Behavioral Treatment Record Review Tool

Scoring Options

Y/N	1	The Record is **Legible.**
Y/N	2	**Presenting problems** and relevant psychological and social conditions affecting the patient's medical and psychiatric status are documented.
Y/N	3	Documentation of Existence or Absence of **special status situations** such as imminent risk of harm, suicidal ideation, or development potential are prominently noted, documented, and revised.
Y/N	4	**A psychiatric history** is documented (a psychiatric history might include previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.)
Y/N	5	A **mental status evaluation** is documented (patient's affect, speech, mood, thought process, thought content, judgment, insight, attention/concentration, memory and impulse control)
Y/N	6	**Medical History:** One the following is documented: 1) There is no history of a medical condition relevant to the presenting problem, or 2) There is a history of some medical condition relevant to the presenting problem in which case there is documentation of the condition, treatment, and medications.
Y/N n/a	7	**Clients 12 & older**: documentation includes last use, amount used, patterns of use, and treatment history or **substances** (includes cigarettes, alcohol, illicit or prescribed and over-the-counter drugs.)
Y/N	8	A **DSM-IV diagnosis** is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data.
		Treatment Planning
Y/N	9	Initial **treatment plan includes measurable goals**, including documentation of any changes to treatment plan.

Y/N **n/a**	10	Patients who become **homicidal, suicidal**, or unable to conduct activities of daily living are promptly referred to the appropriate level of care. (Select n/a if no SI/HI noted and ppnt able to conduct ADLs)
Y/N	11	The record documents **preventive services** as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes and referrals to community resources. (includes advice/info on diet, exercise, smoking cessation, etc.)
Y/N	12	**Progress note** is documented on each visit.
		Coordination of Care (for complex and complicated cases only)
Y/N **n/a**	13	The record reflects attempts to coordinate behavioral care with the **primary care physician** at ANY time during treatment when coordination of care is indicated. (NA for marital therapy, adjustment disorder - see comment)
Y/N **n/a**	14	The record reflects attempts to coordinate behavioral care with other **behavioral** clinicians or institutions or ancillary providers as indicated at any time during treatment. (see comment for when n/a)
		Medications/Allergies (Applicable only for physicians & some nurse practs that prescribe meds)
Y/N **n/a**	15	The record documents whether or not the patient has any **allergies** or adverse reactions to medications. (n/a for practitioners who do not prescribe medications -- master's level and non-prescribing PhDs)
Y/N **n/a**	16	All medications prescribed by THIS provider are listed along with the dosage of each.
		Child / Adolescent (SKIP Question 17 if not a child/adolescent)
Y/N **n/a**	17	For children and adolescents, prenatal and perinatal events, and a complete **developmental history** (physical, psychological, social, intellectual, academic, and substance abuse) are documented. (n/a ONLY if an adult)
		MEDICARE (SKIP questions 18 and 19 if not a MEDICARE participant)
Y/N	18	Documentation of whether or not an advance directive was executed.
n/a	19	Evidence that a copy of executed advanced directive, or documentation of refusal, was sent to the PCP.
The record contains validated and standardized diagnostic/severity rating scales for the following conditions		
Y/N	20	Depression
Y/N	21	Alcohol and other substance abuse

*Items 20 and 21 are not scored. For information purposes only

Items on the **EAP** record review: 1, 2, 3, 7, 9, 10, 11, 12, 13, 14, 17, 20, 21