Appendix F

Magellan Healthcare
EAP Clinical Record Review Tool

Magellan Case #		Date Reviewed	
Clinician Name		Reviewer Name	
Client Company/Code		Reviewer Title	

Score	N/A	Audit Item
		1. Is the Statement of Understanding (SOU) completed and signed? (If a required company-specific SOU was not used, score "0".)
		2. Is there a history, course and duration of the presenting problem?
		3. Is demographic information presented, either in face sheet, client intake form, or documentation?
		4. Is permission to contact and how to contact client clear? (Both required. See Client Information Form.)
		5. Is there documentation of environment or home support?
		6. Is the client's relevant medical information documented?
		7. Were workplace issues identified where present?
		8. Does documentation include descriptions of client's strengths and limitations in achieving goals?
		9. Was risk of suicide and threat of harm to others assessed?
		10. Is the DSM diagnosis, problem formulation and prognosis complete?
		11. Does documentation include a screening for substance abuse? If screening indicates potential substance abuse, was a complete evaluation that includes detailed current pattern of use and consequences completed if client is age 12 and older?
		12. Are the goals and strategies behaviorally specific and measurable?
		13. If there were special identified needs (e.g., religion, race, culture, gender, sexual orientation, physical condition) did the therapist appropriately address these issues?
		14. If risk/threat of violence (TOV) was identified, was the intervention appropriate and adequate?
		15. For treatment involving more than one session, do progress notes document the client's effort to implement interventions or attempts at behavior change (e.g., progress toward goal)?
		16. Does the documentation support the clinician's decision to refer or not to refer for specialized treatment?
		17. When a post-treatment referral is indicated, were appropriate providers/resources identified and was the client given choices (e.g., MD for medication needs, higher level of care, community/self help resources)?
		18. If the client was referred, is there documentation of link-up and follow-up?
		19. Were there follow-up contacts (or attempts) with the client within 4 weeks?
		20. Is there documentation of the outcome of the case? (e.g., client chose not to continue, case resolved, case referred)?
		21. Results of supplemental assessment are included when appropriate. (e.g., CD assessment, depression assessment)
		22. Documentation of case consultation when needed.
		23. Is the Authorization to Use and Disclose Protected Health Information (AUD) complete, including a) to whom, b) signature, c) witness signature, and d) date?
		24. Were all entries/documents signed by the clinician with credentials noted?
		25. Is the record legible, organized, and easy to follow?
		26. For treatment involving more than one session a counseling plan was developed and the client agreed to the plan.