



## Behavioral Health Treatment Record Review Documentation Worksheet

Name of Licensed Clinician: \_\_\_\_\_ Name of Practice/CSB Location: \_\_\_\_\_

Sentara Member ID#: \_\_\_\_\_ Member Age: \_\_\_\_\_ Member Primary Dx: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Review Type:     Practice/CSB Review     Focused Review

CLINICAL DATA COMPONENT IS DOCUMENTED IN THE CHART	YES	NO	COMMENTS
<b>HISTORY OF PRESENT ILLNESS</b>			
1. Presenting problems and relevant psychological and social conditions affecting the patient's medical and psychiatric status are documented.			
<b>PSYCHIATRIC HISTORY</b>			
2. A psychiatric history is documented, including:			
a. outpatient treatment			
b. hospitalizations			
c. suicide attempts			
d. response to prior treatment interventions			
e. relevant family history			
3. For children, developmental history is documented			
<b>SUBSTANCE USE ASSESSMENT</b>			
4. For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over the counter drugs.			
<b>MENTAL STATUS EVALUATION</b>			
5. A mental status evaluation documents the patient's:			
a. affect			
b. mood			
c. thought content			
d. judgement			
e. insight			

CLINICAL DATA COMPONENT IS DOCUMENTED IN THE CHART		YES	NO	COMMENTS
<b>DSM-IV DIAGNOSIS (ALL FIVE AXES)</b>				
6.	A full DSM-IV diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data.			
<b>MEDICAL HISTORY (PHYSICIANS)</b>				
7.	Relevant medical conditions are listed, prominently identified, and revised.			
8.	Allergies and adverse reactions are clearly documented <b>or</b> a lack of known allergies and sensitivities to pharmaceuticals and their substances is prominently noted.			
<b>MEDICATION MANAGEMENT (PHYSICIANS)</b>				
9.	Each record indicates medications have:			
	a. the date prescribed/changed			
	b. the dosage, route, and frequency			
	c. the subsequent prescription dates			
	d. and reflect the psychiatrist has documented an informed consent process regarding prescription medication (including potential side effects, risks/benefits, questions invited and addressed)			
<b>TREATMENT PLANNING</b>				
10.	Treatment plans are consistent with diagnoses and have:			
	a. symptom specific goals			
	b. criteria for decreased frequency of visits			
11.	The patient's understanding of the treatment plan is documented.			
<b>CONTINUITY AND COORDINATION OF CARE</b>				
12.	The treatment record reflects continuity of and coordination of care. There is evidence of timely referral and follow-up is verified (i.e. letters, reports, test results, documentation of telephone calls, etc.) with : <b>(Or, patient refusal is documented)</b>			
	a. primary care physician (if not notified, a reason is indicated)			
	b. other behavioral health provider			
<b>RISK ASSESSMENT</b>				
13.	Any documented ideation or action concerning a potential danger to self or others includes a specific assessment of risk.			