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ORGANIZATIONAL CONTROL THROUGH ADMINISTRATIVE FORMS

A Case Study of Documentation at a Public Psychiatric Hospital

by

EDITH SOLL

A dissertation submitted to the Graduate Faculty in Sociology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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Abstract

ORGANIZATIONAL CONTROL THROUGH ADMINISTRATIVE FORMS

A Case Study of
Documentation at a Public Psychiatric Hospital

by

Edith Soll

Adviser: Professor Robert Alford

The impetus for this thesis was the observation that from the mid 1970s to the early 1990s documentation on forms that comprised psychiatric medical records became increasingly central to organizational processes at a public psychiatric hospital. One of the effects of that trend has been a substantial change in the nature of work for members of professions designated to treat psychiatric inpatients, as resources were increasingly allocated toward generating entries in medical records and oversight of those entries.

Precipitants of increased documentation on forms at the psychiatric hospital were noted to be related not only to increased use of forms in the general society but also to the financial and legal pressures that have been affecting public psychiatric services in particular. Unless psychiatric medical records display compliance with a

multitude of specifications, regulatory groups, established by entitlement legislation to survey health care facilities, will not release funds on behalf of patients. A by-product of the civil rights movement was legislation that afforded rights for psychiatric patients, including the right to treatment and the right to refuse treatment; substantiation that those rights have been not been violated is expected to be evidenced in patients' records. Wariness about potential litigation induced further concerns about documentation. Uncertain technology and uncertain product extant in psychiatric services are additional factors that have resulted in cumbersome, often stressful documentation processes. Since it is difficult to demonstrate the value of specific staff inputs entries on sanctioned forms are structured to reassure the reader.

Organizations develop forms in reaction to external and internal pressures. Forms are designed, through questions stated and allocation of spaces, to elicit requested data and constrain responses not deemed pertinent. Forms therefore become mechanisms for inculcating organizational ideology. While organizations control documentation output through forms, individuals who must fill them out can be targeted for accountability purposes when they provide required signatures, thus participating in generating their own vulnerabilities for self-incrimination.

ACKNOWLEDGEMENTS AND DEDICATION

First and foremost I must convey my gratitude to my advisor, Robert Alford. He has been steadfast in his support, encouragement and guidance over the long time period (yes, it was overly long!) that I took to complete this project. His belief that I could and should do it became a beacon when self doubt plagued me. Thanks also to Paul Attewell and Lindsey Churchill, members of my committee.

While I appreciate all of the support and help I had from friends, I owe a special thanks to Marilyn Glass. To my son, Clifford, thanks for the technical help when I needed it.

I would like to acknowledge staff at The Psychiatric Center who assisted and supported this study. This thesis is dedicated to those of you who strive to remain clinicians despite the bureaucracy.

CONTENTS

ABBREVIATIONS

CPL	Criminal Procedure Law
DAP	Data, Assessment, Plan
DMH	Department of Mental Hygiene
HCFA	Health Care Financing Administration
JCAH	Joint Commission on Accreditation of Hospitals
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LPN	Licensed Practical Nurse
MHLS	Mental Health Legal Services
MHTA	Mental Health Therapy Aide
OMH	Office of Mental Health
PMR	Periodic Medical Review
RN	Registered Nurse
TPC	The Psychiatric Center
UCR	Uniform Case Record

ORGANIZATIONAL CONTROL THROUGH ADMINISTRATIVE FORMS

INTRODUCTION

Over the course of my employment at a New York State Psychiatric Center, a period of more than twenty years, I observed certain changes that I believed warranted a formal study. Psychiatric medical records seemed to have become increasingly central to the organization. Processes involved with their compilation had resulted in sets of dilemmas. There was increasing emphasis on the forms that comprised those medical records. Increased focus by the organization on administrative forms enabled psychiatric medical records to become central.

The main research question is: What are the causes and effects of the proliferation of administrative forms utilized by public psychiatric organizations? Secondary questions are: What explains the emphasis on the use of particular kinds of administrative forms as the basis for entries in the psychiatric medical record? What explains New York State Psychiatric Centers' increased focus on medical records with concomitant increased allocation of scarce resources in that direction? What are the

consequences of increased focus on administrative forms for organizational functioning? What are the effects on the staff who fill out psychiatric medical record forms? What are the effects of filling out forms on interactions among psychiatric patients and staff? How does the language of forms effect displays of ideology?

By the term "administrative forms" I mean those common sheets of paper that have defined spaces for answers to written questions. Generally individuals who fill in spaces also are required to sign in a space allotted for that purpose, thus acknowledging who entered those notations, and thus accepting responsibility for what has been stated. We all use administrative forms; they are prototypical artifacts of modern daily life. They are the kinds of documents we all know what others mean when they talk about having to fill out "the form". Administrative forms are organizational tools that have propelled bureaucratic processes throughout society. These processes have enabled displays of control in the daily lives of most individuals. A major example is the degree to which an organization, the United States Government, is able to reach into the private lives of the population. Internal Revenue Service forms concern every individual and business. That there is a vast "underground" economy with multitudes of people seemingly outside the government's grasp does not dispute this

argument since hidden economic activities must be conducted with recognition of likely penalties upon discovery.

We are a population habituated to filling out forms, providing information about ourselves to faceless, distant centers. We are also habituated to signing those forms, thus accepting potential self-incrimination aspects of that act. We learn to answer questions as asked on forms and not enter "extraneous" comments. Organizations also learn from forms. When reviewing entries on filled out forms organizations can decide that their forms don't elicit sufficient data or respondents have been able to avoid giving a full "accounting". Since forms are readily adapted for various purposes, information not requested on one form can appear when a subsequent one is issued. Therefore through forms an arena of non-personal interaction is created.

In this study I analyze the forms used by the New York State Psychiatric Center, emphasizing those constituting medical records. Since the mid 1970s there has been a substantial increase in the number and kinds of administrative forms comprising patient medical records. Many of the forms have become more detailed, with increased demands for specificity of information, as numerous examples will verify. In attempting to derive possible causes of those changes it was necessary to review changes that had

taken place at the organization, The Psychiatric Center, and to explore important extra-organizational factors. Legal and financial pressures from a variety of sources have resulted in increased emphasis on documentation in medical record forms.

As would be expected, documentation requirements affect those required to document: the staff. Increased emphases on documentation has changed the nature of work for the clinical professions, sometimes expressed by the dichotomy of "paperwork instead of peoplework." As documentation has become more central to the organization, issues surrounding that paperwork became increasingly an arena of staff interaction. Elaborating how staff has reacted to pressures of changes in documentation requirements and what those reactions have been are important aspects of this study.

Methodology

This case study has been based in large measure upon my observations as a participant in (as an employee of) The Psychiatric Center. Holding titles of Social Work Supervisor, Outpatient Clinic Coordinator and Treatment Team Leader, progressively, I was delegated responsibility for ensuring the paperwork output of others, and when necessary and feasible doing that work myself; as a Certified Social Worker I was qualified to make any entries due from social

workers, but not from members of other professions. I had been present at multitudes of meetings and situations during which forms and their usage were primary issues. Examples are many: when forms were introduced with instructions about disseminating regulations related to their use; reports about the status of medical record documentation were presented and discussed with strategies devised to correct deficiencies; conferences about and/or with employees who were "behind"; displays of rage by employees who expressed resentment at being coerced into documenting in accordance with regulations they believed to be inane; displays of anguish and resentment by employees who expressed feeling overwhelmed by "all those forms"; and disputes about who was expected to complete which forms.

Far from being detached about the outcomes of what has just been described, I often viewed them as matters of utmost importance. In other words, often I was in the fray. For example at some of the meetings mentioned it was suggested that Treatment Team Leaders should be designated as the staff category that should write treatment plans (forms which will be discussed later). In order to guard against being "shafted", I was vociferous in opposition. When one of "my" staff demonstrated poor paperwork skills I was concerned about possible reflections upon myself. As a participant, there was no question of my "going" native, I

was a native. It was, after all, how I earned my living. That level of participation had, it turned out, advantages for the purposes of developing this study; I did not have to induce circumstances that would provide opportunities for observing medical record documentation processes -- such situations were pervasive and inescapable. Nor did I have to lead or induce my colleagues to talk about problems related to medical record documentation processes, we were in the same boat. For the most part I have limited illustrations of staff activities to that which I participated in or observed directly and, particularly when there might be implications of ethical or even legal breaches, I want to make it clear that no staff were used as informants.

Forms used by The Psychiatric Center have been another major source of the data upon which this study is based. Forms that comprise the medical record are discussed in detail. Those designed to track staff's medical record entries were also an important group of forms analyzed here. Additionally, many other forms and their usage have provided examples of form documentation processes at the organization. Further sources of data were manuals, newsletters and memoranda concerned with documentation requirements. The terms "psychiatric medical record", "medical record", "patient record", "record" and "chart" are used interchangeably throughout this research.

The Study

Chapter 1 is a brief historical overview of organizational documentation perspectives that led to psychiatric medical records' reliance on form usage to attempt control of workers' activities. Widespread use of forms, according to JoAnne Yates, can be traced to the first decades of the twentieth century because of their usefulness in facilitating management's control of growing commercial organizations. Peter Blau (1963) provides an attempt at organizational control through statistical reports. Documentation of "the examination" of defective individuals, Michel Foucault claims, was an expression of power over those subject to and subjects of surveillance. Effects of dossier compilations are described by Jaber Gubrium (1979), Erving Goffman (1961) and John Johnson (1973). Harold Garfinkel (1967) directed attention to missing entries in records as worthy of study. Forms, as phenomenon in records or as a contrast with narratives, are commented upon by Stanton Wheeler (1969), Abbott Weinstein (1975) and Marc Berg(1996). Stanley Raffel (1979) and Marc Berg (1996), from differing perspectives, studied effects of record keeping practices on patient care in medical hospitals. Addressing what he saw as a need to better organize medical records Lawrence Weed (1969) introduced the "problem oriented medical record", a concept that became a major

influence in medical record keeping practices. Particular problematics of psychiatric records were described by Kai Erikson and Daniel Gilbertson (1969) and Erving Goffman (1961). Ralph Ryback, Richard Longabaugh and Robert Fowler (1981) noted that accountability pressures mandated psychiatric records reflect the problem oriented format. New York State's Office of Mental Health mandating that its psychiatric centers all use a Uniform Case Record format is presented as a response to accountability pressures and as mechanism to attempt control over staff activities.

Sources of accountability pressures, financial and legal, are elaborated in chapter 2, "The Medical Record, The Regulators and the Law". New York State statutory laws, outcomes of court cases, and criteria developed by organizations with authority to survey psychiatric organizations become incorporated into psychiatric medical records.

Chapter 3, "The Organization", discusses the Psychiatric Center's place within a system of public mental health services. The organization, beset by uncertainty of technology and uncertainty of product, is presented as attempting to manage its staff activities, using documentation on forms as both display and control mechanisms. The organization's need to manage its forms is demonstrated.

Chapter 4 tracks medical record usage from patients' admissions to discharges. Using an inpatient ward as the locus of records, duties of clinical staff are described and their record documentation responsibilities are delineated. Impediments to completing record documentation are illustrated.

Audit preparation processes are depicted in chapter 5. Of note is the extent to which they expend resources and generate tensions and intimidations among staff. An audit is recounted to illustrate effects of audit processes. Appendix A contains examples of forms and memoranda pertaining to audit preparation.

Chapter 6 presents discussions of selected forms to illustrate their historical development and documentation processes they entail. Additionally all forms on the 1991 file order form are described and discussed. Copies of those forms will be found in appendix B.

Chapter 7 discusses some implications of the study for organizations that develop forms and individuals who must fill them out.

