

PROVIDER NAME: _____ DATE: _____

Instructions: If provider supplies mock record, review one chart; if provider supplies actual or blinded records a sample of three should be reviewed.

R = blinded or actual record (circle one) M = mock record

		R	M		R	M		R	M	
STANDARD		Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1	Each page in the treatment record contains the patient name or identification number.									
2	Each record includes patient address, employer or school, home and work telephone numbers including emergency contacts, marital/legal status appropriate consent forms, and guardianship information (if applicable).									
3	All entries in the treatment record include the responsible clinician's name and professional degree.									
4	All entries are dated.									
5	The record is legible and reproducible.									
6	Relevant medical conditions are listed, prominently identified, and updated.									
7	Presenting problems and relevant psychological & social conditions affecting the patient's medical & psychiatric status are documented.									
8	Special status situations, such as imminent risk of harm, suicidal ideation, or elopement potential are prominently noted, documented & updated in compliance with written protocols.									
9	Each record indicated what medications have been prescribed, dosages of each medication, and the dates of initial prescription with documentation of changes in regimen and compliance/non-compliance.									
10	Allergies and adverse reactions are clearly documented.									
11	A past medical & psychiatric history is documented including previous treatment dates, provider information, therapeutic interventions & responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.									
12	For children & adolescents, prenatal & perinatal events, and a complete developmental history (physical, psychological, social, intellectual, academic) documented.									
13	For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and OTC drugs.									
14	Mental Status Exam is documented to include affect, mood, speech, thought content, judgment, insight, attention/concentration, memory & impulse control/risk management									
15	A DSM-IV diagnosis is documented, consistent with the presenting problems, history, mental status exam, & or other assessment data including 5 Axis.									
16	Treatment plans are consistent with diagnoses & have objective measurable goals & estimated time frames for goal attainment or problem resolution.									
Total Pg. 1			0			0			0	

	STANDARD	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
17	There is documentation of the patient's understanding of the treatment plan.									
18	There is documentation describing patient strengths and limitations in achieving treatment plan goals & objectives.									
19	Patients who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.									
20	The treatment record documents preventive service as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources.									
21	The treatment record reflects continuity & coordination of care between the primary clinician, consultants, ancillary providers, and health care institutions.									
22	The treatment record documents dates of follow-up appointments and a discharge plan.									
23	Treatment is recorded in a chronological manner.									
24	For individuals with a substance abuse diagnosis, provider has assessed the safety & well-being of the individuals living in the home with the individual receiving treatment for substance abuse.									
25	Evidence of inquiry about the status of BHRSCA screens for the children they are treating as well as the children of the parents they may be treating, whether or not those children are in BH treatment.									
26	There is evidence of documentation of follow-up to failed appointments.									
27	There is an appropriate release of information included in the medical record for PCP notification or there is documentation that the Member refused to sign a release of information to notify the PCP.									
28	There has been notification of the PCP if the release of information is available.									
Total Raw Numbers Pg. 1:			0			0			0	
Total Raw Numbers Pg. 2:			0			0			0	
Total Score:										
Items 29, 30 and 31 is a must pass item; corrective action plan required if not met.										
29	Treatment records are secured in storage with double locks and inaccessible to the public.									
30	Providers maintain an individual record per patient which is clearly marked with a unique identifier (this may be a medical record number).									
31	Current treatment records are easily retrievable.									
COMMENTS										
<p>Scoring Instructions: All items marked "yes" are given 1 point value All items marked "no" are given a zero point value All items marked "N/A" are given a 1 point value; items where N/A is shaded must be scored yes or no. If scoring one mock record a minimum score of 23 is required to pass the reiew. If scoring three blinded or actual records a minimum score of 70 is required to pass the reiew. If required score is not met, a corrective action plan is required.</p>										