



Agency code	
Date of review	
Client record ID	
Clinical reviewer	

1 Client Demographics

A	Date of birth ___ / ___ / ____ <input type="radio"/> if no dob in chart, age on 8/1/2008 ____ <input type="checkbox"/> Age not documented								
B	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Not documented in chart								
C	Race/Ethnicity (select one) <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino/a <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> More than one race <input type="checkbox"/> Not documented in chart <input type="checkbox"/> Other: Specify:								
D	HIV risk factor (check all that apply) <input type="checkbox"/> Men who have sex with men (MSM) <input type="checkbox"/> Injecting drug user (IDU) <input type="checkbox"/> Heterosexual contact <input type="checkbox"/> Hemophilia/coagulation disease or receipt of blood products <input type="checkbox"/> Perinatal transmission <input type="checkbox"/> Undetermined/unknown <input type="checkbox"/> Not documented in chart <input type="checkbox"/> Other: Specify:								
E	ZIP code client residing in on 8/1/2008 (or first entry in review period) _____ City, if no ZIP code indicated: _____ <input type="checkbox"/> Not documented in chart								
F	Client's rights documentation Does client chart contain a signed statement by the client that he/she received a copy of:? <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">1. Client rights and responsibilities</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>2. Consent for treatment</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>3. Agency's grievance procedures</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>4. Client confidentiality agreement</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	1. Client rights and responsibilities	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Consent for treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Agency's grievance procedures	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Client confidentiality agreement	<input type="checkbox"/> Yes <input type="checkbox"/> No
1. Client rights and responsibilities	<input type="checkbox"/> Yes <input type="checkbox"/> No								
2. Consent for treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No								
3. Agency's grievance procedures	<input type="checkbox"/> Yes <input type="checkbox"/> No								
4. Client confidentiality agreement	<input type="checkbox"/> Yes <input type="checkbox"/> No								

2 Clinical performance measures

Note: If a patient's chart includes multiple treatment episode, then for the purpose of this review, select the most recent admission/transfer to substance abuse services that occurred before the end of the review period (July 31, 2009), and complete this instrument based on this selected treatment episode. (i See instructions for further guidance on selection of the treatment episode for review.)

G Treatment Episode: Transfer 1. Is the treatment episode being reviewed the result of a patient transfer from another of level of care at the agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

Dates of review period: August 1, 2008 to July 31, 2009

H Substance abuse assessment

Note: Substance abuse assessment may have been completed prior to the beginning of the review period (August 1, 2008); if there are multiple treatment episodes, please review the assessment associated with the treatment episode being reviewed.

1. Does patient chart document completion of substance abuse assessment?


Yes  **CONTINUE TO H.1.a**
 No  **GO TO H.3**

a) Date completion of substance abuse assessment: ___ / ___ / ___ Date not documented

2) Does patient chart document as part of assessment each of the following?

a) Medical history	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) TB testing/screening	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Current medications and allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) Current substance use/abuse pattern	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e) History of prior treatment for substance abuse/dependence	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f) Emotional/behavioral problems, treatment and/or history	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g) History of trauma: physical/sexual abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h) Name of the patient's primary care physician	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i) Home and/or living environment	<input type="checkbox"/> Yes	<input type="checkbox"/> No

3) Diagnostic impression of substance abuse and/or dependence defined by DSM-IV:

Instructions: For each axis indicate the documented diagnosis (list DSM-IV code, if provided; otherwise, list written diagnosis) or check "Not documented" if no diagnosis is documented. (Note: If there is no multi-axial diagnosis, then check "Not documented" in each of the 5 axes.) 

Axis I Not documented

Axis II Not documented

Axis III Not documented

Axis IV Not documented

Axis V/GAF Not documented


▶Current GAF: _____

▶Highest GAF in previous 12 months: Not documented

a) Was this diagnostic impression confirmed by a physician?

Yes  **CONTINUE TO H.3.b**
 No  **GO TO H.4**

b) Date of confirmation of diagnostic impression: ___ / ___ / ___ Date not documented

4) Level of residential care recommended established by ASAM Patient Placement Criteria 

Level not documented
 III III.1 III.3 III.5 III.7 IV Other/specify

ASAM levels: III-Residential/Inpatient; III.1 Clinically Managed Low-Intensity Residential Treatment; III.3-Clinically Managed Medium-Intensity Residential Treatment; III.5-Clinically Managed High-Intensity Residential Treatment; III.7-Medically Monitored Intensive Inpatient Treatment; IV-Medically Managed Intensive Inpatient Treatment

Dates of review period: August 1, 2008 to July 31, 2009

I Patient Admission to Residential/Inpatient Substance Abuse Treatment Program

Note: The substance abuse admission associated with the treatment episode being reviewed may have occurred prior to the beginning of the review period (August 1, 2008).