CHAPTER 1

DOCUMENTATION

This overview of documentation is presented since a key aspect of this study is to demonstrate that organizations develop administrative forms in order to elicit entries that facilitate their control over staff behavior. Weber notes documentation as fundamental to his definition of bureaucracy:

> The management of the modern office is based upon written documents ("the files") which are preserved in their original draght form. There is, therefore, a staff of subaltern officials and scribes of all sorts.[1]
>
> ....The combination of written documents and a continuous operation by officials constitutes the "office" (Bureau) which is the central focus of all types of modern organized action.[2]

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[1] Weber: 1946 p. 197

[2] Weber: 1968 p. 219

The documents do not belong to the "scribes", but to the "office", thus enabling its perpetuity. Weber mentions files and documents but seems to assign them a passive role, providing a record of the actions of the "scribes". Hall reifies this stance in his discussion of organizational goals, observing that many activities are not goal related since "Some activities are sheerly administrative, such as filling out forms which assure that the organization is complying with some set of government regulations."[3] In the following chapters I will illustrate the degree to which documentation can become central to, rather than merely a byproduct of, organizational activity.

Carruthers and Espeland postulated that double entry bookkeeping (which Weber claimed was vital to the development of capitalism), has rhetorical as well as manifest aspects. Comparing rambling narrational account records used in the fourteenth century with tabular groupings of double entry bookkeeping, the authors said it is the latter that allows for displays of legitimacy: "Accounting must be understood as an attempt to convince some audience of the legitimacy of the business venture".[4] Throughout this paper illustrations will be offered to

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[3] Hall: 1982 p. 31

[4] Carruthers and Espeland: 1991 p. 31

demonstrate the extent to which documentation in the psychiatric medical record is determined by the organization's attempt to reassure potential audiences.[5]

That documentation requirements became a means to attempt control of activities within organizations was illustrated by Yates in her study of the development of management trends:

> Systematic management as it evolved in the late nineteenth and early twentieth centuries was built on an infrastructure of form communication flows; impersonal policies, procedures, process and orders flowed down the hierarchy; and documentation to coordinate processes crossed the hierarchy. The flow of documents were primary mechanisms of managerial control.[6]

It was during this period that firms developed and increased the use of forms to facilitate control Yates said:

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[5] On a personal note, I am very familiar with double-entry bookkeeping since it was how I earned a living for over a decade. I vividly recall repetitive, seemingly endless entries onto journal and ledger forms. At a critical personal juncture I enrolled in Social Work School so that I could have an interesting, meaningful job working with people; that led later to employment at a New York State psychiatric center. Filling out forms for the psychiatric medical record and compiling data about entries became increasingly reminiscent of the work entailed with double-entry bookkeeping. The "deja vu" sensation was one of the stimuli for choosing this area to study.

[6] Yates: 1989 p.20

> Either notes or forms could be used to communicate specific instructions....some systematic and scientific managers adopted printed or duplicated forms with standard elements and space for filling in specific details, for conveying routing instructions as efficiently as possible. Forms were widely used as part of the upward reporting system; they could also, one form expert pointed out, be used to "provide the means for carrying out decisions and policies."[7]

Yates informs us of Frederick Taylor having advised daily distribution of instruction cards to each worker with directions that output be entered in allotted spaces. Forms, Yates said, were thus simultaneously mass communication and individual communication. She tells of a book "devoted entirely to the design and use of forms" having been published in 1925, an indication that their expanding usage was just beginning. Contrary to our association of forms with bureaucracy, it was their utility for commercial enterprises that initially spurred their growth.

Attempts at organizational control through documentation has also been illustrated by Blau. He conducted research in a department of a public agency geared

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[7] Ibid.: p. 73

to finding jobs for the unemployed. Statistical data were compiled to evaluate agency workers' performances, using the number of employment referrals made as criteria, and then widely distributing the results among the staff. Blau illustrated intimidation aspects of much documentation in the following:

> What makes statistical records of performance a potent force is that they make differences and deficiencies in performance generally visible not only to every official, but also to colleagues and superiors.[8]

Blau noted that following implementation of those statistical records workers shifted their energies toward developing data that would improve their standing even if it meant disservice to clients, for example referring them for jobs for which they were not suited and could not obtain. He said the data collection "had consequences that transformed them from an indirect means for controlling operating operations into a direct mechanism of control".[9] Observe, though, that the control attempts by the organization were subverted into control attempts by the employees.

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[8] Blau, P.: 1963 p.50

[9] Ibid.: p. 37

Compilations of documentation about individuals has been an ongoing focus of interests and concerns. Those compilations may be called "files", "dossiers", "records" or "charts" under varying circumstances. Compilers may be in the private or public sectors: examples of the former are credit reports and corporate personnel files, examples of the latter are public school records and, most relevant to this study, state hospital psychiatric medical records. A number of writers have observed that those compilations induce "case building", that is justifications for records or dossiers having been developed. What is entered into those files may, in addition to reflecting the past, influence futures of individuals for whom files exist. Tracing back to the eighteenth century views that individuals considered defective should be subjects of and subject to the surveillance of "the examination", Foucault says that its documentation:

> clearly indicates the appearance of a new modality of power in which each individual receives as his status his own individuality, and in which he is linked by his status to the feature, the measurements, the gaps, the 'marks' that characterize him and make him a 'case'.[10]

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[10] Foucault: 1977 p.192

Those who were in a position to do the writing were thereby documenting the inferiority of those written about Foucault points out, a familiar characteristic of case building.

Gubrium, referring to documentation in what he calls "the human service record" said that the individuals and problems portrayed "are as much the products of staff members' participation in record completion as they are descriptions of clients in need."[11] To provide an example he described a conflict that erupted between two residents at a residential treatment center for emotionally disturbed children. He recounted that a teacher, unaware of the reasons for the start of the conflict, apparently contributed to its escalation. The teacher proceeded to document in the residents' records statements of "acting out", statements which are reviewed by other staff when they make decisions about meting out rewards and punishments. Gubrium observes that "the social organization of record keeping" produces written accounts of disturbed individuals and not of the institution, staff or situations. Records "do not reveal their practical productions"[12] Nothing that the teacher wrote indicated that she too may have been "acting out".

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[11] Gubrium: 1979 p. 260

[12] Ibid.: p. 272

In a similar vein Goffman earlier wrote that one of the purposes of the psychiatric record is:

> to show the ways in which the patient is "sick" and the reasons why it was right to commit him and is right currently to keep him committed; and this is done by extracting from his whole life course a list of those incidents that have or might have "symptomatic" significance.[13]

At The Psychiatric Center it is far more important now that records show why patients are justifiably being contained since patients have more "rights" and the organization is under greater financial and legal constraints than at the time Goffman made his observations.

Earlier in this chapter display of legitimacy was linked to the value accorded accounting records. Wheeler, who edited a volume about records, listed "legitimacy" as one of the distinctive characteristics of dossiers.[14] Zimmerman, who studied intake processes at a public welfare agency asked, "How do such records achieve the authority of objective and impersonal accounts of persons' lives?" He had noted that eligibility assessments were dependent upon documents such as birth certificates, bank statements and "a

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[13] Goffman: 1961 pp. 155-156

[14] Wheeler: 1969

case narrative dictated by the worker."[15] Zimmerman concluded that: "whatever the use or misuse of records, they attain their significance largely because they are regarded as official, authoritative accounts".

Johnson, in an unpublished thesis, focused on "the heretofore unanalyzed social organization of *doing record-work* and *doing statistics-work.*"[16] His study was conducted at a welfare agency where social workers were expected to make home visits to clients in order to assess their eligibility for funds and services. The workers, who had to document results of those visits, often expressed much inner conflict about how to write accounts of what had occurred. For example they might have witnessed or heard something which, if entered into the record, could have resulted in a cut-off of funds and by accurate, full reporting would violate some sense of allegiance to their clients, resulting in a moral dilemma for some. Workers' concerns with respect to constructing official records were "(1) the 'audience' who will read them, namely one's supervisor, and (2) judgements of the actual or potential evaluative use to which such records might be put."[17]

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[15] Zimmerman: 1969 p. 325

[16] Johnson: 1973 p. 3

[17] Ibid.: p. 162

Concern for potential use of records had earlier been stated by Garfinkel. During the course of attempting to collect data from records at an outpatient psychiatric clinic he noted the paucity of information available to him. Garfinkel, in focusing on this "trouble", determined that administrators and personnel knew that "the information must be gathered for unknown purposes that only the future can reveal."[18] Those who wrote in records were aware of not being able to predict when, why and by whom the records would be reviewed and were therefore uneasy about providing specific information: "Candor in reporting carries well known risks to careers and to the organizations".[19] Lack of documentation did not generate penalties at the time Garfinkel gathered his data. This study will demonstrate that missing information subjects personnel and organizations to still other risks. In addition to being evidence of employee non-performance missing documentation can become evidence of lack of treatment, even negligence. "If it isn't written it didn't happen" is the oft cited bureaucratic maxim.

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[18] Garfinkel: 1967 p. 193

[19] Ibid: p. 197

In the following Wheeler stated recognition that entries on forms in records reflected organizational and societal change:

> It should be noted that the record forms themselves can serve as useful indicators of social change. The forms contain those matters that the organization in question believes it is important to know about, and therefore changes in the kind of information that is requested reflect changes in the organization itself or its problems....It is apparent that what is asked, as well as answered, may be important data about the organization in question, its ideology, its problems and its fundamental concerns.[20]

While Wheeler viewed record forms as "indicators of social change" I will be making the case that forms are also inducers of social change. For example workers' thought processes and behaviors adapt to documentation requirements. Actually that is also true of individuals in more private realms as they plan their activities with tax forms and consequences in mind.

Documentation in records does not necessarily take place on forms: narratives have been an alternative. The contrast has also been stated as between structured and

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[20] Wheeler, op. cit.: p. 14

unstructured formats. Johnson described home visit reporting processes by a welfare agency's social workers: their accounts were recorded onto dictaphones and later transcribed by typists for placement into clients' records. Johnson wrote:

> The dictated narrative by a social worker for any one given a home call (or other interaction) may be as short as one single spaced typewritten page, totaling perhaps 500-600 words, or may be as long as ten or twelve single spaced pages totaling 5,000-7,000 words describing the events which have transpired on one or a series of home calls.[21]

Johnson relates problems social workers had "learning how to construct organizationally competent narrative accounts" since they were expected to address all categories of a preset format.

Johnson mentions, but does not analyze, that toward the end of his investigation procedural changes had been taking place, resulting in a "new reporting format [that] only contained a few lines for recording the narrative comments." After reading the above citation one may be impelled to say now, "No Wonder!" Think of reading those lengthy, probably very often unwieldy, pages in the attempt to know "what

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[21] Johnson, op. cit.: p. 122

happened" or what was relevant for the agency. Think too of the pool of typists pounding away as they listened to dictaphones playing. I was somewhat familiar with the system Johnson depicted since it was similar to that which was in place at a psychiatric outpatient clinic where I worked in 1969, about the time Johnson was conducting his research. Not co-incidently, I believe, the system changed at that clinic shortly thereafter, precipitating a redeployment of many typists. Enactment of entitlement legislation along with development of regulations designed for standards setting were affecting how varied agencies documented their services.

That multi-functions of documentation influenced the development of the medical profession was elucidated by Foucault:

> Among the fundamental conditions of a good medical "discipline", in both senses of the word, one must include the procedures of writing that made it possible to integrate individual data into cumulative systems in such a way that they were not lost; so to arrange things that an individual could be located in the general register and that, conversely, each datum of the

> individual examination might affect overall calculations.[22]

"The nature of records" was Raffel's interest when he embarked on his study of medical record processes at a public hospital in New York City for two years, 1969 to 1971. He concluded that entries in medical records indicate a depersonalization necessitated by bureaucracy:

> The bureaucrat's problem is to be able to *use* the record ....The idea of using, means to be able to establish the kind of relationship in which ego (bureaucrat) can conceive of alter (record) as an object which, like a ripe apple, is there for the picking.[23]

Comparing "speech" exhibited in medical records with Socrates' discourse Raffel believes that medical personnel who made entries did so as disengaged observers of events rather than as participants with opinions.

