# Behavioral Health Chart Audit Sample Tool

Use this tool to review clinical documentation for compliance, medical necessity support, and accreditation readiness.

## Patient Identification

- Patient name and identifiers present
- Admission date documented
- Diagnosis documented with ICD code
- Consent for treatment signed
- HIPAA acknowledgment documented

## Assessment and Intake

- Comprehensive assessment completed
- Substance use or mental health history documented
- Risk assessment completed
- Medical history documented
- ASAM level of care documented if applicable

## Treatment Planning

- Individualized treatment plan present
- Goals measurable and clinically relevant
- Treatment plan signed by clinician
- Treatment plan reviewed and updated as required
- Patient participation documented

## Progress Notes

- Progress notes present for each service date
- Notes reflect interventions provided
- Notes support treatment plan goals
- Notes signed and dated by clinician
- Documentation supports continued stay

## Discharge Documentation

- Discharge summary present
- Aftercare plan documented
- Reason for discharge documented
- Referrals documented if applicable
- Patient condition at discharge recorded