

MEDICAL RECORD REVIEW WORKSHEET

Date of Review: _____ **Reviewer:** _____
Provider Name: _____ **Type:** _____
Location: _____ **Patient ID #** _____

Italicized text indicates NCQA Standards

ASSESSMENT STANDARDS	yes	no	na	EXPLANATION	possible points	Actual points
SECTION I. GENERAL INFORMATION						#
<i>Legible handwriting</i>					.5	
<i>Member name and ID number noted on each page</i>					1.0	
<i>Member's address</i>					.5	
<i>Member's employer or school</i>					.5	
<i>Home and work phone numbers</i>					1.0	
<i>Guardianship information if applicable</i>					.5	
<i>Marital/Legal status</i>					.5	
<i>Emergency contacts</i>					.5	
Signed treatment consent form					1.0	
Notation of Primary Care Physician					.5	
Consent to communicate with PCP signed or refusal noted.					2.0	
Signed Bill of Rights					.5	
<i>All entries are dated and signed by practitioner with professional degree and ID # if applicable.</i>					1.0	
				TOTAL POINTS	10	
SECTION II: INITIAL EVALUATION						
<i>Members presenting complaint is documented</i>					1.0	
<i>Psychiatric history includes previous providers and treatment dates if applicable</i>					1.0	
<i>Psychiatric History includes sources of clinical data</i>					1.0	
<i>Psychiatric History includes treatment interventions and response to treatment</i>					1.0	
<i>Psychiatric History includes relevant family information</i>					1.0	
<i>Psychiatric History includes results of lab test and consultation reports if applicable</i>					1.0	
Psychosocial information includes <ul style="list-style-type: none"> ○ support systems ○ legal history ○ educational history 					5.0	
<i>Relevant medical history is noted</i>					1.0	
<i>Medical history includes current providers caring for member</i>					1.0	
<i>Medical history includes current medications and prescribed dosages and dates of initial prescription or refills.</i>					1.0	
<i>For members 12 and over, a substance abuse</i>					1.0	

<i>evaluation is completed to include nicotine</i>						
<i>For children and adolescents, prenatal and perinatal events are documented</i>					1.0	
<i>For children and adolescents, a complete developmental history is documented</i>					1.0	
ASSESSMENT STANDARDS	yes	no	na	EXPLANATION	possible points	Actual points
<i>Allergies and adverse reactions or no known allergies is documented.</i>					1.0	
<i>Mental Status Exam documents member's</i> <ul style="list-style-type: none"> ○ <i>affect</i> ○ <i>speech</i> ○ <i>mood</i> ○ <i>thought content</i> ○ <i>judgement</i> ○ <i>insight</i> ○ <i>attention/concentration</i> ○ <i>memory</i> ○ <i>impulse control</i> 					5.0	
<i>Risk factors noted to include:</i> <ul style="list-style-type: none"> ○ <i>non compliance with treatment</i> ○ <i>AMA elopement potential</i> ○ <i>prior behavioral health inpatient admissions</i> ○ <i>history of multiple behavioral diagnosis</i> ○ <i>suicidal/homicidal ideation</i> 					5.0	
<i>DSM-IV Diagnosis (all five axes) is documented</i>					5.0	
<i>Primary Care Practitioner Report completed at initial evaluation</i>					1.0	
<i>Follow up appointment is scheduled</i>					1.0	
				Total Point Section II	35	
SECTION III. TREATMENT PLAN (<i>not for psychiatrists doing medication management only</i>)						
<i>Individualized treatment plan included in members record</i>					5.0	
<i>Treatment plan goals are objective and measurable</i>					5.0	
<i>Treatment plan goals have estimated time frames for completion.</i>					5.0	
<i>Treatment interventions consistent with treatment plan goals</i>					5.0	
<i>Member understanding of treatment plan is documented</i>					5.0	
				TOTAL POINTS SECTION III	25	
SECTION IV. PROGRESS NOTED IN TREATMENT						
<i>Progress notes describe member's strengths and limitations in achieving treatment plan goals</i>					2.0	
<i>Progress notes reflect continuity/coordination</i>					3.0	

<i>of care between</i> <ul style="list-style-type: none"> ○ <i>PCP</i> ○ <i>consultants</i> ○ <i>ancillary providers/services</i> 						
<i>Treatment record documents dates of follow up appointments</i>					2.0	
Documentation that member is receiving treatment according to Best Practice Guidelines.					2.0	
ASSESSMENT STANDARDS	yes	no	na	EXPLANATION	possible points	Actual points
Discharge note documents achievement of goals or necessary referrals to assist in final attainment of goals.					2.0	
Discharge note documents member's feeling of goals being achieved/not achieved.					2.0	
Discharge note is completed within 60 days of last visit.					2.0	
				TOTAL POINTS SECTION IV.	15	
SECTION V. MEDICATION (<i>for psychiatrists only</i>)						
Medication flow sheet completed or progress note includes documentation that treatment is per Best Practices Guidelines for current psychotropic medication, dosages, date(s) of dosage changes.					1.0	
Documentation of member education regarding possible medication side effects					1.0	
Documentation that the reason for medication was explained to the member					1.0	
Documentation of member education of women of child bearing age to avoid becoming pregnant while taking psychotropic medication, and to notify psychiatrist immediately upon becoming pregnant					.5	
Documentation of member verbalization of understanding of member education					1.0	
Record reflects DEA scheduled drugs are avoided in treatment of members with a history of substance abuse/dependency if applicable.					.5	
				TOTAL POINTS SECTION V.	5	
SECTION VI. REFERRAL/OUTREACH						
Treatment record documents preventative services as appropriate: <ul style="list-style-type: none"> ○ <i>relapse prevention</i> ○ <i>stress management</i> ○ <i>wellness programs</i> ○ <i>lifestyle changes]</i> ○ <i>referrals to community resources</i> 					8.0	
<i>Members who become homicidal, suicidal or unable to conduct activities of daily living, are referred to appropriate level of care if</i>					2.0	

<i>applicable.</i>						
				TOTAL POINTS SECTION VI	10	
				TOTAL POINTS	100	
FINAL SCORE						