With a somewhat less philosophical stance he recounts maneuvers by medical record room clerks to achieve record completeness. For example, after finding a signature missing from a physician's note they would approach any physician to sign it. Those clerks were not at all interested in accuracy, i.e. that the right person, through

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[22] Foucault: 1977 p. 190

[23] Raffel: 1979 p. 79

a signature, accepted responsibility for what was written. Instead they were interested in relieving themselves of the burden of an incomplete record. Should a note prove troublesome later, perhaps because a patient's treatment was subject to some inquiry, it would be the signer's problem, not the clerk's. I assume that currently it would be very difficult for medical room clerks at that hospital to manipulate or cajole physicians to sign documentation written by others. At TPC the medical records department reports (on forms) missing documentation to discipline supervisors, unit administrators and central administration, thus directing that responsibility outward.

The medical record, according to Berg, is such a vital force in medical practice that he says "Without the *interrelation* of people and paperwork....doctors could not be doctors and nurses could not be nurses."[24] He added:

> Through practices of reading and writing, the medical record functions as a constitutive element of current medical work. It enters into the 'thinking' processes of medical personnel and into their relations with patients and with each other.[25]

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[24] Berg: 1996 p. 501

[25] Ibid: p.520

Documentation as a molder of professional expertise was also addressed by Siegel and Fischer as they described historical aspects of training of contributors to psychiatric records:

> In social work, it is stressed that the very process of recording compels the worker to engage in critical thinking and to organize the material carefully to make an effective analysis of the client (patient) situation. This last point was amplified in 1946 by Gordon Hamilton who saw the actual act of writing or dictating records as an important device in stimulating the worker's understanding and diagnostic acumen about a case.[26]

While the style of documentation that social workers then were taught later fell into disfavor, what may be culled from the preceding is that there is a tradition of documentation being used to transform the writer.

Using their entries in medical records, Berg portrayed physicians' reactions to entries by others and to the patients. The process he describes is dynamic as data is not merely gathered but also simultaneously categorized and assessed. The record, he says, must be considered active because it "also affects its *content*."

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[26] Siegel and Fischer: 1981 p. 21

> It structures the selections made: through its set-up, for instance, through its pre-printed forms and categories, it aids in the process of creating a problem-definition which is 'medically relevant'. The form lists the questions to ask, and differentiates between relevant and irrelevant information (by, for example, not mentioning a topic, or having only a small space for 'social history').[27]

But Berg, whose research was conducted in Britain, also reports that unstructured case history forms "leave it up to the physician constantly to create order, to maintain a focus".[28] He believes access to use of unstructured formats promotes maintenance of professional hierarchies; as evidenced by nurses having to confine their entries to small spaces allotted for discrete entries such as patients' temperatures. Professional hierarchies will be evidenced in the psychiatric medical record keeping practices I will be depicting, but they will be less pronounced. I will be demonstrating central administration as the prominent hierarchic force.

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[27] Ibid.: p. 506

[28] Ibid.: p. 512

Developments in the Psychiatric Medical Record

References have been made earlier to changes that have taken place in documentation requirements for patient charts at The Psychiatric Center. These changes have been related to changes that had been taking place in record documentation in general medicine during the 1970s. Most influential in providing the direction of those changes was Weed, a physician who asserted that patient records must be improved because they did not reflect the needs of modern medicine. He began publishing his concept of "the problem-oriented medical record" in 1964. In a later article he stated:

> No one can point to an individual and say, "I am her doctor." *A system will be her doctor,* and it turns out that the thing that holds the system together is the record...With the problem-oriented record, we are not just making a simple little administrative change in medicine: We're not of the thought that here is the record, and here is the practice of medicine. It is just dawning on people now that the *medical record is the practice of medicine.* It is all we know about the practice of medicine.[29]

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[29] Weed: 1976 p. 7

Readers who have no familiarity with medical records usage and history may infer Weed was exaggerating the impact of his concepts but he is the most often cited authority on the subject. For example Hunter said:

> L.L. Weed's revolutionary problem-oriented medical record, which has gone a great way toward integrating chart writing into the modern clinician's investigative stance, brought a pared, thematic order to a wordy, encoded multiauthored chronicle.[30]

In reiterating the advantages of Weed's system Easton[31] declared style can be narrative and random or outlined and organized. A problem oriented record system is contrasted with one that is source oriented, keeping all laboratory reports together, for example.[32] The problem oriented record system encompassed a data base, a numbered and titled problem list, and plans to treat each of the problems. Progress notes had to be related to the problem list by number and title and to be written in accordance with a "SOAP" format, an acronym for Subjective, Objective,

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[30] Hunter: 1991 p.92

[31] Easton: 1974 p.ix

[32] While TPC implemented a problem-oriented treatment plan format for several years in the late 1970s most of the record remained source oriented, as will be evident in the chapter which discusses forms.

Assessment and Plan. Weinstein, who was working on improving medical records for the New York State Department of Mental Hygiene[33] said, "The problem oriented medical record is one of the most promising developments in the structure of medical records."[34]

In 1978 The Psychiatric Center adopted a problem oriented treatment plan format; previously there had been no treatment plans forms or formats. The problem oriented treatment plan was soon supplanted by a modification, the goal oriented treatment plan after "problem oriented" terminology was considered problematic by the Office of Mental Health. Their intention was to redirect staff attention away from patients' problems and toward goals to attain discharge, an example of attempts to construct and display ideology through forms. In keeping with Weed's model progress notes have to be keyed by letters and numbers to treatment plans. SOAP progress notes have been replaced by a DAP progression, an acronym explained in a TPC memorandum as: Data -- subjective accounts by the patient and/or objective facts ascertainable by individuals other than the patient, Assessments -- evaluations by clinicians

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[33] An agency which was later to be subdivided, one part to become The Office of Mental Health, the agency that governs The Psychiatric Center.

[34] Weinstein, A. 1975 p. 457

based on data and Plan -- actions to be taken based on data and assessments. Thus it is clear that changes in medical records practices in the general medical community later directly affected record keeping practices at TPC. Treatment plans and progress notes in TPC's medical records will be discussed in more detail later.

Psychiatric records had always presented special problems. Erikson and Gilbertson observed a difference between psychiatric records and:

> their counterparts in most other institutional settings. For one thing, they include a far greater range of information about the client than one is likely to find anywhere outside the files of intelligence agencies.[35]

They pointed out that psychiatric records had no limit on the scope of information that could be considered pertinent. Goffman had earlier written that "since mental hospitals have a legitimate claim to deal with thee 'whole' person, they need officially recognize no limits to what they consider relevant." The psychiatric record then could present wide ranging biographical and interpretative entries and over time the record could become quite massive, particularly if those who were involved in the patient's treatment saw him or her as interesting.

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[35] Erikson, and Gilbertson: 1969 p.390

In the 1970s the American Psychiatric Association was sufficiently concerned about medical records that it formed a task force to guide its members' documentation practices. In the report they compiled the authors proposed that psychiatrists could improve their status situation by converting to the problem oriented record system at their facilities since:

> A record keeping system which would bring psychiatric records into line with, and make them a readily understandable part of, the general medical record would thus reaffirm the psychiatrists' kinship with the broad field of medicine.[36]

Psychiatrists working in mental hospitals had experienced a sense of lowered status when compared with physicians in other specialties. Additionally those psychiatrists were competing with other professions and occupations; from some perspectives, there were no differences in the value of their contacts with patients other than the sanction to diagnose, prescribe medication and administer ECT. By recasting charts as medical records, psychiatrists could assume their "rightful" dominant role within psychiatric facilities. Records are reaffirmed as medicalized in numerous ways. Evidence of psychiatric decision making is

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[36] Report of the Task Force of the APA: 1977 p.7

assured by requiring psychiatrists to sign for every possible patient status change. For example patients may not be admitted, discharged, allowed off wards, secluded or administered medications without written orders from psychiatrists. Records are further medicalized by increasing emphasis on adhering to more stringent general medical standards by requiring evaluations by medical specialists, at least yearly laboratory testing, immunization recording and follow-up, weight and blood pressure recordings and other medical reports, all evidenced by documentation.

Assuaging egos of psychiatrists was not the only impetus for the increasing emphasis on medical record documentation at psychiatric facilities. When the American Psychiatric Association's task force published its recommendations they listed "four major societal forces currently operating to bring about this renewed interest in the psychiatric records." In addition to benefits that would accrue to the psychiatric profession, the three other forces addressed, essentially accountability issues, were: outcomes of court cases, legislation, and demands of third part payers, issues that are discussed later.

Other proponents of the Problem Oriented Record were Ryback, Longabaugh, and Fowler who claimed that it would make information more readily available. They said,

"Psychiatry more than any other area in health care delivery needs a structured logical approach to document its thinking so that it may find out what it's doing or not doing."[37] The limited technology extant in psychiatry required an increased emphasis on documentation. In a later publication they noted that implementing the problem-oriented record was not without its problems, acknowledging clinicians complaints about the increased documentation and the time it took. The authors ask:

> What is the optimal ratio of thinking and planning time to time spent interacting with a patient? When is more patient contact without forethought more effective than less patient contact with forethought?[38]

Ryback et al conclude there is "no simple answer", but the nature of their question makes it clear, although they do not say so explicitly, that they questioned the value of many clinicians' interactions with patients. Staff dissatisfaction with increased documentation, Ryback et al observed, was perhaps being misdirected toward the problem oriented record rather than to the convergence of pressures for accountability.

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[37] Ryback et al: 1974 p 4

[38] Ryback et al: 1981 p.8

Barrett, who studied record development processes in a psychiatric hospital wanted to:

> draw attention to the major institutional structures in which clinical psychiatry is embedded -- the administrative, the professional and the legal -- and how they influence clinical writing.[39]

He also observed that psychiatric records influence how patients are viewed because "The segmentary structure of the record itself shaped the definition of the patient." In later sections I will be illustrating the segmentary structure of psychiatric records but here I will note that such structure is concretely manifested through dividers that separate categories of documentation.

Concerns by the New York State Department of Mental Hygiene[40] (DMH) with psychiatric medical record forms (aside from those related to legal statuses) were initially for data collection purposes. Forms, designed to be compatible with centralized computer programs, allowed the department to devise mechanisms to track services rendered by its programs to patients in its system.[41] During the early 1970s the DMH established a unit to evaluate medical

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[39] Barrett: 1988 p. 269

[40] Later re-organized with one component to become the Office of Mental Health

[41] As P. Blau's research (1963) suggested and as I can verify from my experience, data collection mechanisms could display inflated productivity results by programs seeking to maintain funding.

record practices. Weinstein, from the viewpoint of that organization, discussed issues with which the agency grappled as changes in record documentation were being planned. At the time of publication of his article the department was working on a format to improve "clinical output notes". The narrative style, still dominant at the time, was considered to be unsatisfactory because "significant points were buried in verbiage".[42] Documentation was being viewed as needing to be managed through state central offices. Forms and regulations for entries on them would become mechanisms for that management, just as they had for manufacturing firms in the first decades of this century.

