

Tri State Child Health Services

Psychiatry/Psychology Medical Record Review Tool for Therapy and Treatment
(Note: to also be used for CCHMC-employed Social Workers within Psychiatry Department)

Clinician Name: _____

Review Date: _____ Review Person(s) _____ Credential - Recredential

Note: This document is part of the quality assessment activities of TriState PHO and, as such, is a confidential document not subject to discovery pursuant to Ohio Revised Code Section 2305.25 and 2305.251. All Committees involved in the review of this document, as well as those individuals preparing and submitting information to such Committees, claim all the privileges and protection afforded by ORC 2305.25, 2305.251, and 2305.28 and any subsequent legislation.

Need to see documentation by each physician in practice (minimum of 5 records each)	Yes = 1 No = 0	Yes = 1 No = 0	Yes = 1 No = 0	Yes = 1 No = 0	Yes = 1 No = 0	Balance
Record Number						
1. Each page in record contains the patient's name or identification number.(Ex. Sticker chart)						
2. Personal/biographical data includes:						
a. Address						
b. Employer and/or School						
c. Responsible person (parent/guardian/self)						
d. Informed consent for medication (psychiatry only) and understanding of treatment plan						
e. Home and work telephone numbers						
3. All entries in the MR contain the author's identification. Author identification may be a handwritten signature, an initials-stamped signature, or a unique electronic identifier.						
4. All entries are dated						
5. Entries are legible by review person (Another/second reviewer for any judged illegible)						
6. Significant illnesses and medical conditions are indicated on an intake problem list.**						
7. Allergies and adverse reactions or NKA are prominently noted in the record.** (psychiatry)						
8. Past medical history in record to include:						
a. Prenatal events						
b. Perinatal events						
c. Developmental and physical history						
d. Psychological and Social history						
e. Intellectual and academic history						
9. Appropriate past psychiatric history in record if applicable.						
10. For patients 14 years and older there is an appropriate notation concerning the use of tobacco, alcohol, and other substances						
11. Diagnostic evaluation that includes:						
a. Pertinent history						
b. Presenting problems/complaints						
c. Relevant psychological and social conditions						
d. Imminent risk of harm – suicide ideation or homicidal ideation						

12. Mental status evaluation documents: (If able to determine, example too young) Examples: Patient's affect, speech, mood, thought process, judgment, insight, attention, impulse control.						
SCORE FOR THIS PAGE:						
Clinician Name:	Date of Review:					
13. Documented working diagnoses are consistent with findings **						
14. Record indicates treatment plan goals and objectives are documented and consistent with diagnoses (tests, prescribed medications, referrals) **						
15. Documentation of patient's strengths and limitations in achieving treatment plan goals and objectives.						
16. Notation regarding preventative services such as relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources.						
17. Notation regarding follow-up care (call, visit, time specific and place)						
18. Patient's who are or become homicidal or suicidal or unable to conduct activities of daily living are promptly referred to the appropriate level of care.						
19. Termination summary if the patient has terminated treatment.						
20. Patient/parent education documented if indicated at visit						
21. Neither over or under utilization of consultants is apparent						
22. If a consultation was requested, a note from the consultant is in the MR						
23. Consultation, lab, imaging or other reports filed in the chart are initialed by the clinician to signify review (Nurse practitioner and physician assistant do not meet requirement). If reports are presented electronically or other method, there is a note by the clinician that these have been reviewed.						
24. Explicit notation of follow-up plans documented after consultation, abnormal lab or other studies.						
25. Documentation that results of clinically significant tests/labs have been discussed with patient/parent.						
Total scores for this page						
Total scores from page one						
Total of both Scores						
Total Possible	36	36	36	36	36	36
Not applicable	()	()	()	()	()	()
Net possible score						

Required score to pass = **85%** of **Sum of Net Possible Scores** of all charts reviewed

Sum of Net Possible Score _____

85 % of Net Possible Score _____ or Minimum score required to Pass

Total Score of charts reviewed _____

PASS (Medical Record Review combined scores meet or exceed required minimum)

FAIL (Medical Record Review combined scores did not meet required minimum)

** Criteria strongly recommended by NCQA standards