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Compliance with the Standard of Care

BEGINNING PHASE

Create rapport

Mental status exam (use form)

Details of presenting problem

Medical
- Current medical issues
- Current symptoms
- Referrals / releases for medical concerns
- Medical history

Drug & alcohol
- Current use / issues
- Drug & alcohol history
- Recovery assessment
- Referrals for drug / alcohol concerns

Crisis / danger issues
- Suicidal
- Mandates
- Domestic violence
- Violence
- Drug / alcohol abuse (impairs ability to function)
- Protocols

Disclosures / Authorizations
- Informed consent
- Consent to treat a minor
- HIPPA notice
- Releases

Other legal & ethical issues
- Dual relationship conflicts
- Safety plans
- Other referrals

Therapy history

Family history

Relational history

Human diversity considerations
- Ethnicity, culture, marital status, age, religion, socioeconomic status, specific group affiliations…

Set and prioritize goals for treatment

Assessment tools

Client strengths and weaknesses

MIDDLE PHASE

Areas of concern / optional diagnosis
- Optional provisional diagnosis
- Optional v-codes
- Justification for diagnosis
- Psychosocial stressors, environment…

Theoretical orientation
- Which theory might help this client best and why?
- Is your theoretical choice based on the symptoms you see and your client's goals?

Theory Specific Treatment Plan (initial & updated)
- Treatment goals (1-5 short and long-term goals)
- Interventions (several tied to each goal)
- 1st goal: forming a therapeutic alliance
- Crisis situations?
- Scientific or theoretical rational for the intervention
- When appropriate, rationale for ruling out certain standard interventions
- Response to plan

Progress notes
- Documentation of progress / lack thereof
- Evaluation of the effectiveness of the interventions
- Reactions to interventions
- Evolving nature of relationship
- Changes in diagnosis / areas of concern
- Why certain interventions may not have worked

Prognosis
- What factors would indicate improvement?
- What could impede improvement from happening?
- Based on clinical judgment and experience of client, how likely is client to improve or not?

When applied, records should include:
- Test results
- Collateral information
- Consultations
- Referrals
- Follow ups
- Crisis interventions
- Emergency sessions
- Special phone calls
- Authorization to treat and to release information
- Office policies
- HIPAA notices and authorizations

Extra documentation is often required in the following cases:
- Emergencies
- Violence, abuse
- Mandated reporting
- Boundary crossings and dual relationships
- Abrupt termination
- Crisis intervention
- And in complex clinical, legal and ethical cases

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END PHASE

- Termination notes
- Gains
- Work in progress
- Open door
- Support system