The New York State Office of Mental Health responded to regulatory pressures by introducing the Uniform Case Record (UCR) in 1981, a project they had been developing for five years prior. The UCR is both a concept and a collection of forms. The concept referred to the view that psychiatric medical record practices should be standardized throughout the system: all psychiatric centers in New York State would be required to use those same forms, thereby centralizing control. After all, when HCFA surveyors cited facilities for poor medical record documentation it was the State that

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[42] Weinstein: 1975 p.453

lost reimbursement funds. Uniform case record forms initially had instructions printed on them, but they were also accompanied by manuals. Central offices, having set standards were also positioned to review records at all psychiatric facilities in the State. Forms that comprise the UCR and processes surrounding documentation on them will be discussed later. Copies of those forms, along with others that were used in TPC psychiatric medical records as of 1991, are in the appendix.

A redesigned uniform case record set of forms was issued by the Office of Mental Health in 1992. Specific changes that were made and their implications will be discussed in later chapters; but here it will be noted that the new forms displayed modified perspectives of JCAHO and HCFA as evident in their publications and users' critiques of the first UCR. Certain forms, their structure and the responses they elicit have become so crucial that resources continue to be expended for their design, redesign, printing, distribution and training staff to use them, (which of course also involves "unlearning" and discarding obsolete ones.) While bureaucratic processes are certainly cumbersome they also reflect responsiveness over time.

Documentation processes on forms, as one can glean from the above, are far from being passive by-products of bureaucracy. They have been shown to be mechanisms to

evaluate workers' productivity, expressions of control of defective individuals, influences in shaping professions and developing professional expertise, means to promote professional status, vehicles to display organizational legitimacy, indicators of organizational change, arenas of non face-to-face interaction, and avenues to obtain resources.

CHAPTER 2

THE MEDICAL RECORD: THE REGULATORS AND THE LAWS

One can view the psychiatric medical record as the reflection of the outcome of an amalgam of regulations and court proceedings, most of which originate outside the facility, and then become incorporated into The Psychiatric Center's policies. Organizations that can impel medical record documentation have sufficient interest and power to affect psychiatric medical records and psychiatric centers have sufficient interest and need to comply. The ensuing discussion will provide illustrations of how laws and regulations impact the psychiatric medical record. While several separate organizations are mentioned it is helpful, at the outset to understand them as part of the same "organization field", defined by DiMaggio and Powell as:

> Those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and

other organizations that produce similar services or products.[1]

Regulations, therefore, that appear in one of those organization's policies and manuals are likely to be repeated and/or incorporated into those of another. Further, the organizations involved may also engage in discussions prior to development and revision of regulations. For example representatives of The Joint Commission on Accreditation of Healthcare Organizations and the Health Care Financing Administration, two organizations discussed below and elsewhere in this paper, meet at least annually to ensure that their directives are not contradictory.[2]

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) conducts wide-ranging surveys of hospitals, ascertaining the adequacy of the building structures, safety procedures, electrical wiring, and space allocations for patients as examples, in addition to staffing, programming, and medical records. JCAHO distributes its manual to health care organizations seeking its accreditation. The 1995 version of that manual, encompassing 671 pages (about double that of the 1991

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[1] DiMaggio and Powell: 1991 pp.64-65

[2] This information was told to me in a telephone interview I conducted with a spokesperson at JCAHO

version), not only lists and categorizes standards by which health care organizations will be judged but also specifies its scoring system.[3] Every section that is relevant to the operation of TPC is pored over by administrators. Details of this process will be discussed in Chapter 5 about audits, but here it is the intent to convey the explicitness of JCAHO medical record requirements. After stating that every individual "assessed or treated" must have a medical record initiated and maintained the manual states it is required that:

> The medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately, and facilitate continuity of care among health providers.[4]

Twenty-three discreet documentation categories, "the goals of treatment and the treatment plan" and "progress notes made by the medical staff and other authorized individuals" to cite two examples, are listed as bases upon which final ratings are issued. There are in addition numerous other categories related to medical records for which hospitals

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[3] In its own four page outline entitled "Joint Commission History", 1926 is the year "The first standards manual is printed consisting of 18 pages."

[4] The Joint Commission on Accreditation of Healthcare Organizations Comprehensive Accreditation Manual: 1995, p.397

are rated; for example that they are "reviewed at least quarterly for completeness, accuracy and timely completion of information, and action is taken as necessary to improve this process."[5] In developing its own medical record policies TPC uses the latest issue of the manual issued by JCAHO, a stratagem which meets with the approval of the survey organization since it promotes its publication as a teaching device.

The Joint Commission on Accreditation of Healthcare Organizations is invited by TPC to conduct a survey. In fact JCAHO is paid by the Office of Mental Health to do so (as is true for all New York State psychiatric centers.) Accreditation reflects well on the hospital. A JCAHO failure is not only a public embarrassment, it precludes an audit by the Health Care Financing Administration (HCFA) the federal agency responsible for disbursing Medicare and the federal portion of Medicaid funds. Accreditation by The Joint Commission on Accreditation of Hospitals[6] had been acceptable for hospitals to participate in Medicaid and Medicare according to the Social Security Act of 1965, but that changed in 1972 when the act was amended to require that their findings be validated by the Department of Health

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[5] Ibid: p. 388

[6] Later to become the Joint Commission on Accreditation of Healthcare Organizations in 1987.

and Human Services, the agency from which HCFA was later formed. Public psychiatric hospitals are not able to receive Medicaid funds; they are eligible, however, to be paid a specific daily rate for each patient who qualifies for Medicare, a sum when totaled amounts to several million dollars a year for TPC. The facility is not the direct recipient of Medicare funds, rather they are funneled through the Office of Mental Health into the general state coffers. Understandably OMH central offices are very concerned when any of the psychiatric centers is in danger of failing a HCFA audit.

HCFA standards are published in "The Code of Federal Regulations" and then distributed, as they are amended and updated, to health care organizations they will survey. Included for TPC are audit protocols and a section geared to evaluating psychiatric hospitals, entitled "Interpretive Guidelines - Psychiatric Hospitals". Those guidelines are actually addressed to surveyors who will perform the tasks of auditing; thus the facility is apprised of instructions to prospective auditors. For example HCFA auditors are instructed to "Review each patient's record in your sample for compliance with the Special Medical Record Conditions Standards". An example of a regulation as stated in the "Federal Register" is: "The medical records maintained by a psychiatric hospital must permit determination of the degree

and intensity of the treatment provided to individuals who are furnished services in the institution."[7] The guidelines then elaborate and specify the medical record documentation that would comply with that regulation. Another of the regulations states:

> The hospital must have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measure and engage in discharge planning.[8]

The Psychiatric Center, in response to the preceding, hires the complement of professions and occupations that would enable demonstration of compliance. An example of the specificity of regulations located in the "Interpretive Guidelines" is: "The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first 2 months and at least once a month thereafter." That regulation about the frequency of progress note writing is incorporated into professional discipline and medical records manuals and is repeated as part of the instructions on the File Order Form. How progress note regulations affect staff practices will

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[7] Code of Federal Regulations: S482.61 9/95

[8] Ibid. S482.62

become evident in Chapters 4, 5 and 6; at this point it should be clear that there is a direct link between federal regulations and medical records policies at TPC.

To assist psychiatric centers in their preparation for audits central OMH offices disseminate HCFA specifications and then conduct pre-survey surveys. HCFA audits have primarily focused on medical records and staff/patient ratios of various disciplines. As of 1996 HCFA standards have been redirected from a process oriented compliance to an outcome orientation and auditors have been mandated to correlate their finding in the medical record with observations of direct patient care as is stated in this excerpt from a pre-audit training memorandum:

> HCFA's Annual Recertification Survey's for psychiatric hospitals was formerly a process oriented compliance survey against which compliance with the special medical records requirements and special staffing requirements for psychiatric hospitals were assessed. HCFA has revised this survey process to an outcome orientation. This new survey protocol employs the techniques of observation and interview as well as a review of the medical record documentation.[9]

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[9] From a survey information packet developed by HCFA and distributed to TPC staff by OMH.

From the preceding we have an illustration of recent changes taking place in procedures for auditing psychiatric hospitals, changes with which they must grapple. In anticipation OMH revised some of the forms used by its psychiatric centers, as will be noted in Chapter 6.

New York State laws also have direct impact upon psychiatric medical record practices. The New York State "Official Compilation of Codes, Rules and Regulations" (NYCRR) of which a portion, Title 14, is relegated to Mental Hygiene Law, and "McKinney's Consolidated Laws of New York" are publications which contain laws and regulations related to patient rights and administrative responsibilities within New York State institutions for the mentally disabled. Dates of enactment provide some insight into their historical progression and, on occasion, cases that generated them. The NYCRR lists requirements for the medical record but not with much specificity. However the reader is referred to various manuals, including a Medical Records Manual, for details of requirements. Manuals are required to reflect any changes in regulations. One of HCFA "Conditions of Participation" mandate compliance with state and local laws, in effect incorporating them into its own regulations.[10]

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[10] Code of Federal Regulations: S482.11

New York State regulations demonstrate a long standing recognition of the relationship between control over its facilities and the forms they use:

> The commissioner shall have the power to make regulations governing admissions to hospitals, schools, and alcoholism facilities and the identification and processing of patients. He shall prescribe and furnish forms for use in procedures for admission. Admission shall be had only upon such forms.[11]

Forms used to admit patients state the rights of those individuals, establishing at the same time their legal statuses, i.e. voluntary or involuntary. Thus not using designated state forms (see chapter 6 and appendix B) creates a vulnerability for accusations of illegal incarceration.

Every patient has a legal status on admission, a status which is subject to change. Many patients are admitted with and maintain a voluntary status, which means they can request discharge within 72 hours from any time they serve notice.[12] If the treating psychiatrist believes the patient is not ready for discharge, an application to the

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[11] McKinney's Consolidated Laws of New York: p.229

[12] A situation requiring no form -- the only needs to write some discernable statement to that effect on a piece of paper. An individual unable to write is entitled to assistance from staff.

court for a status conversion to "involuntary" will then be initiated. Mental Health Legal Services (MHLS), a department outside of the administrative chain of the hospital, has a patient advocacy function, with every patient having an assigned lawyer who has direct access to the patient and the medical record. MHLS lawyers have keys which allow them entry to wards for access to records and patients.

In many instances the patient will withdraw the "72 hour notice" before the court date, often because they have no viable place to live and often because they have become socialized to the hospital system (referred to by many staff as "three hots, a cot and a shot".) A number of patients become adept at "working" the legal system, sometimes putting in a "72 hour notice" just to watch staff scurrying to arrange the paperwork. Irrespective of staff conjecture about a patient's motivation in submitting a "72 hour notice" it must be taken seriously. Should a court hearing ensue and the judge agrees that the patient is not ready to be released (blatantly psychotic rambling in the courtroom is an example of evidence the judge will use in addition to the medical record,) the patient's status will become "involuntary" for a specified period, requiring a renewed court hearing when that period expires. Court hearings and their applications are time consuming, encouraging the

initiation and maintenance of voluntary statuses whenever it isn't precluded by some court order.

Individuals gain entry to the hospital via several routes. A common one derives from individuals behaving in a manner that causes one or more people (very often family members) to feel threatened, the police are called, and they in turn bring the person to a psychiatric emergency room at a general hospital. Or the individual may behave in a manner that is considered a threat to him/her self, resulting also in psychiatric emergency room evaluation. Both situations described meet a criteria of dangerous to self or others. Psychiatric emergency room evaluations are frequently a first step in a series of procedures that lead to state hospitalization.

Another route is the court system, the patient having been charged, indicted and/or convicted of a crime with mental illness being deemed a factor in the commission of that crime, or the patient having been charged or indicted for a crime but is considered not to have the mental capacity to understand the nature of the act or the legal proceedings. Court related statuses derived from Criminal Procedure Law (CPL) put constraints on the capacity of patients with those labels to gain increased "privilege" levels which permit situations of decreased supervision for specified periods. For example certain patients are not

allowed off wards unless they are with a staff person whose only duty is to serve as watchful escort while other patients are permitted to leave wards on their own; a number of patients reside on unlocked wards. While patients with "civil" statuses", i.e: not court remanded, can "earn" privilege levels by obeying the rules, CPL patients must have applications (on a special form) made on their behalf to the forensic committee, a task group which must include at last two board certified psychiatrists (many of the psychiatrists on staff are board eligible but not board certified.) The committee evaluates documentation presented, which should include entries about the degree to which the patients have been able to display the capacity to keep out of trouble and the likelihood of their committing a violent criminal act when not supervised.

Inattention to implications of legal statuses of patients has resulted in jeopardizing staff, the organization and the Office of Mental Health. As an extreme example, a patient with a CPL status was given permission by a staff psychiatrist to take unescorted trips off the hospital grounds; on one of those trips the patient murdered a relative. With so much at stake the hospital has taken certain precautions. One staff member reviews records of all "CPL" patients monthly to ensure that there is "correct" documentation of legal and privilege statuses and

that psychiatrists do not allow privileges not sanctioned in writing by the forensic committee. For many staff the policy of using patients' criminal histories as the determining factor in their destinies is troubling: "Are we a hospital or a prison?" is a question asked, sometimes with resignation.

Many regulations derive from court case proceedings that resulted in redefinitions of patients' rights, rulings which become incorporated into federal and state laws and which, as we have seen, become part of institutional policies. One example is "the right to treatment". The intent of the ruling was to counteract conditions in which psychiatric patients in hospitals were left to languish. Evidence of treatment is a requirement of JCAHO, HCFA and the state. As a result the medical record is required to display documentation that the patient has participated in or an attempt has been made to help the patient participate in twenty hours of programming per week. Staff at TPC experience difficulty and discomfort with filling in (guessing at?) time periods spent with patients, a process discussed chapters 4 and 6, but here it is useful as an illustration of the progression from court ruling to the psychiatric medical record.

The "right to the least restrictive alternative" is another ruling which for which the medical record will be

sought as evidence of compliance. That "right" means that patients should be allowed the highest level of freedom advisable for their psychiatric condition and legal status. For example patients who have been evaluated as able to benefit from off ward privileges must be granted them. If patients are viewed as ready for discharge the record must indicate that efforts have been made to effect it. The Utilization Review staff (a work group mandated by JCAHO), assesses every record periodically for documentation justifying the patients continued stay in the hospital.

The medical record is subject to scrutiny not only by auditors and organization staff. Litigiousness, which has been observed to be a common trait in our society, presents perpetual potential for damaging outcomes. For example a family member may sue when a relative has been hurt during a fight with another patient. Even if it is found that their relative "started" the fight, the family may claim the staff, psychiatrist and/or the organization failed to provide protective treatment. Some families are spoken of as "looking for a lawsuit so they can get rich." Lawyers who have been retained by patients or others acting on their behalf can subpoena medical records, searching them for documentation (or lack thereof) which will bolster claims being made. Simon warned, "Technically the law considers

that what is not recorded is not done."[13] Using actual malpractice cases Simon illustrates how carefully documentation decisions must be made; there can be lawsuit peril with every word written or omitted. On the other hand part of the training of professionals, particularly physicians, is learning to write enough to comply with all regulations without inserting potentially self-incriminating statements. Incident reports, forms used by the organization to document information concerning any questionable patient related event, are expressly not included in the medical record.

As much as rules, regulations, and laws aim for precision and clarity they cannot eradicate a basic ambiguity pervading treatment of incarcerated psychiatric patients. An example is an issue that on occasion has presented staff with a predicament: when should the city police be summoned to arrest a patient on a ward? If that patient severely hurts a staff member or another patient, disputes may take place as to whether the incident was a manifestation of mental illness or of someone "taking advantage" of the "mental patient" label, in which case an arrest could be used as a public display and a warning to other aggressive patients. On the other hand since there is

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[13] Simon: 1987 p. 166

already documentation of mental illness, regulations bind the courts almost always to remand the patient back to where s/he came from, The Psychiatric Center. Another example is determining when a CPL patient with a long past criminal history, perhaps having committed one or more murders, can be considered trustworthy enough to gain privileges and ultimately be discharged. Some CPL patients may be "cooperative with treatment" and "currently asymptomatic" but "what if" questions plague those responsible for documenting readiness for increased freedom

Keeping staff apprised of rules, regulations, laws and policies is a major administrative task. While training sessions will be most efficient when something is being introduced, ensuring that staff practices reflect rules and regulations involves ongoing attention. For example when policies are introduced or changed the organization's central administration distributes memoranda of policy statements accompanied by instructions to "post" them. Another method of disseminating such information is to compartmentalize knowledge needed within existing categories of occupational disciplines and rely upon discipline and unit supervisors to intercept and correct errors. Additionally the facility uses designated staff to oversee specialized areas; examples already presented above are the staff person who reviews documentation in records of CPL

patients and the staff from Utilization Review who ascertain records affirm patients need hospitalization.

Regulations accumulate and change. Further, staff who may have accrued knowledge to function at least competently in one of the Office of Mental Health treatment settings may, for one reason or another, be transferred to another treatment setting which utilizes different regulations. For example staff who work in outpatient units might not be cognizant of the importance of "72 hour notices". Should those staff later work inpatient units, knowledge and experience gaps may not be brought to light until something goes wrong. Therefore there is always a tension that something important can slip by. Awareness of effects of regulations has been expressed well by Schwartz in the following:

> Perhaps no medical specialty has experienced the impact of regulation to quite the degree as has psychiatry. Indeed, concerns about abuses possible in psychiatric institutions, the liberty interests of involuntarily treated patients, the possible overlap of treatment and "behavior control," along with the seemingly unscientific nature of the psychotherapeutic enterprise, have all contributed to the regulation of psychiatric specialty practice most subject to cost-control regulation, perhaps because of a persistent skepticism

on the part of the public and policymakers regarding the disease model of mental illness and a reluctance to acknowledge the efficaciousness of psychiatric treatments.[14]

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[14] Schwartz: 1994 p. xvi

CHAPTER 3

THE ORGANIZATION

This chapter presents the setting where the case study was conducted. The organization, also referred to within this paper as "the facility", "The Psychiatric Center", or abbreviated to "TPC", is one of the psychiatric centers operated under the jurisdiction of the New York State Office of Mental Health (OMH). Eighteen OMH psychiatric centers provide a range of treatment services, including outpatient clinics, day treatment programs and work training, in addition to inpatient treatment for adult mentally individuals (there are separate facilities for children.) "Psychiatric center" has supplanted "state hospital", the label which earlier had been understood to be an institution relegated to the care of those mentally ill. States accepting responsibility for that care was in reaction to reformers' national crusade to alleviate abusive, neglectful situations. For New York State it was a tentative beginning.

From 1843, when the first New York State mental hospital was opened until 1889, the state mental hospitals were

> independent organizations....In 1889, the state hospitals were brought together under a three-member State Commission in Lunacy.[1]

As the system of state hospitals increased, an administratively separate system of "after care" clinics was developed, headed by its own commissioner and with its own hierarchal chain. In 1971 each of the after care clinics was placed under the control[2] of the state hospital which was the source of its patient caseload. In 1974 "State Hospitals" were retitled "Psychiatric Centers", thus providing acknowledgement of the consolidation of services.

Each of the psychiatric centers serves patients from a designated geographic area unless it has been allocated for treatment of a specific type of population such as those deemed to be extremely dangerous to others or who have certain pending criminal charges. New York, as is well known, is a geographically large, and economically and culturally diverse state. Psychiatric hospitals developed and maintained within its boundaries became responsive to and reflective of their localities. One cannot overlook the

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[1] Weinstein, A. 1975 p.442

[2] Aftercare clinic staffs engaged in a public demonstration to protest the change. The state countered by laying off all outpatient supervisors and administrators who then scattered as they sought positions for which they had "bumping" rights.

extent to which the psychiatric centers are influenced by politics at the most local level and that of statewide elected officials. Several psychiatric centers are key employers for their region thus heavily impacting those economies; closing or downsizing those organizations are destabilizing for entire communities as well as for employees and patients.

Patients treated by The Psychiatric Center are those who have been assessed as meeting criteria for being severely and persistently mentally ill. A state psychiatric center is a segment of a larger system of mental health services delivery which includes local governmental and private agencies such as general medical hospitals with psychiatric services components. Complex, sometimes convoluted, but not necessarily consistent, financial, legal and political agreements are made among various agencies in order to apportion responsibilities for categories of mentally ill individuals within geographic areas. To cite one example, the Office of Mental Health has allocated funds for use by city and proprietary hospitals which have psychiatric units for patients who are newly diagnosed or expected (or hoped) to have short term stays. Also, there are arrangements for staff relocations between and among agencies. Schools of medicine and nursing use a number of hospitals as training grounds and some staff, psychiatric

residents for example, may be on a New York City hospital payroll while working at The Psychiatric Center. On the other hand nurses on the payroll of the state facility may perform most of their duties in a psychiatric emergency room of a nearby city hospital.

The network of agencies involved with psychiatric patient care extends beyond hospitals to outpatient programs and residences. All psychiatric outpatient service agencies, such as clinics and day treatment programs, which receive public funds, either through direct grants or medicaid reimbursements are part of a centralized data collection system and are subject to centralized state regulations. One of those regulations, for example, prohibited more than one outpatient program from receiving medicaid reimbursements on behalf of a particular individual. While outpatient program designs and their financing arrangements have undergone changes, developing a managed care model, the data system continues to track outpatient service usage by post-hospitalized patients. Agencies which provide services adapt them to funders' regulations in order to maximize income. Often adaptations are more focused on how to document existing services so they appear to conform to changing regulations.

Psychiatric centers are under ongoing pressures to discharge inpatients, pressures which stem from several

sources. One source had been deinstitutionalization policies which started in the 1960s. It was the belief that the dependent, withdrawn behavior displayed by patients was based upon adaptation to institutional expectations and routines. It was thought that discharged patients would relearn how to meet the challenges of living "on the outside", a belief that was not entirely unfounded since many patients at that time were being confined unjustifiably. Sometimes the most capable patients were purposefully kept for personal tasks they performed for higher status staff, such as cleaning their homes for almost no pay (services then considered routine perks for state hospital management.) But it also turned out that severe mental illnesses could cause individuals to become dysfunctional with respect to being able to develop the capacity to earn a living or even maintain acceptable hygiene. Dependent, withdrawn behavior was not necessarily due to institutional acculturation or neglect. The rights of patients to live in the least restrictive environment, discussed earlier in chapter 2, creates additional pressure for discharge. Since inpatient psychiatric treatment is much more costly than other living/treatment situations, impetus to reduce the census is impelled additionally, often primarily, by budgetary considerations.

Psychiatric centers are prohibited from releasing patients without a "proper" discharge plan (documented, of course).[3] Patients may not, even if they so choose, be sent out to live "on the streets" or at shelters for the homeless. Patients needing post-hospitalization housing can be referred to residences that have any of several of "level of care" designations, referring to the degree of services and supervision provided.[4] Residences, which can open only after their applications are approved by the state, must be ready to submit to oversight by various groups such as the Office of Mental Health. Interdependence and tension characterize the relationship between residences and psychiatric hospitals. While the former become financially viable when "beds" are at or near fill level they are leery of "getting stuck" with occupants they fear will be too troublesome, even "unmanageable".

Financing of patient stays at residences is generally based upon Supplemental Security Income (SSI) housing allocations for disabled individuals. Usually social work

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[3] This should not be interpreted as meaning that patients are sent to reside only in safe, nurturing environments. Pressures to effect administratively acceptable discharge rates have induced some staff to devise stratagems to place patients in over-crowded rooming houses.

[4] On the other hand inpatients discharged to live at residences become outpatients with rights to choose not to stay. Many of those individuals may end up living in "the streets" or re-hospitalized.

staff at psychiatric centers are assigned responsibility for filing and following applications for housing and entitlement, a process that generates what many consider an onerous amount of paperwork, an issue pertinent to this study. Residences have agreed to accept, as the basis of assessing patients' acceptability, copies of paperwork submitted to the New York City agency that releases housing funds, but many insist that, in addition, their own forms be filled out. Copies of medical record material, such as psychiatric and social assessments accompany those applications, often creating concerns that the documentation as presented will provoke residences to reject certain patients. If existing documentation portrays referred patients too negatively, perhaps stating episodes of violence, staff are expected to write "updated" material that highlights improvement. Later I will discuss issues of missing or incomplete paperwork in more detail, but here it is relevant to note that delayed discharges due to missing or incomplete paperwork will induce ire from supervisors.

As previously stated, The Psychiatric Center's main purpose is to treat individuals who are categorized as severely and persistently mentally ill. Diagnoses are achieved through criteria described in the *Diagnostic And Statistical Manual of Mental Disorders (DSMIV)*, with requirements that physicians use the latest issuance of the

publication. The organization has been defined by the Office of Mental Health as an "intermediate" facility, implying that it should not be the locus of a patient's first hospitalization(s) and every patient should be considered potentially dischargeable. However a substantial number of patients have been hospitalized continuously for over five years, some for decades. Admissions almost always result from pre-arranged transfers from other facilities such as general hospital psychiatric units or emergency rooms, prison psychiatric units and other psychiatric hospitals, perhaps one designed to treat criminally violent individuals. Since admissions to psychiatric centers are reduced when non-state hospitals have psychiatric units the state has developed funding allocation formulas to encourage development of those "bed" resources. At times The Psychiatric Center is "over the fill level", that is it contains more patients than considered permissible as determined by regulatory groups. Administrators ordinarily take the stance that a high census is due to staff being remiss in discharge efforts and escalate discharge pressures. But attempts can also be made to control admissions, possibly by diverting them to other facilities. Admissions create other sets of tensions. Staff at TPC may express feeling victimized by the kinds of patients "we have to take". Objections may be voiced, for example, when

patients with histories of violence against staff, as learned from the paperwork previously forwarded, being transferred from a forensic facility. Or staff may complain of being sent "the undischargeable" and then being accused of holding on to patients. Protestations may be most pronounced on wards receiving those patients, complaints being more about positioning with respect to other wards, resulting in statements such as "How come we're the ward they sent the worst ones to?" Or unit management may be berated for not ensuring a better selection of patients.

One way to view the organizational structure is through staff departmental delineations of four major groupings: administrative, support, quality assurance and clinical. Administrative staffs are responsible for areas such as personnel, plant maintenance, purchasing and distribution of supplies. Support staffs work in areas such as housekeeping, safety and food service. Quality Assurance staffs work in areas such as utilization review, incident review, and medical records. The last, clinical, includes departments involved with direct patient care such as psychiatry, medical, nursing social work, psychology, and rehabilitation. Quality assurance and clinical are the staff groupings that are most relevant to this research.

Another view of the organizational structure is the formation of work divisions functionally, spatially and

through time (the facility operates "24 - 7"), a view that centers mainly on clinical staff distribution. Direct service areas are divided generally into inpatient and outpatient services. Inpatient services, which utilize the majority of staff, comprise eighteen wards distributed among five units, an arrangement subject to frequent revisions. Additionally areas are allocated to the "rehab" department and other task oriented work groups, a discharge team, for example. Outpatient services include a clinic and a day treatment program.

Not every work group using space at the facility is part of the organization's hierarchy. For example there is a unit, Patient Resources, that collates financial data about patients and seeks payment from any viable resource such as Medicare or private insurance. Another work group, called "Mental Health Legal Services" (MHLS), are lawyers who advocate for inpatients. MHLS represents inpatients in proceedings such as allegations of abuse or petitions for discharge against medical advice. Judges preside weekly at hearings held at The Psychiatric Center, in effect one room temporarily becoming a court. Legal issues are elaborated elsewhere in this paper.

It is important here to take an additional view of the organization from a labor market perspective. Almost all staff are employed by New York State and are, therefore,

subject to and shielded by Civil Service law. In addition most staff are members of one of several bargaining agents such as unions. Which union a staff person becomes a member of is based upon that individuals job title, with those considered "professional" part of one major union and most others, such as therapy aides and cleaners part of another. Staff with management-confidential titles cannot be represented by a union but may join the organization established to advocate for them.

Hierarchical relationships can be both constrained and reinforced by civil service and union regulations. For example if a supervisor attempts to initiate disciplinary actions against an employee for not having completed paperwork the employee is likely to seek protection from the union. That union could, for example, demand documentation that the employee in question had been trained, was being supervised by an individual with a proper title and rank [5] and was formally counseled first verbally and later in writing. Attempts to enforce line staff documentation obligations entails a whole set of supervisory documentation obligations. Supervisors enter into outright adversarial stances with much caution since any lapses in their

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[5] At times employees work "out of title", accepting supervisory responsibilities in exchange for relief from direct service tasks.

documentation of having followed procedures subjects them to what becomes a public display of their own ineffectiveness. Most supervisory titles are considered non-management which means those staff could be members of the same union as their supervisees. Supervisor and supervisee may each be seeking support and protection from the same union at the same time but for different purposes, a factor which also may inhibit initiation of disciplinary actions.

Hierarchical relationships can be contextual. For example a Treatment Team Leader may have overseeing responsibility for one or more wards and may therefore be expected to ensure that psychiatrists attend treatment planning meetings. But psychiatrists, as a scarcer and less replaceable resource, may be granted more leeway (albeit not formally sanctioned) for infractions through their supervisory chain than other staff, a result that will not go unnoticed and perhaps challenged with statements such as "They should have to obey rules, just like I do, we're all state workers." Staff allegiances can be shifting and fluid, perhaps to the most immediate work group at some times, as examples when all staff work together to prime their ward for holiday parties or band together to object to having to cope with certain patients. At other times unit chiefs and treatment team leaders may unite in their objections to departmental supervisors not taking more

responsibility for following paperwork deficiencies of their supervisees. Successful audit preparation outcomes depends upon staff loyalty to the organization predominating over other interests.

Another issue the organization has to grapple with is defining "task and duties" expectations of its staff. While this can be problematic for dealing with almost all staff groups, the tasks and duties of some staff can be readily delimited, maintenance workers for example.[6] Delineation of clinical care in psychiatric hospitals has historically been elusive, as pointed out by Goffman whose study was conducted before the development of psychotropic medications had made an impact.

> What skills of this kind a staff may have cannot easily be broken down into the skill-status hierarchy characteristic of other service establishments, where high-placed personnel perform the crucial brief tasks and unskilled lower levels perform routine preparatory work or merely ensure that the environment is kept benign. A ward attendant often seems as well equipped

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[6] All employees are expected to be cognizant of patients' behaviors which they are likely to encounter and to have a repertoire of "appropriate" responses. Further there are also formalized arrangements which may blur the parameters of some workers' duties.

> to offer a "good" relation to a patient as a highly trained psychiatrist.[7]

In previous paragraphs the term "treatment" or some equivalent has been used without having defined it. Ultimately it must remain as undefined and problematic as mental health services are. As Feldman observed:

> In mental health our product is intangible and our degree of success is very difficult to determine and measure. The terrain is littered with ill-conceived and poorly executed evaluation studies, and the technology of mental health evaluation remains quite limited. It is therefore very difficult for the mental health administrator to evaluate the effectiveness of the organization, or even of the individual staff members. These difficulties also exist for outside groups and organizations attempting to evaluate the utility of mental health programs.[8]

Blau also commented cogently upon uncertainties in psychiatric treatment. Work in mental health, she said, is an extreme on the continuum of work that seeks to transform

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[7] Goffman: 1961, p.357

[8] Feldman: 1980 p.xix

people due to "the degree of uncertainty of the task and the capacity to standardize it."[9] She continues:

> Owing to the complex nature of the task -- variable patients, difficulties of diagnosis, and the wide-ranging strategies of intervention -- the performance of workers is difficult to evaluate, and standards for outcome are generally relative, not absolute. Moreover, because the task is uncertain, judging outcomes is difficult, and differences of opinion become easily translated into conflict.[10]

While there has been substantial progress made in the development and usage of psychotropic medications since the preceding were written, mental health services organizations continue to grapple with the effects of an uncertain technology. Fancher affirms this view:

> The century and a half of work to discover psychopathologies and methods of cure has not resulted in any generally accepted, authoritative body of evidence defining illnesses, their causes, and their cures. Depending on who is counting, between fifty and five hundred different forms of therapy exist, each with the

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[9] Blau, J.: 1983 p. 137

[10] Ibid. p. 138

full panoply of professional organizations, journals, and training programs.[11]

Therefore the term "treatment" has been applied to very varied staff to patient situations. Questions arise as to the relative "value" of activities performed by recreation workers, social workers, therapy aides or peer counselors[12] for example. Even within any of the occupations or professions there are varying interpretations of "doing therapy" versus merely engaging in a verbal interchange with a patient. Emphasis on medical record documentation of staff activities, as later chapters will illustrate, encourage interpreting almost every patient contact as having a "therapeutic" purpose, particularly since the facility is required to demonstrate that patients do indeed receive treatment.

How to evaluate that treatment has been an ongoing problematic for psychiatric organizations and the agencies that evaluate them. The problematic has generally been expressed as, Mattson reported, a dichotomy of process versus outcome criteria:

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[11] Fancher: 1995 p. 19

[12] Peer Counselors are work titles developed to use some former inpatients to motivate current inpatients to make the transition to outpatient status.

> Process refers to what health professionals do to and for patients....Outcome refers to what happens to people in terms of their health status after an encounter with the health care system.[13]

As stated above outcome criteria seemed too elusive. Process criteria, apparently more realistic and inferable from documentation, had become the standard used by major auditors. However a shift toward use of outcome criteria has taken place in the 1990s, as is evident by language used in 1995 JCAHO and HCFA manuals. To display an attempt to meet that challenge, treatment plan review forms issued with the redesigned uniform case record has highlighted sections labeled "outcomes", obligating staff to document how patients responded to treatment methods listed in the treatment plan despite the lack of clarity of cause and effect. More will be said about this in the chapter on forms.

Administrative expectations of tasks to be performed by staff may readily shift with interpretations of new stipulations by regulatory agencies. For example Registered Nurses are assigned tasks of leading or co-leading therapy or educational groups, perhaps those which encourage patients to discuss their medications. But many of those

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[13] Mattson: 1984 p.608

nurses have neither the training nor the interest in that kind of patient involvement and express discomfort with even the idea of leading groups.

Psychiatrists may be no different, as I vividly recall from an episode that occurred sometime in 1989. As coordinator then of an outpatient clinic I was expected to ensure that clinic psychiatrists "ran" (one of those vague "therapy" terms) two groups each. When I informed one of the clinic's psychiatrists, a Russian emigre, of the new demands she said, "I escaped Russia to get away from people like you!" While admittedly I was upset then at being compared to a commandant, in retrospect I recognize how intimidating it must have been for someone to have a "group therapy" task thrust upon her, without even knowing what that task entailed. For administrators the issue was not whether she had been trained to run groups, knew anything about them or had the potential for being an effective group leader. For them the goal was being able to document that psychiatrists ran groups.

If Goffman informed us that any of the staff at an "asylum" could be as therapeutic as another, it was also a stance that had gained some legitimation in some arenas of

mental health services.[14] TPC, which opened in 1963 (as a state hospital) was in the forefront of that "progressive" approach. Some therapy aides were imparted work titles, such as "team leader", that may have carried some prestige, but offered no additional remuneration. In the 1970s Mental Health Therapy Aides working in clinics were given "therapist" titles and "carried" caseloads similarly to professional staff. But those were times of minimal regulations and sparse documentation. Changes in the 1970s and 1980s emphasized credentialed professional staff as purveyors of treatment that they would have to document. I will show how uncertainties of psychiatric services are manifested in the psychiatric medical record practices.

The Organization's Forms

While this study will focus on forms used in the medical record the organization is form driven throughout. If a hundred or so forms can be used in the medical record, the total forms used by the facility could number well over a thousand. A memorandum entitled "Forms Control" was distributed in August 1989 for inclusion into policy and procedure manuals. Work units were thereby advised that

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[14] Goffman, according to Shorter, was one of the major influences of the anti-psychiatry movement that burgeoned in the 1960s. (Shorter: 1997 p. 275)

administrative permission was required before they could devise and distribute forms that seemed to fit their own purposes. The Quality Assurance department had not only to approve any forms, they needed to label and categorize them. While the memorandum referred only to forms designed within the facility it highlighted the fact that they were too important to be left to uses about which administration was unaware. Most forms in use, though, are not designed by the facility but by central offices located in Albany.

Numerous forms are patient treatment related in addition to those used in the medical record. Many are designed to fulfill specific task requirements. For example there are several forms which enable distribution of funds to patients (a standard allowance of $35.00 monthly per patient is apportioned in weekly sums for discretionary spending.) Various forms derive from the process of prescribing use of particular medication categories, including those which have designated restrictions because of their potential to induce addiction or cause other physical problems.

Other forms are designed to survey the work of others. For example the pharmacy has a checklist to be filled out by their staff during inspections of medication storage on wards. Pertinent to this study are forms designed to survey documentation in the medical record. "Ticklers", which must

be filled out monthly, have spaces to denote the presence or absence of documentation in each chart. Prior to audits additional medical record review forms are filled out by "task force" staff deployed from other units. In outpatient units "service recording" forms are filled out to obtain third party reimbursements and to display productivity.

A multitude of forms track personnel transactions. Included are those used to canvass potential employees from hiring lists, applications for employment, those which show employee statuses (e.g.: permanent, temporary, provisional), performance evaluations (each of the unions and/or bargaining agents use different evaluation forms), and those which follow the course of disciplinary actions against employees.

Ensuring that staff get paid requires a large number of different forms. These include time and attendance forms submitted monthly on behalf of each employee, time off duty request forms and those which record the presence or absence daily of those employees (these vary with respective unions.) There are payroll distribution forms which route paychecks to divers units, requiring employees' signatures as those paychecks are picked up. Separate forms are used to record "overtime". Since overtime expenditures are very problematic for the organization, it has designed forms which require supervisors to state justifications for

overtime, calculating the hours needed. "Lost time" forms record the days an employee should be off the payroll and another form enables the employee on "lost time" to get paid. Forms are used to permit staff to go "off duty", perhaps because of an injury, and forms are used to authorize those employees to return to duty.

Problems arise when needed forms are not readily available as I can attest from my own experience. One such situation arose when the secretary of the unit for which I was responsible had left for vacation without submitting payroll distribution sheets. I was informed that unless those forms were produced immediately, unit employees would not get paid the next day. "Don't mess with the paycheck" is a tenet one quickly learns to heed; a frantic search through files and drawers ensued until those needed forms could be located and rushed to the department that releases paychecks.

The above paragraph illustrates form management as an organizational issue. "Common sense" efforts should result in keeping at hand a supply of forms that one is likely to use and the evidence is that work units, for the most part, make this attempt. But a clinical unit, one comprised of several wards, will need access to hundreds of forms, some of which are used very frequently by many staff, progress notes for example, and some of which are used only

occasionally, such as the one used to request replacement of furniture. Keeping at hand all that one may need takes a great deal of space and an investment in ordering and keeping track of all those forms. Unit secretaries are differentially able and interested in the task. In addition, the location of the office where forms are kept may be in a location several floors away and perhaps may be locked. When forms have recently changed the problem can be compounded by uncertainty as to the legitimacy of older forms still on hand. Much time is spent in the attempt to locate forms when they are needed. Unit secretaries order forms (on a form, of course,) from a central facility storage area.

Management of filled out forms is also problematic. Certain forms are used very frequently, and thus accumulate over time. An example is the hourly check sheet which is filled out by each shift for each ward. Similarly each shift on each ward has a work assignment form to be filled out by a nursing supervisor. While there are no directives as to where each ward will store these filled out forms it is clear that they must be saved. Staffs vary with respect to how carefully they treat the forms; many stuff them in the nearest file or drawer in the nursing station. Since most of the time those forms will never be looked at again, batches will be collected and brought to more distant

storage areas where they are piled on those that have amassed over the years. However at times particular hourly check sheets and assignment sheets must be located. For example a patient may state that she was sexually molested during a particular night by a staff member. The ensuing investigation would necessitate obtaining both the hourly check and assignment sheets for the time in question, sometimes resulting in searches through file cabinets and various desk drawers. When those forms cannot be located staff may be suspected (but not openly) of tampering with evidence.

At The Psychiatric Center forms have often been developed when critical management problems arose. For example during one period overtime costs had been declared unacceptably high by state central offices. Forms were designed to enter expected staffing patterns for each inpatient unit, covering each of three eight hour shifts daily. To ensure that unit administration knew of and took responsibility for those forms, their entries were read aloud in administrative meetings held daily. Earlier, lower level staff had been filling out overtime projection forms, a different version of the form but with the same intent. When overtime containment became a primary goal, unit chiefs had to make the entries themselves and publicly report attempts they had made to avoid that extra expense.

Another critical problem at The Psychiatric Center has been "census management", that is keeping the number of patients within sanctioned limits. When the census is deemed too high while agencies are pressuring for admission of patients, discharge becomes an imperative. In response to one high census period forms were developed to display discharge reports. Since the discharge process involves filling out and submitting packets of other forms, especially if the patient is slated to reside at one of the community residences, the discharge report form listed progress (or lack thereof) of discharge form packets. Here too, through forms, unit administrators demonstrated their efforts to participate in overcoming problems of the organization.

Discussed above were several forms designed at The Psychiatric Center. Yet much of this study emphasizes forms designed at the Office of Mental Health and mandated for use at TPC. How then is it that The Psychiatric Center is "the organization" rather than the Office of Mental Health? Perhaps the answer can be found in the following citation from Aldrich:

> From an organization's perspective, the ability to *control* boundaries is critical for the maintenance of organizational autonomy. When the boundaries of an organization become blurred for an observer, it is

> probably a sign of change in the relative power of the organization vis-a-vis its population.[15]

When OMH distributed sets of forms accompanied by instructions for documentation that all psychiatric centers had to follow, it was an overt demonstration of centralized authority impelled to respond to financial and legal changes.

For the purposes of this study the organization is defined as The Psychiatric Center, as has been stated in the opening paragraph of this chapter; TPC has, after all, been the locus of my access to research. I do want to draw attention to forms as a mechanism capable of blurring organizational boundaries.

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[15] Aldrich: 1979 p.5

CHAPTER 4

THE INPATIENT MEDICAL RECORD AT THE TREATMENT SITE

The Treatment Site

Inpatients at the facility reside on one of eighteen wards located in either building "A" which has fourteen wards or building "B" with four. Both buildings have spaces allocated for additional uses. For example the Rehabilitation Department uses the space equivalence of two wards in building "A", a result of a specially designed rehabilitation building having to be closed due to poor construction. Each ward has a "bed capacity" for approximately thirty-five patient unless it has, for example, a specialty designation such as "Secure Care". Wards housing residents in building "A" have a large dayroom, an activities room, a dining room, staff offices and sleeping areas which include two large dorms and several smaller bedrooms, even a few single rooms. In building "B", which was designed to house fewer patients per ward, patients spend daytimes on a ward where the spaces are used for a dayroom, activities, offices and dining, and then cross a hallway every evening to another ward, the "sleep side", where dorms and smaller bedrooms are. Every morning

the reverse transition is made. Because of structural defects in building "B" it cannot pass an audit conducted by the Joint Commission on the Accreditation of Healthcare Organizations. While that organization surveys building "B" patient care and records when conducting the survey of the whole organization, the Health Care Financing Administration limits its review process to building A patients. Audits and the processes they entail are discussed in greater detail in other sections of this paper but here it should be noted that the organization will receive HCFA medicare funds only for eligible patients in building "A".

In addition to the space allocations described above every ward has a "nursing station", an area bordered by plexiglass on three sides so that staff can see into the dayroom and the hallways (with some assistance from strategically placed mirrors.) Adjoining the back wall of every nursing station is a treatment room, an area where physical examinations take place, medication is stored and dispensed, and where medical records of the ward's patients are kept. A room close to the nursing station and the treatment room, with ready access to both, is allocated for "seclusions". Access to these and a number of other areas is enabled by the same key that opens the door to the ward, a key that should be in every employee's possession at all times.

Individuals for whom admission is being sought are brought to the Triage Unit area, a set of a few small offices close to the Safety Department, allowing for prompt assistance should a patient become violent. From the triage unit a patient is escorted, by pre-arrangement, to the ward where s/he will reside, an issue that would have been determined based upon factors such as "bed" availability on that ward, age (there are two geriatric wards), potential for imminent violence (for example it may be advisable to start with the secure care ward), whether there is an significant reason the individual shouldn't be on a mixed sex ward (for example a recent history of rape), evidence of significant organic brain disease (should the person be placed with those who have both intellectual and mental disabilities), if the person is a mono-lingual Hispanic (there are two wards where all professional staff are fluent in Spanish), and other considerations. A new admission is likely to be assigned to reside on one of three admission wards, which might then involve transferring one of the patients on an admission ward to another, again based upon the factors delineated above.

The Inpatient Medical Record on the Ward

A person becomes a "patient" at the time admission forms are filled out, when the psychiatric medical record is

started. The triage unit has already prepared record binders with dividers and start-up forms such as the face sheet, file order, admission screening form, progress note sheets, a psychiatric evaluation and several other forms. Any paperwork that had been forwarded previously or accompanied the prospective patient would be placed in the "past records" section of the binder. The triage unit psychiatrist fills out the psychiatric evaluation (probably using existing paperwork as a basis), and by entering diagnoses and signing that form and the Admission Screening Report that has earlier filled out by a social worker or another staff person. At this time the patient's legal status must be established; voluntary or involuntary admissions forms are filled out and signed, unless they are pre-empted by criminal procedure law orders.[1]

The medical records department is called to have a "C (consecutive) number" assigned to the patient. If the person has had a previous admission(s), either as an inpatient or outpatient, the number used in the past is retained. The record binder is labeled with the patient's "C#", name, birth date and admission date. Pasted in front of every chart binder are "universal precautions" instructions as infection control reminders. In addition

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[1] See chapter on Regulators and the Law

there may be alert stickers attached to call attention to certain illnesses, allergies and court related legal statuses.

When patients are brought to reside on a ward they are always accompanied by their medical record. Records, one for each of the approximately thirty-five ward residents, are expected to be located mainly in the treatment room. It is important that records be kept where staff would expect to find them, since they are used and reviewed for a variety of purposes, sometimes with some urgency as would be the case if a patient suddenly became physically ill. Task force staff conducting audit preparations, those conducting investigations following incidents and dieticians writing monthly note and assessments are some of the staff groups not assigned to the ward but which regularly require access to records. Records are placed on moveable racks (most wards have two) so they can be moved relatively easily as groups when necessary, possibly because staff members want to write monthly notes in their own offices. On wards which have separate daytime and sleep sides the racks of records are moved along with the patients, twice daily.

