Clinical Record Review Tool

Date of Review: ___________________

REVIEW INFORMATION		
Client Name:	DOB:	Case #:
Primary Clinician:	Reviewer:	Case is: ☐Open ☐Closed

PROGRAM
☐OPT ☐CSM/SC Adult ☐CSM/SC Child ☐HSW ☐ACT ☐IDDT ☐Psychiatric

LEGAL	YES	NO
Client has a legal guardian?		
If yes, court papers are present?		

VERBAL	YES	NO
Client is verbal?		

DIAGNOSIS:

Primary:____

Secondary: ____

Tertiary: ____

Additional: ____

____

____

LIVING ARRANGEMENTS
☐Independent ☐Semi-Independent ☐AFC ☐Specialized Residential
☐Other: ______________________

ASSESSMENT	YES	NO
Did Recovery Technology complete the Assessment?		
If No, which LifeWays Network Provider completed the Assessment?		

If client participates in an Evidence Based Practice or is a child, please be sure to also complete the appropriate sections noted.

*If client refused to provide consent, please mark N/A for the appropriate elements.

ELEMENT #	ASSESSMENTS	YES	NO	N/A
1	Psychosocial is present? Date: ___________________________			
2	Input/Coordination with others is present			
3	Current Symptoms (pg. 6) are identified and recorded as observed or reported?			
4	Substance Abuse History has “comments” even if marked “N/A”?			
5	Mental Health Treatment History filled out completely?			
6	Psychiatric Date? _______________			
7	Psychological Date? ____________________			
8	Nursing Date? _________________________			
9	OT Date? _____________________________			
10	PT Date? _____________________________			
11	Nutrition/Dietary Date? ________________			
12	Health Screen Appraisal Date? ___________________________			

ELEMENT #	NATURAL SUPPORTS	YES	NO	N/A
13	Natural Supports were assessed?			
	Need identified? ☐ Yes ☐No			
14	✓Action taken?			
Comments:				

ELEMENT #	COMMUNITY INCLUSION AND MEANINGFUL DAY ACTIVITIES	YES	NO	N/A
15	Community inclusion and meaningful day activities were assessed?			
	Need identified? ☐ Yes ☐No			
16	✓Action taken?			
Comments:				

ELEMENT #	HEALTH ASSESSED	YES	NO	N/A
17	Health was assessed?			
	Need identified? ☐ Yes ☐No			
18	✓Action taken?			
Comments:				

ELEMENT #	SAFETY AT RISK BEHAVIORS	YES	NO	N/A
19	Safety and at-risk behaviors were assessed?			
	Need identified? ☐ Yes ☐No			
20	✓Action taken?			
Comments:				

✓ **If need is identified an action should have been taken and therefore documented**

ELEMENT #	PRE-PLANNING	YES	NO	N/A
21	♦Pre-plan present?			
	♦If no, reason? ____			
	♦Pre-plan date: ______________________			
22	♦Personal preferences are considered?			
23	♦Client/Guardian chose location, time and date of meeting?			
24	♦Client/Guardian chose participants in the meeting?			
25	♦Independent facilitator was offered?			
26	Information on the Informal Complaint Process was given?			
27	Client was oriented to services?			
28	Release of Information forms are current?			
29	Consent for participation is current?			
30	Fee Assessment/Assignment of Benefits is current?			

♦ **#21 – #25 do not apply to OPT – Mark N/A**

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ELEMENT #	TREATMENT PLANNING/IPOS	YES	NO	N/A
31	Treatment Plan is current?			
32	If IPOS was updated in the treatment year, there is an Addendum present?			
33	Crisis Plan was offered?			
34	If client chose to have a Crisis Plan, it is in the record?			
35	Notice of Hearing Rights was given?			
36	Copy of IPOS was given w/in 15 (business) days of the treatment plan date?			
37	Update/Sent date was completed?			
38	IPOS was signed by a licensed practitioner?			
39	IPOS was signed by client/guardian?			
40	If Adequate Notice was given, it was timely?			
41	Frequency of face-to-face contacts is documented?			
42	Quarterly Reviews are present (Monthly for OPT)?			
43	Quarterly Review indicates on-going client satisfaction?			
44	IPOS includes amount, scope and durations?			
45	Goals match personal desires?			
46	Goals are measurable?			
47	Goals are recovery focused?			
48	For "Specialized" clients, the PC/CLS Form or HCBS Form is attached to IPOS?			
49	For "HAB Waiver" clients, the HAB Waiver Support Services Form is attached?			

