Chart Review Tool
Mental Health Programs

Note: Before completing this form, save/download to your computer (Workspace); close out this form from the website, then open the form from your computer to complete.

Program:

EHRS/Chart Identifier	Admit Date	Primary Counselor	Review Date

Please review each of the forms in the Resident/Participant chart listed above. Note whether the form is complete or not applicable. Be sure to check for signatures, dates, and ensure that all questions/fields have been addressed. If a form has not been completed, note what information or field is missing.

All admission documents must be signed and submitted on date of admission. All documents which require a participant/resident or staff signature(s) must be signed and submitted on date of service.

	Admissions	Yes / No	N/A
1	Referral Tab is complete.		
2	Client Data is complete.		
3	Screening Tab is complete.		
4	Assignment Tab is correct and complete.		
5	Financial Tab is correct and complete.		
6	Payer Financial Information (PFI) Tab has been completed and contains all necessary signatures. As applicable, the form has been updated each year participant has been in treatment.		
7	Acknowledgement of Receipt.		
8	Admission Agreement.		
9	Advanced Healthcare Directive Acknowledgement Form.		
10	Authorization for the Mutual Exchange of Information: Criminal Justice System.		
11	Authorization for the Mutual Exchange of Information: Emergency Contact.		
12	Authorization for Release of Confidential Information.		
13	Consent via Telehealth or Telephone.		
14	Consent for Email.		
15	Health Questionnaire.		
16	Los Angeles County Department of Mental Health Consent for Services.		
17	Notice of Privacy Practices: Acknowledgement Form.		
18	Fees Agreement (scanned).		
19	Screening Form (scanned).		
20	Copy of Medi-Cal or Insurance Card.		
21	Participant's/Resident's photo and/or copy of I.D./D.L.		
22	Quality of Life Survey (Admission).		
23	If participant/resident has been in treatment for more than one year, the applicable forms have been updated and signed.		

Admissions (continued)
Comments on Admissions section

	Assessment	Yes / No		N/A
1	Effective Date and Service Date are the same and match date of Admission.			
2	Special Service Needs section is completed.			
3	Reason for Referral/Chief Complaint notes the precipitating event that led the participant/resident to seek treatment at the time they did as opposed to any other time.			
4	Current Symptoms and Behaviors (intensity, duration, onset, frequency) and Impairments in Life Functioning caused by the symptoms/behaviors (from perspective of participant/resident and others).			
5	Columbia Suicide Screener is complete including Self Harm section. Assessed for Self Harm and/or need for a Personal Safety Plan.			
6	Mental Health History - Outpatient and inpatient history (include dates, providers, interventions, and responses).			
7	Current Risk and Safety Concerns section is complete.			
8	Relevant Medical Conditions section is complete.			
9	Developmental History section is complete - Only for children.			
10	Medications is noted as: See medication section above and the Medication Tab in Medical Record or at the top of Assessment is completed.			
11	Substance Use / Abuse section is complete.			
12	Relevant Psychosocial Information section is complete: Describe any of the following issues that may impact linkage/referral: education/school history, employment history, vocational information, legal/Juvenile Court history, child abuse/protective service information, dependent care issues, current and past living situations, family history/relationships, family strengths, family history of mental health and substance use/abuse.			
13	Other Agency Involvement section is complete.			
14	Mental Status Exam is completed in the Tab above with comments on each section.			
15	Clinical Formulation and Plan section is complete - Strengths to assist with achieving treatment goals.			
16	Clinical Formulation and Diagnostic Justification: a. General Demographics (age, gender, sexual orientation, gender identity if applicable, and ethnicity).			
17	Clinical Formulation and Diagnostic Justification: b. Presenting problem including history of presenting problem and resulting functional impairments (symptoms and behaviors that substantiate initial diagnosis).			
18	Clinical Formulation and Diagnostic Justification: c. Precipitating event for this treatment episode and referral source if applicable.			
19	Clinical Formulation and Diagnostic Justification: d. Staff perception and appearance of resident/participant including current mental status.			

