

Reviewer Name:					
Practitioner Name:				Prescriber: Yes/No	
State:					
Member Name & DOB:					
Member Ethnicity:					
Member Race:					
	Yes	No	Inc	N/A	Comments
<i>Treatment Record Structural Components</i>					
Q9. MR 1: Demographic sheet present in each chart					
Q10. MR 2: Member ID number/name on each page of the medical record					
Q11. MR 3: Clinician Name					
Q12. MR 4: Title					
Q13. MR 5: Date					
Q14. MR 6: Handwritten record is legible (N/A for electronic)					
Q15. MR 7: Initial/Annual Assessment present					
Q16. MR 8: Assessment completion date within 12 months of chart review date					
Q17. MR 9: Presenting Problems(s) are identified					
Q18. MR 10: Mental status exam					
Q19. MR 11: Psychiatric history					
Q20. MR 12: Significant medical conditions					
<i>Assessment Components</i>					
Q21. MR 13: Medication list					
Q22. MR 14: Assessment of risk					
Q23. MR 15: Substance abuse assessment to include nicotine use					
Q24. MR 16: Identification of support systems					
Q25. MR 17: Current level of functioning					
Q26. MR 18: Identifies strengths and needs to be included in comprehensive treatment plan					
Q27. MR 19: DSM Axis I-V diagnosis present					
Q28. MR 20: Brief physical assessment recorded for each visit					
<i>Medication and Lab Services/For Prescribers only</i>					
Q29. MR 21: Medication allergy/adverse reaction documented					
Q30. MR 22: Medication list is current					
Q31. MR 23: Medications prescribed by primary care provider (PCP) are included on the medication list					
Q32. MR 24: Lab work is monitored					
Q33. MR 25: Follow up for abnormal lab work documented in record					
Q34. MR 26: Informed consent present for prescribed medications including possible side effects					
<i>Treatment Plan Components</i>					
Q35. MR 27: Member education clearly documented					
Q36. MR 28: Member family/support system clearly documented					
Q37. MR 29: Treatment plan available in chart with member and provider signatures					

Q38. MR 30: Member and family have been introduced to and encouraged to attend self-help treatment organizations					
Q39. MR 31: Treatment plan identifies member goals and relates these to treatment objectives					
Q40. MR 32: Level of member insight into illness as it relates to medication administration					
Q41. MR 33: Member perceptions about lack of benefit from treatment					
Q42. MR 34: Monitoring and maintaining therapeutic alliance					
Q43. MR 35: Financial concerns					
Q44. MR 36: Transportation concerns					
Q45. MR 37: Lack of family or other social support					
Q46. MR 38: Cultural beliefs					
Q47. MR 39: Treatment plan integrates the treatment of multiple clinicians					
Q48. MR 40: Evidence of documentation of communication among behavioral health clinicians involved in care delivery					
Q49. MR 41: Treatment plan includes development of coping strategies and stress reduction techniques					
Language Assessment and Needs					
Q50. MR 42: The primary language was english					
Q51. MR 43: If not English, documentation present to indicate that a language interpreter was used					
PCP Communication					
Q52. MR 44: Documentation in chart identifies member's PCP					
Q53. MR 45: Documentation in chart indicates contact with PCP in the quarter being evaluated					
Follow-up Appointment Planning					
Q54. MR 46: A date is documented for a follow-up visit appointment					
Q55. MR 47: A discharge plan is documented from the outpatient setting					
SSHHP Only					
Q56 MR 48 FARSCFARS is present in the record.					
Informational Only					
Is the presence of an Advance Directive noted in the record					
if yes, is a copy of advance directive executed by the member present in the record.					
Referrals noted in the record for the time period assessed					
If hospitalization noted, a discharge summary is present					
If Emergency Department use was noted, a summary from the ED is present					