ELEMENT #	PROFESSIONAL RECOMMENDATIONS ADDRESSED IN PLANNING (Service is an identified need, referrals made, service is occurring)	YES	NO	N/A
50	Occupational Therapy			
51	If yes to # 52, OT Prescription is present?			
52	Physical Therapy			
53	Registered Nurse			
54	Primary Clinician			
55	Psychosocial Rehab			
56	Registered Dietician			
57	For Children, ABA Supports			
58	For ID/D - SIS Assessment			

ELEMENT #	PROGRESS NOTES			
59	Progress Notes address goals from the IPOS?			
60	Progress Notes reflect on-going need for service?			
61	Progress Notes reflect the appropriateness of the service?			
62	Progress Notes address community integration?			
63	Progress Notes support services are occurring as outlined in the IPOS or, if IPOS is not occurring as outlined, Progress Notes reflect the deviation from goals/amount/scope, etc.			
63.1	If no, what notes are missing or what other documentation is missing?			
Comments:				

ELEMENT #	CHILDREN'S CASES ONLY	YES	NO	N/A
64	IPOS includes family focused elements?			
65	If applicable, a copy of IEP from school is in the record?			
66	CAFAS is occurring at the established frequency? (quarterly)			
	Last CAFAS date: ________________			
67	ABA Supports are in place?			

*If client refused to provide consent, please mark N/A for the appropriate elements.

ELEMENT #	ACT CASES ONLY	YES	NO	N/A
68	Client is seen at appropriate level of care per Treatment Plan (at least 2 hrs wk)?			
69	Evidence that the client is receiving interventions to promote health?			
70	Evidence that the client is being seen by multiple team members?			
71	Natural Supports are included in the treatment plan?			
72	Evidence of rapid response to early signs of relapse (increased contacts, support)?			
73	Evidence of counseling/therapy services being provided?			
74	Evidence of other supports being provided (housing, employment, etc.)			

ELEMENT #	ACT & IDDT CASES ONLY	YES	NO	N/A
75	Contacts are occurring in the community?			
76	Quarterly nursing contacts are occurring in the community?			
77	Bost Mental Health and Substance Use are addressed in the Treatment Plan?			
78	Evidence of staging taking place (may be in separate book)?			

ELEMENT #	DBT CASES ONLY	YES	NO	N/A
79	Evidence the client is attending group on a regular basis?			
80	Evidence that skills coaching has been offered? (form in scanning)			
81	There is a signed DBT treatment agreement?			
82	Natural supports are included in the treatment plan?			
83	Does the client have a diagnosis of borderline personality disorder?			
84	Is the treatment contract renewed if in DBT for over a year?			
85	Evidence of primary and secondary targets being addressed in individual sessions?			
86	Evidence of clinician using Behavioral Chain Analysis?			

ELEMENT #	PSYCHIATRIC SERVICES	YES	NO	N/A
	Client receives RT or LW Network psychiatric services? ☐ Yes ☐No			
	******If no, where are they getting psychiatric services? ________________________			
87	If yes to #86, AIMS testing is present?			
88	If yes to #86, Lab work was ordered within the year?			
	If yes to #86, What is the date of last prescription: ___________________			
89	If yes to #86, Medication Consent Forms are present?			
90	If yes to #86, Medication Consent Forms are signed by client/guardian?			
91	If yes to #86, LW Psych, Medication Consent Forms are signed by MD/DO/RN/NP			
92	***If no** to #86, There is a consent to exchange information with their psychiatric provider (noted above******)?			
93	*If yes to #92, is there clear evidence that information was requested?			
94	*If yes to #92, is there clear evidence that information was received?			

ELEMENT #	ADDITIONAL	YES	NO	N/A
95	*There is a consent to exchange information with others identified in the IPOS?			
96	*There is evidence of coordination with others identified in the IPOS?			
97	*There is a consent to exchange information with the Primary Care Physician (PCP)?			
98	*There is evidence that the clinician requested information from the PCP?			
99	*There is evidence that information was received from the PCP?			

ELEMENT #	BEHAVIOR TREATMENT PLAN	YES	NO	N/A
	Client has a Behavior Treatment Plan ☐ Yes ☐No			
	If yes, are there restrictions? (Meds for behavior control, restriction of rights, etc.)			
100	If yes, has the case been reviewed by LW Behavior Treatment Committee?			

ELEMENT #	DISCHARGE	YES	NO	N/A
101	Discharge/Transition planning is completed			

*If client refused to provide consent, please mark N/A for the appropriate elements.