Department of Mental Health

Child, Adolescent, and Family Unit

Client Record Review Form

File Review Date: Click here to enter text.

File Reviewer Name: Click here to enter text.

Agency/Service Provider: Click here to enter text.

Record #: Click here to enter text.

Client DOB: Click here to enter text.

Services/Programs: Check all that apply for current rating period.

ECMH ☐
SB6 Clinician ☐
SB6 BI Program ☐
Outpatient ☐
JOBS ☐
Crisis ☐
EFT ☐
ISB ☐
Residential ☐
Other ☐ Click here to enter text.

NOTES TO REVIEWERS

- The Compliance Section elements have one rating for present/not present and doesn't have a quality component. The Quality Section elements have two rating sections to indicate if the element is present/not present and then a quality rating if it is present.
- When indicating that something needs attention, please explain in the "comments" section.

Revised 5/2016

CAFU Chart Review Form
Compliance Section

Standard/Guideline	Present (1)	Not Present (0)	N/A	Comments
A. GENERAL				
General Information				
1) Signed authorization by parent/guardian to release information form ◊	☐	☐	☐	Click here to enter text.
2) Consent to evaluation & treatment/services signed by client	☐	☐	☐	Click here to enter text.
3) Medical home/PCP identified or evidence thereof	☐	☐	☐	Click here to enter text.
4) Dental home identified or evidence thereof	☐	☐	☐	Click here to enter text.
SECTION I SCORE				
B. CLINICAL EVALUATION, ASSESSMENT AND/OR SCREENING ◊				
Presenting Issues, Symptoms and History				
1) Assessment is completed within 45 days of intake or within 2 years for a re-evaluation	☐	☐	☐	Click here to enter text.
Formulation Interpretive Summary				
2) Qualified provider's name and credential are present (see guidance document for specific requirements)	☐	☐	☐	Click here to enter text.
SECTION II SCORE				
C. PLAN OF CARE				
1) If the initial plan fell under the period under review it was completed within 45 days of client initiating services. For prenatal to age 6, the plan must be completed within 45 days of referral ◊	☐	☐	☐	Click here to enter text.

Standard/Guideline	Present (1)	Not Present (0)	N/A	Comments
2) If the plan is an update, it was completed within the last year.	☐	☐	☐	Click here to enter text.
3) Signature of psychiatrist/ psychiatric nurse practitioner is required **only if** any of the following conditions are present:	☐	☐	☐	Click here to enter text.
4) The family's and/or youth's signature is present. If signature is not present, there is evidence that the plan is reviewed with the client and family.	☐	☐	☐	Click here to enter text.
5) Signature of clinician (at least licensed master's level clinician operating within the scope of their licensure or an advanced practice psychiatric nurse practitioner operating within the scope of their licensure)	☐	☐	☐	Click here to enter text.
SECTION III SCORE				
D. Crisis Management and Screenings				
1) If appropriate, there is a proactive crisis plan	☐	☐	☐	Click here to enter text.
SECTION V SCORE				

IFS Chart Review Form
Quality Section

Standard/Guideline	Minimum Standard			Quality Review				Comments
	Present (1)	Not Present (0)	N/A	Needs Attn. (1)	Meets Std. (2)	Exceeds Std. (3)	N/A	
I. CLINICAL EVALUATION, ASSESSMENT AND/OR SCREENING ◊								
A) Presenting Issues, Symptoms and History								
1) History of presenting issues, needs or deficits, target symptoms from multiple informants, where appropriate, and described in multiple settings (home, community, school)	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
2) The evaluation clearly indicates why the family and youth have asked for help and what they hope to accomplish. This includes the liabilities and weaknesses	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
3) Educational information and relationships with school and teachers	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
4) Clear indication of client's strengths, abilities, interests, and, resources.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
5) Developmental history and needs	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
6) Medical history	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.

Standard/Guideline	Present (1)	Not Present (0)	N/A	Needs Attn. (1)	Meets Std. (2)	Exceeds Std. (3)	N/A	Comments
7) Psychosocial history • Significant life events and family history • Relationships with family & friends, including who currently lives in household • Natural supports: who are they and how do the youth and family wish others to be involved? • Family Stressors (income/housing/food insecurity, legal issues) • Education information and relationship with school & teachers. • Cultural, ethnic/spiritual resources & influences	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
8) Complete mental status exam	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
9) At least one standardized screening/assessment tool is used to assess clients' functioning and/or care/treatment needs	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
10) Evaluation is trauma informed as evidenced by the following: a brief trauma screen, if screen yields a positive result a follow up trauma assessment is completed or child is referred for an assessment	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
11) Documentation of screening for substance use/ abuse is present (if applicable)	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
12) A full substance abuse assessment is completed for treatment implications, if indicated.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.