	Assessment (continued)	Yes / No		N/A
20	Clinical Formulation and Diagnostic Justification: e. Physical Health. Include: health history, current health needs, current pregnancy or prenatal care, medical complications, medication history and current use profile, efficacy of current or previously used medication, and medication allergies or adverse reactions to medications. Also, include complimentary health approaches (use of natural products such as dietary supplements; mind and body practices such as acupuncture, massage therapy, meditation, movement therapy, yoga, and relaxation techniques; and homeopathy, naturopathy, and traditional healers).			
21	Clinical Formulation and Diagnostic Justification: f. Behavioral Health History and Trauma. Include co-occurring disabilities and disorders; past and current treatment history; current level of functioning; history of trauma experienced or witnessed (abuse, neglect, violence, and sexual assault); risk factors and history of suicide, self-harm and violence towards others; and medication (history and current use profile, efficacy of current or previously used medication).			
22	Clinical Formulation and Diagnostic Justification: g. Substance Use History. Include past and current treatment history, substances used, route of administration, frequency of use, duration of use, and any withdrawal potential.			
23	Clinical Formulation and Diagnostic Justification: h. Employment History and Military History.			
24	Clinical Formulation and Diagnostic Justification: i. Legal Involvement. Include: history of incarcerations, Department of Child and Family Services (DCFS), and probation or parole status.			
25	Clinical Formulation and Diagnostic Justification: j. Family, Social, and Life Circumstances. Include living situation, family history, relationships, support, culture, religion, and spirituality. Include family history of mental health and substance use/abuse.			
26	Clinical Formulation and Diagnostic Justification: k. Diagnostic Impression and Recommendations.			
27	Clinical Formulation and Diagnostic Justification: l. Medical Necessity Determination / Level of Care / Access Criteria.			
28	Clinical Formulation and Diagnostic Justification: m. Strengths, Needs, Abilities, Preferences			
29	Disposition, Recommendations, and Plan section are complete? (Note which program participant/resident will initiate services, date to begin treatment, and contact person).			
30	Diagnostic Descriptors: Diagnosis including Mental Health Codes and Medical Codes are complete in the Diagnosis Tab.			
31	Staff signature, license and/or registration/certification number is included.			
32	Written and submitted to LPHA for approval on the date of admission.			
33	Approved by LPHA within 48 hours of admission.			

	Comments on Assessments section

	Assessment / Admission Summary	Yes / No		N/A
1	Demographics (age, gender, sexual orientation, gender identity if applicable, and ethnicity).			
2	Presenting problem resident/participant is seeking treatment for and resulting functional impairments.			
3	Enter Diagnosis from the Assessment.			
4	Summary of Health History and Current Health Needs.			
5	Summary of Behavioral Health History and Trauma.			
6	Summary of Substance Use.			
7	Summary of Legal Involvement.			
8	Diagnostic Impression and Recommendations.			
9	Initial Course of Treatment.			
10	Goals and objectives for treatment.			
11	Orientation – Name of program admitted into, walkthrough of the facility, show where fire extinguishers, emergency exits, first aid kits, Narcan, etc… are located and review of resident/participant handbook. Conducted training on the use of Narcan upon admission.			
12	Medications for Addiction Treatment (MAT) discussed, including referral provided.			
13	Transition planning – referrals for medical, mental health, housing, legal, etc. that resident/participant will need now and at the time of discharge.			
14	Written and submitted on the date of admission.			
	Comments on Assessment / Admission Summary Note section			

	Problem List	Yes / No		N/A
1	Problem List was completed on the date of admission.			
2	Problem List has been updated on an ongoing basis to reflect the current presentation of the resident / participant. This includes adding new problems and or removing problems when there are resolved.			
3	Each Diagnosis has a matching Problem.			
	Comments on Problem List			

	Needs Evaluation Tool (NET) or Child and Adolescent Needs and Strengths (CANS)	Yes / No		N/A
1	Needs Evaluation Tool (NET) or Child and Adolescent Needs and Strengths (CANS) was completed on the date of admission.			
2	All sections are completed, including comments for Specific Needs, if applicable.			
3	Completed annually, if applicable.			
	Comments on Needs Evaluation Tool (NET) or Child and Adolescent Needs and Strengths (CANS) section			

