

Contents of Case Files

CHART

<u>Left Side</u>	<u>Right Side</u>
1) *Spousal & DV Reporting	
2) *HIPAA	
3) Face Sheet	
4) Master Problem List	
5) New referral	
6) What I want from Treatment	
7) Verification letter	Progress Notes ONLY!
8) Releases (inc. HIV)	
9) Cultural Assessment	
10) Biopsychosocial Assessment	
11) CBHS Assessment	
12) MPI Psych/Social Assessment (Clt completes)	
13) HIV Counseling Info/HCV Risk/Voc-Rehab form (if applicable)	
14) ASI-Lite	
15) Patient Treatment Plan (Clt completes)	
16) Treatment Plan	
17) Intervention Forms w/assignments	
18) ORS/SRS	
19) Referrals	
20) Recovery Planning	
21) Discharge Summary (book version)	

- No white-outs, scotch tape, etc.; corrections must be single-lined through, such as:

“Clt met with this counselor for first assessment. Clt expressed no interest in receiving SUD’s services as this time however clt states he is interested in family sessions to assist with marital problems. Clt agreed to meet with Family Therapist for evaluation ASAP.”

- Case file should have minimum of 4 problems with interventions. Charting must include:
 - 1) Date, problem #, time, type of session
 - 2) Chart notes MUST be in DAP or SOAP style
 - 3) Chart minimum of 3x weekly, such as: 1) group, 2) 1x1, 3) family session (you should have 6 notes total)
 - 4) Chart notes must be signed and include credentials, i.e., Stout, MA, CADC II
 - 5) Only blue or black ink can be used, no pencil or colored inks
 - 6) Be sure to sign off on Master Problem List
- Problems can be selected from Counseling text (see me)
- See Chap 24 for Goals and Objectives
- See Chap 23 for Charting

- See Chap 25 for D/C Summary
- See Chap 21 for Referrals and Charting
- See p 267 for hints on how to present your case
rev 1.20.10