

OUTPATIENT DOCUMENTATION REQUIREMENTS

- A. The Physician Initial Assessment should contain all of the following:
1. Date of patient contact
 2. Identifying data
 3. Reason for visit
 4. History of present illness
 5. Past psychiatric history including prior medication trials and the clinical response, medication adherence and side effects if applicable or available
 6. Substance abuse history – including list of substances used as well as the prescription controlled medications, last use, amount and duration of use and substances overdosed with
 7. Past medical history – particular attention to prior head injuries, neurological disorders, cardiac history
 8. Developmental history in children
 9. Drug allergies
 10. Family history of mental illness- include diagnoses and treatment response if known
 11. Personal/Social history
 12. Current medications- include prescription, non-prescription, alternative remedies, medication adherence and side effects
 13. Mental status examination, including assessment of suicidality and homicidality
 14. Diagnostic formulation
 15. Treatment plan – use Biopsychosocial model
 - A. In all patients with suicidal or homicidal ideation, or histories of violence toward self or others, document a dangerousness risk assessment emphasizing protective and exacerbating factors.
 - B. Address risks of treatment during pregnancy or breast feeding if applicable
 16. Consent for medications
 17. Release of information if necessary
 18. Physician signature
- B. The Physician Progress Note, for each medication visit, should contain all of the following:
1. Date (month/day/year)
 2. Location where service was provided
 3. Type and duration of service
 4. Information in the subjective section of the progress note should be pertinent to symptoms/diagnoses listed in the assessment section.
 5. Description of treatment response

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6. Assessment of adherence (medication and appointments) and steps taken to address non-adherence
7. Assessment of medication side effects & plan to address them
8. Assessment of laboratory data and vital signs (if applicable)
9. Assessment of substance use (if applicable)
10. Status of medical appointments and conditions
11. Mental state examination including SI/HI status
12. Documentation of rationale for medication changes; if symptoms are noted, rationale for continuing the current regimen
13. Documentation of dangerousness risk assessment and plan, if applicable. If suicidality and homicidality present, documentation should include risk assessment and plan to address them
14. Treatment plan including frequency of follow up appointments
15. Physician signature

C. Physician's Order Sheet

1. All new orders including lab orders or changes in the patient's medication regimen by the physician are to be written here (applicable to clinics with paper chart).
2. Reserved for Physician's order only

D. Outpatient Prescription Forms must include, but not limited to:

1. 2 patient identifiers
2. Physician's name and signature