

BHRS Standards for Clinical Records

- I. All clinical records will be maintained for seven (7) years from the date of last service. For children, the records will be maintained for seven (7) years from last service or until one year after the child reaches age 18, whichever comes later.
- II. All clinical records will be kept in a securely locked area.
- III. The assessment must contain:
 - a. Presenting problems and relevant conditions affecting physical and mental health status (e.g. living situation, daily activities, and social support, cultural and linguistic factors and history of trauma or exposure to trauma);
 - b. Mental health history, previous treatments dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information, lab tests, and consultation reports;
 - c. Physical health conditions reported by the client are prominently identified and updated;
 - d. Name and contact information for primary care physician;
 - e. Medications, dosages, dates of initial prescription and refills, and informed consent(s);
 - f. Past and present use of tobacco, alcohol, and caffeine, as well as, illicit, prescribed, and over-the-counter drugs.
 - g. Client strengths in achieving goals.
 - h. Special status situations and risks to client or others;
 - i. Allergies and adverse reactions, or lack of allergies/sensitivities;
 - j. Mental Status Examination
 - k. Diagnosis consistent with the presenting problems, history, mental status examination and/or other clinical data, and,
 - l. For children and adolescents, prenatal events, and complete developmental history, and,
 - m. Additional clarifying formulation information, as needed.
- IV. Assessments will include the following information:
 - a. Any danger to self or others;
 - b. A secondary substance-related diagnosis whenever present.
- V. Each face-to-face client contact will be documented in legible progress notes which will include the following:
 - a. Relevant clinical interventions and decisions;
 - b. Signature (or electronic equivalent) of person providing the service with professional degree, licensure, or job title;
 - c. Date of service;
 - d. Amount (length) of time of the session;
 - e. Referrals to community resources, when appropriate;
- VI. Client Plan characteristics
 - a. Consistent with diagnosis,
 - b. contains specific, observable or quantifiable goals and a proposed duration to treatment;
 - c. The focus of intervention is consistent with the client's goals,
 - d. Contains the client's signature or documentation of why the signature could not be obtained and/or

- e. The client's participation in, and agreement with the plan is documented in the progress notes.

VII. Timeframes

- a. Assessments will be completed within 60 days of the date of first contact.
- b. The Client Plan will be completed within first 60 days from the date of first session, renewed no later than 1 year from initial plan and annually thereafter if services are continued.