Medical Record Standards
Outpatient Mental Health Chemical Dependency Facility
Independent Practicing Practitioners

The medical record shall be current, available, and include all the following:

1. An identification sheet that includes:
    a. Patient's full name
    b. Date of birth (month/day/year)
    c. Sex (gender)
    d. Name of next of kin, responsible person or an emergency contact
    e. HAP ID must be documented in the HAP patient medical record

2. The patient's assessment must be completed by the second visit and includes:
    a. Onset of illness
    b. Provisional diagnosis
    c. Substance abuse patients: completion of bio-psycho-social assessment (includes physical exam completed within the past six months)
    d. Mental health patients: complete history including physician exam completed within past six months
    e. Primary care physician identified
    f. Drug and alcohol/assessment
    g. Baseline liver profile and CBC prior to prescribing neuroleptic medication
    h. Immunization record if patient under 18 years of age

3. Each patient must have an individual treatment plan and must be completed by the second visit and include:
    a. Strengths and weaknesses
    b. Patient input
    c. Diagnosis
    d. Short and long-term goals
    e. Treatment time frames and reassessment dates
    f. Risk behaviors
    g. Specific treatment modalities
    h. Treatment referrals
    i. Revised every 30 days
    j. Individualized to the patient

4. Progress notes must contain the following:
    a. Entries by physician responsible for care
    b. Entries by Allied Health professionals participating in the patient's treatment
    c. Entries documenting each patient encounter
    d. Session type identified for each patient encounter
    e. Documentation for "no show" appointments
    f. Evidence of communication with the PCP

5. A written consent for treatment must be signed by the patient or legally responsible individual.

6. A medication record must be maintained when patient receives medication and include:
    a. Side effect (long term) assessment
    b. CD patients only, receive random drug screens
    c. AIMS testing conducted on a quarterly basis when on neuroleptic drugs
    d. Medication effects must be documented
    e. A written consent for medication treatment must be signed by the patient or legally responsible individual

7. Charting practices must include the following:
    a. All entries must be signed and dated by provider of care/services
    b. Record organized to facilitate review
    c. All entries legible

8. A discharge summary must be present if inpatient care occurred.