain: _____

Section IV: SUMMARY

I understand the clinical privileges requested are psychotherapy (including individual, family, group, outpatient, and inpatient), mental health consultation liaison, acute care/urgent care/emergency room evaluation and triage and disposition, case management, psychological testing if licensed to do so, and telemental health, and my recommendation concerning the specific clinical privileges requested is as follows:

- I recommend granting all privileges as requested by the applicant.
- I recommend granting privileges as requested by the applicant with the limitations specified below:*
- I recommend not granting the applicant the privileges listed below:*
- I recommend not granting any privileges requested by the applicant:*

*Please explain any reservations or concerns regarding any specific privilege/services requested by the applicant.

Regarding this applicant:

- I recommend the applicant strongly.
- I recommend the applicant as an average therapist/clinician.
- I recommend the applicant with the reservations listed below:**
- I do not recommend the applicant. **

**Please explain any reservations or concerns regarding the applicant's request for appointment/affiliation.

Please use this section for any additional comments, information, or recommendations that may be relevant to our decision to grant appointment/affiliation of specific clinical privileges/services to the applicant.

Thank you for taking the time to complete this form. It is an important responsibility we all share in maintaining the highest quality and standards for our profession. Your time is greatly appreciated. If you would like to discuss this applicant with someone from our organization, please call Dr. John Schaeffer at 916-320-4422, and a mutually convenient time for a phone conversation will be arranged.

Reference provided by: _____

Signature: _____ Date: _____ Field of practice: _____

Telephone: (____) _____ ext. _____ E-mail: _____

I would like for you to call me regarding this applicant: Yes _____ No _____

Best number to call to set up a phone appt: _____

(Name of contact if other than reference): _____

Best times to call to set up a phone appt: _____

And the best times for a phone appointment:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM