

Practitioner Name:		Address			
Practitioner Credentials:		City		State	
Reviewer Name and Credentials:		Phone		Zip Code	
Date of Review:		Fax			
Reason for Treatment Record Review (Fill in one)					
Credentialing	<input type="radio"/>	Recredentialing	<input type="radio"/>	Potential High Volume	<input type="radio"/>
6 month Review	<input type="radio"/>	New Program	<input type="radio"/>	High Volume Initial	<input type="radio"/>
Quality Assessment	<input type="radio"/>	Other (specify):	<input type="radio"/>	High Volume Follow-up	<input type="radio"/>

Treatment Record Element	Var #	Record ID	Record ID	Record ID	Record ID	Record ID	Comments
Check if record element is present	Var #						
Initial Session/Admission date noted	1						
Each page in treatment record contains the patient's name or ID number (e.g. DOB, SS #)	2						
Patient address listed	3						
Employer or school name noted	4						
Home and work phone numbers noted	5						
Emergency contacts noted	6						
Marital status noted	7						
Consent for Treatment Forms signed.	8						
Guardianship/Medical Power of Attorney information present, if applicable	9						
All entries include responsible clinician's name <u>and</u> professional degree	10						
All entries are dated	11						
Treatment record is legible and in ink or typed.	12						
Relevant Medical conditions are listed, prominently identified and revised.	13						
Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status, are documented.	14						
Assessment of severity and imminence of potential harm to self or others is completed and documented at least once and then as often as appropriate. (CRITICAL INDICATOR)	15						
Special status situations, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented and revised, if applicable.	16						
Patients who become homicidal, suicidal or unable to conduct activities of daily living are promptly referred to the appropriate level of care, if applicable.	17						

Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills. (MD/DO specific; N/A for all others)	18						
Allergies and adverse reactions are clearly documented.	19						

		Record ID	Record ID	Record ID	Record ID	Record ID	Comments
Past medical and psychiatric history is documented (for example: previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests and consultation reports)	21						
For persons 12 and older, documentation of past and present use of cigarettes and alcohol, as well as illicit, prescribed and/or over the counter drugs.	22						
Substance abuse evaluation is documented in members with primary mental health diagnosis, if applicable.	23						
Mental health evaluation is documented in members with primary substance abuse diagnosis, if applicable.	24						
Mental status exam is completed that includes assessment and documentation of the patient's affect, speech, mood, thought content, judgement, insight, attention or concentration, memory and impulse control.	25						
DSM IV diagnosis (Axis I-V) is documented, consistent with the presenting problems, history, mental status exam and/or other assessment data.	26						
Treatment plan is consistent with diagnosis and has objective, measurable goals	28						
Focus of treatment interventions are consistent with treatment plan goals and objectives	30						
Informed consent for medication is documented and the patient's understanding of the treatment plan is documented. (Applies to MDs/DO's only)	31						
Treatment record provides evidence of practitioner attempting to obtain consent to communicate with other behavioral healthcare providers or practitioners when appropriate. (CRITICAL INDICATOR)	34						
Treatment record provides evidence of communication and coordination of care with other behavioral healthcare providers or practitioners if they exist. (CRITICAL INDICATOR)	35						
Treatment record provides evidence of practitioner attempting to obtain consent to communicate with primary care physician (PCP) or other ancillary providers when appropriate. (CRITICAL INDICATOR)	36						
Treatment record provides evidence of coordination of care with primary care provider (PCP) or other ancillary providers when they exist. (CRITICAL INDICATOR)	37						
The treatment record documents dates of follow-up appointments or, as appropriate, a discharge plan.	38						
In addition to the elements above, the following must be assessed for children and adolescents (<18 years of age)							
Prenatal and perinatal events are documented	39						
Complete developmental history is documented (physical, psychological, social, intellectual and academic)	40						

PRACTICE GUIDELINE COMPLIANCE							
APA Guideline on Major Depression							
Major Depression: Treated in psychotherapy only							
		Record ID	Record ID	Record ID	Record ID	Record ID	Comments
1. Mild to Moderate depression; no improvement after 6 sessions or 3 months, referred for medication evaluation OR documentation that patient refused.	41						
2. Severe depression; no improvement after 3 sessions, referred for medication evaluation OR documentation that patient refused.	42						
APA Guideline on Substance Abuse							
3. Evaluation of possible mood disorder, especially following detox.	47						
4. Encouraged patient to attend AA, NA, or other community self- help groups.	48						
Overall Score							

Routine Access to Care (Appointment Access by looking at appointment book)	
1. If MD or Masters Level practitioner; is there an appointment available within 10 business days? (Y/N)	49
2. If PhD (psychologist); is there an appointment available within 14 business days? (Y/N)	50

General Comments:

Reviewer (print name)	Credentials	Date
Reviewer Signature	Source Documents: NCQA MBHO Survey Guidelines for Treatment Record Review (TR2)	