Comprehensive Behavioral Health Management Clinical Chart Audit

Patient Initials & SSN										
1=MD or DO or NP, 2=PhD, 3=MFT, 4=LCSW, 5=LPC										
ADMINISTRATIVE DATA (weight = 15)	**1.0**	**2.0**	**3.0**	**4.0**	**5.0**	**6.0**	**7.0**	**8.0**	**9.0**	**10.0**
All pages contain patient's name or ID#										
Patient Address										
Telephone Numbers (home and work)										
Employer or school										
Marital Status (Parent or guardian info for minors)										
Emergency contact										
Appropriate consent Form(s); Release of Information to abide by Federal Confidentiality Guidelines; Consent for Tx of minor										
Office Policies (e.g., N/S, Late Cancel, Emergencies) Acknowledged By Patient										
Review of Patient Rights documented										
All entries include treating clinician's name and professional degree										
Entries are timely and dated										
Record is organized, legible, & forms secured										
SECTION SCORE										
MEDICAL AND PSYCHIATRIC HISTORY (weight=25)										
Relevant medical conditions & current providers are listed, identified and significant changes are noted										
Past treatment: Dates, provider identification, type of therapeutic interventions, and responses										
Allergies and adverse reactions noted: lack of know allergies and sensitivities to pharmaceuticals or other substances is noted										
For children and adolescents, prenatal and perinatal events and developmental history										
For patients 12 and older, past and present use of cigarettes, alcohol and illicit, prescription, and over-the-counter drugs										
Relevant family history										
Record includes laboratory test results and consultation reports (as appropriate)										
SECTION SCORE										
CLINICAL DATA - ASSESSMENT (weight=30)										
Identified problem and history of presenting problem										
Mental Status Exam includes affect, speech, mood, thought content, judgment, insight, attention/concentration, memory and impulse control										
All risk factors (SI, H/I, CD, History of non-compliance) noted with appropriate intervention										
Psychosocial History (includes current living situation, support systems, legal issues)										
SECTION SCORE										

Codes 0=No, 1=Yes, N/A=Not Applicable

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CLINICAL DATA - TREATMENT (weight=30)										
DSM IV Diagnoses Axis 1-V										
Diagnosis is consistent with assessment										
For minors, assessment documents need for family therapy										
Subsequent session progress notes are consistent with diagnosis										
Treatment plan consistent with diagnosis										
Treatment plan includes measurable goals										
Treatment plan includes estimated time frames for goal attainment or problem resolution										
Review of treatment plan documented										
Progress notes describe patient’s strengths and limitations in achieving treatment goals and objectives; summary of progress; interventions and assessment of response										
Patient’s understanding of the treatment plan is noted										
Record indicates what psychotropic medications have been prescribed.										
Dosages noted by MD (N/A for non-MD)										
Length of time on medication (MD notes reflect dates)										
MD notes reflect date of initial prescription										
MD record reflects informed consent for medication										
Risk factor updates noted and referred to the appropriate level of care										
Documentation of preventative services (including use of homework assignments) and referrals to community resources										
HIPAA release of information signed & included for each contact person										
Record reflects continuity of care between all mental health providers (HCCF faxed or mailed)										
Record reflects coordination of care with medical providers. (HCCF faxed or mailed) Patient refusal documented										
Documentation of dates of follow-up appointments, or, as appropriate, a discharge summary										
Quality of Care issues										
Referral to Committee for Review										
SECTION SCORE										
Score per case										

Codes 0=No, 1=Yes, N/A=Not Applicable