	Annual Client Treatment Plans	Yes / No		N/A
1	Initial Treatment Plan was completed on date of admission.			
2	Treatment Plan Date, Plan End Date, and Next Review Date are correct.			
3	Long-Term Goal is in the participant's/resident's words.			
4	SNAP is addressed in Long Term Goal section.			
5	Objectives are SMART: Specific, Measurable / Quantifiable, Attainable within the Treatment Plan review period, Realistic, and Time-bound.			
6	Objectives must be linked to the resident's / participant's functional impairment and diagnosis / symptomatology; explains how the behavior impairs one of the four areas of functioning (daily activities, social support, living arrangements, or physical health as related to a mental health diagnosis). Uses specific behavioral terms that are individualized to the resident / participant (they are descriptive and not generic).			
7	All information identifying the type and provider of services is included. All services currently provided to the participant/resident are listed. Proposed Frequency and Duration are included.			
8	Client Involvement section is complete with Action Steps required to meet the Objective.			
9	Family Involvement section is complete.			
10	Correct start and end dates for selected Service Categories.			
11	Resident / Participant Signature.			
12	Staff signature license and/or registration/certification number is included.			
13	Written, submitted, and approved on date of admission.			
14	An Updated Treatment Plan has been completed annually.			
	Comments on Annual Client Treatment Plans section			

	Treatment Plan Development Note	Yes	No	N/A
1	Basic Demographics and Precipitating Event.			
2	Substance Use history including each substance, duration of use, frequency of use, and last use.			
3	Mental Health history, symptoms/behaviors that substantiate the initial diagnosis.			
4	Functional impairments.			
5	Primary Goal for treatment.			
6	Initial course of treatment – include quantity of groups and frequency, individual sessions, and the purpose/coping skills development for this course of treatment.			
	Comments on Treatment Development Plan Note section			

	Service Documentation												
	Individual and Group Progress Notes - GIRP												
	Staff First Name:												
	Staff Last Name:												
	Type of Note:												
	Date:												
		Yes	**No**	**NA**	**Yes**	**No**	**NA**	**Yes**	**No**	**NA**	**Yes**	**No**	**NA**
1	Goal - Resident's/Participant's current focus and/or identified short-term goal(s).												
2	Intervention - A narrative describing the service.												
3	Intervention - Goal and objective of the service.												
4	Response - Outcome(s) of the specific interventions, modalities, and/or services.												
5	Response - Resident's/Participant's response to the specific interventions, modalities, and/or services.												
6	Response - Resident's/Participant's progress made towards achievement of identified goal(s).												
7	Plan - Next steps including, but not limited to, planned action steps by the practitioner or by the resident/participant, next scheduled session, collaboration with the resident/participant, collaboration with other provider(s), and any update to the Problem List as appropriate.												
8	Note is unique to the service provided; note could not have been written for another Resident/Participant or another service.												
9	Start and end times are noted.												
10	Documentation date and start and end times are noted.												

Service Documentation (continued)
Comments on Service Documentation section

Medication Support Notes - GIRP													
	Staff First Name:												
	Staff Last Name:												
	Type of Note:												
	Date:												
		Yes	**No**	**NA**	**Yes**	**No**	**NA**	**Yes**	**No**	**NA**	**Yes**	**No**	**NA**
1	Goal - Resident's/Participant's current focus and/or identified short-term goal(s).												
2	Intervention - A narrative describing the service.												
3	Intervention - Goal and objective of the service.												
4	Response - Outcome(s) of the specific interventions, modalities, and/or services.												
5	Response - Resident's/Participant's response to the specific interventions, modalities, and/or services.												
6	Response - Resident's/Participant's progress made towards achievement of identified goal(s).												
7	Plan - Next steps including, but not limited to, planned action steps by the practitioner or by the resident/participant, next scheduled session, collaboration with the resident/participant, collaboration with other provider(s), and any update to the Problem List as appropriate.												
8	Note is unique to the service provided; note could not have been written for another Resident/Participant or another service.												
9	Start and end times are noted.												
10	Documentation date and start and end times are noted.												
	Comments on Service Documentation section												

EHRS/Chart Identifier:

	Medical Record	Yes / No		N/A
1	General Info. Tab in Medical Record is complete.			
2	Medications Tab in Medical Record is complete (Lists all medications, including OTC medications).			
3	Labs Tab in Medical Record is complete.			
4	Vitals Tab in Medical Record is complete.			
5	Clinical Visits Tab in Medical Record is complete.			
6	Dental Tab in Medical Record is complete.			
7	Pregnancy Tab is complete (If applicable).			
8	TB test results are scanned in "External Client Documents" section and tagged as Medical.			
9	County/State required Medical Logs are scanned in "External Client Documents" section and tagged as Medical (Residential Only).			
	Comments on Medical Record section			

	Psychiatric Evaluation	Yes / No		N/A
1	The presenting problem indicates why the participant/residential sought treatment at this time.			
2	Provides a history of the participant's/resident's psychiatric symptoms.			
3	Notes how the current status of the participant's/resident's psychiatric symptoms relates to their history.			
4	Indicates the medications currently prescribed to the participant/resident.			
5	Indicates the medications previously prescribed to the participant/resident.			
6	Summarizes the medical issues experienced by the participant/resident.			
7	Adherence to medication.			
8	Medication allergies.			
9	General medical history is addressed.			
10	Date of last physical exam.			
11	General Health (Height, Weight, BMI, Waist Circumference, etc.).			
12	Current Physical Health Medications (Prescribed, Over The Counter, Herbal).			
13	Other Clinically significant general medical data is addressed.			
14	Substance abuse history indicates the participant's / resident's drug(s) of choice and their period of use.			
15	Participant's/Resident's Family history (Psychiatric, Medical Substance Abuse) is addressed.			
16	Psychosocial History/Developmental History.			
17	Participant's/Resident's current mental status is noted.			
18	Assessment/Clinical Impression.			
19	Psychiatrist and AIA diagnosis are the same.			
20	There is a clear notation of the planned course of treatment including the type and frequency of services (Includes explanation of changes in plan and/or medication).			
21	Chart contains a completed Outpatient Medication Review form.			

	Psychiatric Evaluation (continued)	Yes / No		N/A
22	Completed and submitted on date of service.			
	Comments on Psychiatric Evaluation section			

	Discharge Paperwork	Yes / No		N/A
1	Quality of Life Survey (Discharge).			
	Transition Plan	**Yes / No**		**N/A**
1	Correct Interval selected.			
2	Plan is individualized to participant/resident.			
3	Participant's/Resident's progress in recovery is noted.			
4	Participant's/Resident's SNAP is addressed.			
5	At least two short-term goals are noted.			
6	At least two long-term goals are noted.			
7	Information regarding referrals made is noted.			
8	Signed by the participant/resident.			
9	Staff signature, license and/or registration/certification number is included.			
10	Written, submitted and approved within 24 hours of service date.			
11	Session, Other and Appointment times are noted.			
	Comments on Discharge Paperwork and Transition Plan sections			

	Discharge Summary Note	Yes / No		N/A
1	Indicates admit, discharge and date of last contact.			
2	Indicates why the participant/resident sought treatment from the program at the time of admission (Precipitating Event).			
3	Identifies the goals the participant/resident had for their treatment experience (In their own words).			
4	Describes the participant's/resident's progress in their recovery and treatment.			
5	Indicates the reason for discharge and circumstances surrounding the participant's / resident's discharge.			
6	Indicates the discharge plan/treatment recommendations.			
7	Indicates behaviors treated to address each area of impairment and provides the baseline/goal/and status at discharge.			

	Discharge Summary Note (continued)	Yes / No		N/A
8	Interpretive summary includes the participant's/resident's demographic information.			
9	Interpretive summary includes impressions / observations of the participant/resident by staff (Impressions of what you thought happened and why).			
10	Interpretive summary describes the participant's / resident's response to the services provided.			
11	Medications are noted.			
12	Information regarding referrals made is noted.			
13	Written, submitted and approved within 24 hours of service date.			
14	Staff signature, license and/or registration / certification number is included.			
15	Session, Other, and Appointment Times are noted.			
	Comments on Discharge Summary Note section			

Reviewer Name, Signature, Date

Program Director Name, Signature, Date