



Holistic PsychHealth Treatment Record Documentation Standards

1. Each page in the treatment record contains the patient's name/identification number.
2. Each record includes the patient's address, employer or school, home and work telephone numbers including emergency contacts, marital/legal status, appropriate consent forms and guardianship information, if relevant.
3. All entries in the record include the provider's name, signature, professional degree, and identification number (if applicable).
4. All entries are legible.
5. All entries are dated.
6. Each record includes copies of appropriate release of information, consistent with State/Federal regulations.
7. Informed consent for medication/treatment and the patient's understanding of the treatment plan is documented.
8. Presenting problems and relevant psychological and social history affecting the patient's medical and psychiatric status are documented.
9. Special situations such as imminent risk of harm and suicidal ideation are prominently noted, documented and revised. For patients who become homicidal, suicidal, or unable to conduct activities of daily living and are promptly referred to the appropriate level of care, the disposition is noted.
10. Each record indicates what psychotropic medications have been prescribed, dosages of each, and dates of prescription or refills. Each record indicates that psychotropic medication side effects have been explained.
11. Where applicable, the psychiatrist physician record indicates that the results of laboratory tests have been documented and reviewed.
12. Allergies and adverse reactions and/or lack of known allergies/sensitivities to pharmaceutical and other substances are prominently noted.
13. A medical and psychiatric history is documented, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, and relevant family information.
14. A complete developmental history for children and adolescents, including prenatal and postnatal events, is documented.

15. A substance abuse assessment for patients 12 and older, which includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs, is documented.
16. A mental status evaluation, which includes the patient's affect, speech, mood, thought content, judgment, insight, attention/concentration, memory and impulse control, is documented.
17. A DSM-5 Diagnosis code and criteria are documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data. This will include insight specifier (good, poor, absent), diagnosis specific severity scale and diagnostic rule out.
18. Treatment plans are consistent with diagnoses and have objective, measurable goals and estimated time frames for goal attainment or problem resolution. The focus of treatment interventions is consistent with the treatment plan goals and objectives.
19. Progress notes describe patient strengths and limitations in achieving treatment plan goals and objectives.
20. Patient/family education and recommendations are documented.

Holistic PsychHealth Treatment Record Handling Standards

1. Providers will maintain confidentiality of treatment records according to applicable state and federal regulations.
2. Providers will limit access to treatment records.
3. If release of treatment records to an outside party- other than per member or representative written request, contracted entity for review/audit purposes- providers will release treatment records only in accordance with a court order, subpoena or statute. Providers should ensure that any such request for records be legally obtained.
4. Treatment record locations must be secure and accessed only by approved personnel.
5. Any treatment records sent to storage must be secure and retrievable.
6. The treatment record must be available at each appointment.
7. Purging of treatment records must be done according to state statute.