1. Does patient chart document admission to substance abuse treatment program?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> CONTINUE TO I.i.a	<input type="checkbox"/> No	<input checked="" type="checkbox"/> END REVIEW
a) Date of admission: ___/___/___ <input type="checkbox"/> Date not documented				
b) Level of care of admission ⓘ: <input type="checkbox"/> Level not documented <input type="checkbox"/> III <input type="checkbox"/> III.1 <input type="checkbox"/> III.3 <input type="checkbox"/> III.5 <input type="checkbox"/> III.7 <input type="checkbox"/> IV <input type="checkbox"/> Other/specify				
c) Was this admission confirmed by a physician?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> CONTINUE TO I.i.d	<input type="checkbox"/> No	<input checked="" type="checkbox"/> GO TO I.i.e
d) Date of confirmation of admission: ___/___/___ <input type="checkbox"/> Date not documented				
e) Was a comprehensive medical history and physical conducted by a physician, NP or PA,?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> CONTINUE TO I.i.f	<input type="checkbox"/> No	<input checked="" type="checkbox"/> GO TO I.i.g
f) Date of history and physical: ___/___/___ <input type="checkbox"/> Date not documented				

J Initial Treatment Plan

Note: The initial treatment plan associated with the treatment episode being reviewed may have been completed prior to the beginning of the review period (August 1, 2008). ⓘ

1. Does patient chart document an initial treatment plan?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> CONTINUE TO J.i.a	<input type="checkbox"/> No	<input checked="" type="checkbox"/> GO TO K
a) Date of initial treatment plan: ___/___/___ <input type="checkbox"/> Date not documented				
2. Is the treatment plan signed and dated by each of the following?				
	Signed		Dated	
a) Medical director/physician	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Patient	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Professional staff member with primary responsibility for services to patient	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Does the initial treatment plan include the following?				
a) Problems (i.e., injury, dysfunction, loss)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
b) Goals (i.e., statement to guide resolution or reduction of problem)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
c) Objectives (i.e., observable and measurable signposts on the way to achieving the goals)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
d) Methods of service (i.e., treatment services to be provided, site, intensity and duration)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
e) Intensity of services	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
f) Treatment methods specified in plan:				
<input type="checkbox"/> No treatment methods specified	<input type="checkbox"/> family counseling			
<input type="checkbox"/> individual counseling	<input type="checkbox"/> group counseling			
<input type="checkbox"/> family-member counseling	<input type="checkbox"/> individual or group education			
<input type="checkbox"/> peer support	<input type="checkbox"/> neuro-psychiatric treatment/pharmaceuticals			
<input type="checkbox"/> opioid maintenance therapy	<input type="checkbox"/> relapse prevention program			
<input type="checkbox"/> Buprenorphine therapy	<input type="checkbox"/> pre-treatment program/recovery readiness			
<input type="checkbox"/> detoxification				
<input type="checkbox"/> Other/Specify:				
g) Time table for achieving the goals and objectives	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
h) Time frame for continued stay reviews	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
i) Patient education (medication, AIDS risk reduction, infectious disease/TB)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

Dates of review period: August 1, 2008 to July 31, 2009



K Continued Stay Review

Note: The continued stay reviews associated with the treatment episode being reviewed applies only to reviews conducted during the review period (August 1, 2008 - July 31, 2009). (i See instructions for further guidance on continued stay reviews.)



1. Check the level of admission for the treatment episode being reviewed and respond to question for that level.

No level of care documented  **GO TO TO L**

Level III Admission

a) Is a continued stay review documented every 14 calendar days of admission? Yes  **CONTINUE TO Kc**
 No  **GO TO TO L**

Level IV Admission

b) Is a continued stay review documented every 24 hours of admission? Yes  **CONTINUE TO Kc**
 No  **GO TO TO L**

Is **every** continued stay review signed **and** dated by?

	Signed		Dated	
c) Patient	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) Professional staff member with conducting the review	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

L Progress Notes/Documentation of Service Delivery



Note: The progress notes/documentation applies only to services documented during the review period (August 1, 2008 to July 31, 2009).

1. Do progress notes/documentation of **every unit of service** include the following?

a) Type of service delivered	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Location of service delivery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Time and duration of each service delivered	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) Name and credentials of person who provided the service	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e) Signed and dated by individual making the entry	<input type="checkbox"/> Yes	<input type="checkbox"/> No

M Discharge/Transfer

Note: Discharge/Transfer associated with the treatment episode being reviewed applies only if completed during the review period (August 1, 2008 to July 31, 2009).

1. Was the patient discharged/transferred from substance abuse services during the review period? Yes  **CONTINUE to M.1.a**
 No  **END REVIEW**


a) Date of discharge/termination: ___ / ___ / ___ Date not documented

2. Does the patient chart contain a discharge/transfer summary? Yes  **CONTINUE to M.2.a**
 No  **END REVIEW**

a) Date of discharge/transfer summary: ___ / ___ / ___ Date not documented

3. Does discharge/transfer summary include the following?

a) Reason for discharge/transfer

- Reason for discharge/transfer not documented**
- Patient transferred to another ASAM level of care;  Specify: From Level ___ to Level ___
- Patient no longer meets criteria for need for continued active treatment
- Patient request /Patient left AMA
- Patient did not participate in treatment/services; terminated by agency per policy
- Patient incarcerated
- Patient death
- Other/Specify:

b) Progress of the patient relative to each goal and objective in the plan Yes No

c) Prognostic statement of the patient's condition at discharge Yes No

d) Patient's continued recovery plan Yes No