	ODS 2010 Behavioral Health Record Review - Global Scores
93%	1- Do all pages contain patient name and/or patient identification number?
97%	2- Is address contained in demographic information?
97%	3- Is home phone contained in demographic information
93%	4- Is marital status contained in demographic information? (N/A if child)
94%	5- Is guardianship information documented, when appropriate?
93%	6- Are emergency contacts documented?
95%	7- Is there a consent to treatment form in the treatment record?
98%	8- Is there a release of information form in the treatment record? (N/A if no previous treatment and no other providers/family with whom to coordinate care)
84%	9- Do all entries in the treatment record include the responsible clinician's name and professional
100%	10- Are all the entries dated?
100%	11- Is the record legible?
100%	12- Are medication allergies and adverse reactions to medications or the lack of them (NKDS/NKA) prominently displayed on the outside of the record or immediately upon opening the record? (N/A if chart is for therapy services only--no medical/psychiatric services)
N/A	13- Is there documentation of informed consent for medication? (N/A if provider is not prescribing)
88%	14- Is there documentation of coordination of care with PCP and/or other medical providers? (N/A if patient refuses or has no medical providers)
100%	15- Is the record organized, permitting effective patient care and quality review?
70%	16- Are all documents in the record securely attached in the chart?
92%	17- Are relevant medical conditions listed, identified and revised?
87%	18- Is there documentation of a medical and psychiatric history which includes previous treatment dates, practitioner identification, therapeutic interventions and responses, sources of clinical data, relevant family information?
85%	19- If the patient is 17 y.o. and younger, does the history include prenatal and perinatal events, along with complete developmental history (physical, psychological, social, intellectual, and academic history)?
87%	20- If patient is 12 y.o. or older, is there documentation of past and present use of tobacco, alcohol, illicit, prescribed and over-the-counter drugs?
99%	21- Is there documentation of presenting problems, along with relevant psychological and social conditions affecting the patient's psychiatric status?
85%	22- Is there an assessment of special status situations, such as imminent risk of harm, suicidal ideation, or elopement potential?
89%	23- Is there documentation of a mental status evaluation that includes affect, speech, mood, thought content, judgment, insight, attention or concentration, memory
93%	24- Is a DSM-IV diagnosis documented?
96%	25- Is the DSM-IV diagnosis consistent with the presenting problems, history, mental status examination, and/or other assessment data?
2%	26- Is there documented use of a standardized screening tool for alcohol (e.g, CAGE, A 4 question
19%	27- Is there documented use of a standardized screening tool for for depression (e.g., PHQ-9, A 9 question depression screening)?
90%	28- Are treatment plans consistent with diagnoses?
88%	29- Do treatment plans have objective measurable goals?
80%	30- Is there documentation that the patient or responsible party understands the treatment plan?
92%	31- Is the focus of treatment interventions consistent with the treatment plan goals and objectives?

100%	32- Is there documentation of what medications have been prescribed, the dosages of each and the dates of initial prescription or refills? (N/A if chart is for therapy services only--no
N/A	33- Are results of laboratory tests found in record? (N/A if provider has not ordered any lab tests)
100%	34- If a consultation is ordered, is there a report in the record?
91%	35- Are the patient's strengths and limitations in achieving the treatment plan goals and objectives documented in the progress notes?
68%	36- Is there documentation that patients who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care?
17%	37- Is there consistent use of an objective outcomes measure?