Standard/Guideline	Present (1)	Not Present (0)	N/A	Needs Attn. (1)	Meets Std. (2)	Exceeds Std. (3)	N/A	Comments
13) DSM 5 or ICD Diagnosis is consistent with evaluation findings	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
14) Clinical formulation or interpretive summary that uses the information gathered, is developmentally sensitive, and identifies strengths and needs.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
15) Clear and specific treatment/supports/services recommendations that address presenting issues and target symptoms	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
16) Treatment/supports/services recommendations reflect best practices	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
SECTION I SCORE								
II. Plan of Care								
1) Goals/outcomes are meaningful to and have been developed in partnership with client and families, as evidenced by documented input from client	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
2) Goals reflect evaluation and/or other assessments, or recent progress notes if the plan is an update.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
3) Plan includes at least one goal with a clear mental health focus	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
4) Goals have realistic, measurable action steps that clearly define the work and expectations between service provider and family.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.

Standard/Guideline	Present (1)	Not Present (0)	N/A	Needs Attn. (1)	Meets Std. (2)	Exceeds Std. (3)	N/A	Comments
5) Client's plan is accessible and easy to understand for the consumer.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
6) Special status situations, such as imminent risk of harm, suicidal/homicidal ideation, are actively considered and integrated into the plan of care (consider how to take into account confidentiality of parents).	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
7) Type of intervention or service, frequency and time frame are identified	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
8) Plan articulates expected outcomes -What would indicate successful completion of a goal.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
9) Documentation shows who will provide services (an identified name is preferred, but at least a title or position is required).	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
10) Signature of qualified provider on treatment plan (see standards/guidelines for service-specific requirements)	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
SECTION II SCORE								
III. SERVICE DELIVERY & DOCUMENTATION								
A) General								
1) Progress notes document service modality and describe contact, purpose, intervention used, observations, and client's response.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.

Standard/Guideline	Present (1)	Not Present (0)	N/A	Needs Attn. (1)	Meets Std. (2)	Exceeds Std. (3)	N/A	Comments
2) Intervention content is consistent with client's plan goals.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
3) Progress notes document the positive interventions and supports used. ○ If a safety need warrants a restriction or modification to the client-focused plan, it is supported by a specific assessed need and the positive interventions and supports that were attempted prior to the modification are well documented	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
4) Interagency coordination is evident if appropriate	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
5) There is evidence of consultation for complex cases or clients making little or no progress	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
6) Service is delivered or supervised by a qualified provider as noted by clinician signature, degree, and date.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
7) If progress isn't being made on their goals, the reasons are clearly articulated and revisions, if appropriate, to the plan are made.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
8) Progress notes are individualized to the client's service interactions and do not contain excessive repetition over time	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
SECTION III A SCORE								

Standard/Guideline	Present (1)	Not Present (0)	N/A	Needs Attn. (1)	Meets Std. (2)	Exceeds Std. (3)	N/A	Comments
B) Medical Care								
1) Medical History is explored with a summary of health issues/events and allergies (could be included in intake evaluation, discharge summary, psycho-social evaluation, psychiatric evaluation, or noted separately).	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
2) If appropriate, there is documentation of integration or collaboration with primary care.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
3) If seeing a psychiatrist outside of the organization, the chart must contain a psychiatric evaluation.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
4) If the child receives psycho-pharmacologic supports from the DA, the medications are documented with dosage, route and schedule. There is a list of medication changes, start dates and refills.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
5) Medication use or benefits are reflected as well as medical/psychiatric information changes.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
6) If medication management is provided by private provider, there is evidence of coordination and input in treatment planning.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
SECTION IIIB SCORE								

IV. Crisis Management Plan and Screenings								
Standard/Guideline	**Present (1)**	**Not Present (0)**	**N/A**	**Needs Attn. (1)**	**Meets Std. (2)**	**Exceeds Std. (3)**	**N/A**	**Comments**
1) If there are crisis screenings, does the screening form include the following: a. A clear description of the situation b. Safety issues are identified if present and a plan to address them c. If the situation is easily resolved, is there a description of resolution and a follow-up plan identified if appropriate.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
2) If a full screening is appropriate, there is a mental status exam, consultation w/ MD or psychiatrist, the level of care needed is identified, resources are explored, and resolution described with follow- up plan identified.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
3) If client is admitted to hospital or hospital diversion, is there evidence of discharge planning and participation from the DA/SSA	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
SECTION IV SCORE								
V. PERIODIC REVIEW & ASSESSMENT OF PROGRESS								
1) A standardized screening or assessment tool is used to periodically assess progress on goals.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.

Standard/Guideline	Present (1)	Not Present (0)	N/A	Needs Attn. (1)	Meets Std. (2)	Exceeds Std. (3)	N/A	Comments
2) Information from this screening/assessment tool and progress notes are used to inform client plan goals and service delivery as appropriate.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
3) Documentation of ongoing need for continuing intervention (with any description of change in approach if necessary).	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
4) Intensity of services match the documentation of need.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
SECTION V SCORE								
VI. TRANSITION & DISCHARGE PLANNING								
1) Evidence of proper transition/exit planning documentation and notifications. ◊	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
2) If client is receiving services through residential care, there must be ongoing DA participation in treatment and discharge planning.	☐	☐	☐	☐	☐	☐	☐	Click here to enter text.
SECTION VI SCORE								

IFS Chart Review Form
Qualitative Information

Strengths were noted in the following areas: Click here to enter text.
Careful consideration needs to be paid to the following areas of this file: Click here to enter text.
The following needs immediate attention: Click here to enter text.