An area where several records would routinely be found is the nursing station, particularly if a patient is on "special observation" requiring notes from therapy aides. Missing records can be a source of consternation, and in

certain situations an intense search ensues. Staff are not permitted to leave records locked in their own offices, a ban violated with regularity by a few. Because access to all records is considered crucial the facility locksmith must open staff offices for a supervisor conducting a search (every locked area can be opened with master keys.) Patients are not permitted to be in possession of records. When patients have to leave the ward, perhaps for transfer to a different one or to keep appointments such as court appearances, the record is expected to be carried by a staff escort. Stories about what can happen when that rule is broken have become part of hospital lore. In one instance a therapy aide, escorting several patients to the on grounds medical clinic allowed them to carry their own charts. One of the patients, it is said, ran off with his chart and was found later reading aloud from it in a local bar. On rare occasions patients have been known to get hold of their records and destroy them. Such events are likely to trigger attempts to take disciplinary action against staff for laxity.

Ward clinical staff are the most frequent users of records. A typical ward complement of staff includes Mental Health Therapy Aides (MHTAs), nurses, a medical specialist, a psychiatrist, two social workers, and a member of one of the rehabilitation staffs such as occupational therapist or

recreation worker. Psychologists are infrequently assigned to wards since there are no HCFA mandates for their documentation. Entries into the record must also be made by certain staff with temporary treating responsibility. For example psychiatric and medical staff are expected to be available at all times; when ward physicians are off duty, "on call" staff are required to provide documentation about events for which they have been summoned. A number of supervisory personnel, such as unit chiefs and team leaders as part of one hierarchal chain and discipline supervisors as part of another, are considered accountable for the timeliness and quality of documentation, and therefore would be frequent users as reviewers and when advisable to make direct entries. Classic conflicts are ongoing between representatives of line and discipline hierarchies with respect to ultimate responsibility for getting the chart work done. The following discusses work roles of various ward staff and their documentation requirements.

Mental Health Therapy Aides (MHTAs), the lowest paid clinical staff, are the most numerous workers in the hospital. They are under the aegis of the nursing department but do not have the professional standing of nurses. MHTAs must be present on wards at all times, -- that is 7 days a week, 24 hours a day, usually on eight hour

shifts.[2] There should never be fewer than two MHTAS on a ward since in an emergency, such as a patient becoming unconscious, one must be available for direct intervention and the other for calling for additional assistance.[3] Most likely a minimum of three MHTAs will be allocated per ward per shift, particularly during more active daytimes, and in stipulated circumstances, when a patient is placed on "one to one" special observation, the number increases. Central administration at the facility is highly invested in keeping MHTA staffing at bare minimums, especially when overtime costs may be involved.

Medical record documentation requirements for MHTAs are limited to specific situations and regulations. For example if an incident has occurred, perhaps a patient is noted as missing, an MHTA is expected to write in the progress note section of that patient's medical record describing the event and initiate an incident report. If a patient has been placed on "special observation", that is an MHTA has been assigned to observe one patient exclusively, then that

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[2] Under certain circumstances other clinical staff, social workers for example, "cover" for MHTAs. There is often contention between administrators and nursing staff as to when LPNs "count" as ward coverage as the former exert pressures for cost containment and the latter stress safety factors.

[3] Hospital regulations actually state there must never be fewer than two clinically qualified staff on ward duty, thus permitting professional staff, social workers for example, to "cover" should MHTA staff be unavailable.

staff person is expected to write a progress note covering the eight hour shift worked. If a patient is placed in seclusion a therapy aide must observe that patient at least every 15 minutes and must sign the seclusion observation form designed to record that observation.

There are a few forms crucial to the task of therapy aides that are not placed in the medical record. An important one is the hourly check list of patients which obligates staff to sign that each patient present on the ward has been observed at specified times, noting reasons for any absences. Entries into the Communication Book, a bound journal with numbered pages, is another documentation responsibility of MHTAs. Each shift is required to note significant events that occurred during their tour, entries which should be reviewed by staff, including professionals, on subsequent shifts. When serious incidents are investigated entries in the communication book can be compared with entries in medical records and incident reports to uncover gaps and/or inconsistencies. Many MHTAs have limited formal education and, therefore, display much discomfort using written language. Some are so insecure that they seek assistance from co-workers when called upon to write even a paragraph or so. That insecurity is sometimes due to wariness that what they write can be used

against them in the future. But then again that concern is endemic to the documentation process.

"Nurse" may refer to Licensed Practical Nurse (LPN) or the higher status, higher paid, Registered Nurse (RN). Every ward should have one nurse assigned to each of the day and evening shifts. On the night shift nurses may be assigned to cover two wards since it is not a time that medication is routinely dispensed. Nurses are assigned a number of duties, among them reviewing physicians' written orders for medication, arranging for each patient's medication to be available on the ward, dispensing or administering that medication and dispensing or administering ordered medications during emergencies. Very frequently patients are prescribed more than one type of medication and some, particularly those with medical illnesses, may have orders for half a dozen or so. Most medications are in pill form, but they may also be in liquid form or administered by injection. At medication time patients line up in a somewhat orderly fashion in front of the treatment room. On the other hand a number of patients are resistive; they may become expert at pretending to ingest pills or refuse outright. Sometimes after violent episodes injections are administered by the nurse as the patient is restrained by other staff.

Medication transactions require considerable documentation by nurses. Doctors' medications orders are "picked up" by nurses, that is the nurse signs that s/he has noted those orders, has accepted responsibility for entering the medications on "medex" forms and for ensuring that the medications order are received by the pharmacy. Pharmacy staff place pill medications in small bins, each labeled with a patient's name and C#, that are part of a rolling cart that is brought to the ward daily. Medication in pill form is dispensed from those bins, with the entire cart removed when a replacement is delivered. Medex forms have spaces for initials of nurses dispensing medication. From the medexes it is expected that one will be able to ascertain whether a patient actually received those medications, or at least if the nurse has signed that the patient did, events that should be equivalent but are not always since the acts of dispensing and recording are separated in time. Medex forms become part of the medical record when they are filled out, about monthly. Injections require that the nurse write a progress note to the effect that the patient's blood pressure was taken first, stating the reading (which should be within acceptable range) and the body site injected or noting any reason the injection was not given.

In order to comply with hospital regulations nurses must also write progress notes whenever they administer treatment such as applying dressings to wounds. They are also responsible for some of the documentation in the medical and laboratory reports section of the chart. They must record patient's blood pressures at least monthly and countersign patients' weights recorded by MHTAs. In addition the documentation already discussed (and it was not meant to be exhaustive) there must be a monthly nurse's note written by an RN. If the nurse assigned to the ward is an LPN, an RN from the central nursing office is assigned to the task of note writing. Often there will be two monthly notes written by nurses, one from the LPN who has been working on the ward and the other from the "outside" RN, the two notes saying essentially the same thing. LPNs have remarked to me, somewhat resentfully, how wasteful this duplication is, especially since they "do" the medication and know the patients. Nursing assessments which are to be written shortly after admission and yearly thereafter, must be completed by RNs. Again, if the ward is staffed with an LPN, an RN will be sent to write it.

Medical specialists are physicians who evaluate and follow medical statuses of patients. When patients have medical problems those physicians can and do provide limited treatment, but use area public medical hospitals for

diagnosis and treatment of more serious ailments. Sometimes public hospital emergency room staff criticize The Psychiatric Center for not providing minimum treatments when patients (accompanied by one, sometimes two, MHTAs) are brought to have small wounds sutured. One medical specialist is assigned to cover two wards. Each of the wards may be part of two different units and one ward located in building A and the other in building B, a distance that may take 10 minutes to transverse when the elevators are working.[4]

The medical specialist must write a progress note for each patient at least every three months for patients who have no medical problems. Additional medical progress are written whenever there has been an evaluation or treatment. For example if two patients had a fight during which one was hurt, progress notes are to be written in the charts of both patients. With respect to the patient who got hurt a note should be written describing the injury and the treatment recommended. The other patient's chart should record "no visible injury" or words to that effect, indicating that the medical specialist did in fact do an evaluation. When incidents reports concerning fights are filed, medical

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[4] Difficulties in achieving "efficiency" are beyond the scope of this discussion, but medical specialists have sometimes become short tempered when summoned from one ward to another for situations they did not consider urgent.

specialists' notes are expected to be reviewed to ensure that they are in the record. If a physician "forgets" to document an event it is the responsibility of the unit administrator to ensure that the staff person returns to complete paperwork. Progress notes for medical specialists are kept at the end of the medical and laboratory section of the chart. Since those progress note forms are no different from those in the main progress note section, sometimes other staff err and write their own progress notes in the wrong place.

Medical specialists are responsible for several other documentation areas. They fill out consultation requests for dental, ophthalmology, EKG, X-Ray, EEG and other examinations. After consultation requests have been addressed (the form is designed with spaces for the request and the report), medical specialists sign indicating their reviews. They also sign laboratory reports to indicate they have been reviewed and abnormalities have been noted. Medical and laboratory sections of records will be relatively sparse when patients have no medical illnesses but for those who do, for example those with AIDS, medical data and documentation encumber the charta. Medical specialists conduct annual physical examinations (using of course, designated forms) and update medical summary sheets and immunization records. Medications for medical illnesses

are prescribed by medical specialists through entries on doctor's order sheets.

Psychiatrists are physicians who have completed a residency in that medical specialty. The facility attempts to effect distinct realms of responsibility between medical specialists and psychiatrists but each are expected to be cognizant of contraindications and interactions of medications before ordering them for any particular patient. Most wards have one assigned psychiatrist but specialized wards, such as those part of the admissions unit, may be assigned an additional one. Psychiatrists' evaluations of patients should be geared to assessing a number of factors such as the need for containment at the psychiatric center, differential diagnoses, type(s) and dosage(s) of medication, likely precipitants of psychotic episodes, criteria of improvement, readiness for off-ward privileges, readiness for discharge, and potential for dangerousness to self and/or others. These evaluations most often are made with input from other members of the clinical team, as will be discussed later. Irrespective of that input, documentation by psychiatrists is, in a sense, the driving force of treatment and the medical record.

Medication is prescribed by entering medication names, dosages and frequencies on doctor's order sheets, the same form used by medical specialists. Medication orders must

have a start date and a stop date, covering a period of no more than 28 days. A number of events and situations will induce medication changes, temporarily or long standing, all of them requiring documentation by psychiatrists. Sometimes patients are assessed as requiring a level of restraint known as being "put into seclusion". Seclusion order forms are filled out by psychiatrists who must also write that order on the doctor's order sheet, and in addition write a progress note. Patients' statuses with respect to off ward privileges, including the hours allowed, are also entered onto the doctor's order sheet, with start and stop dates. Occasionally staff and patients claim they have been told by the ward psychiatrist that increases in privileges were put into effect for particular patients. Staff who allow patients off the ward based upon verbal statements without checking doctor's order sheets subject themselves to possible disciplinary action, particularly if something should go wrong, the patient fails to return, for example. On the other hand checking each record for off ward privileges documentation is impractical in view of routines which permit many patients to leave wards unescorted once, twice or three times daily, depending upon those written orders. Thus there is very often underlying tension that documentation in the record will not support actions taken by staff.

Psychiatrists must write monthly progress notes and in addition must write notes in that section whenever there has been a significant event such as a suicidal gesture or placing a patient on escape or missing status.[5] Psychiatric assessments are written yearly. Documentation pertaining to patients' legal statuses are the responsibility of psychiatrists. For example, if a patient on voluntary status submits a request to be discharged in 72 hours (a patient right), and the psychiatrist believes the patient should be retained, then documentation consisting of a clinical summary and two physician certificates for retention must be submitted. The psychiatrist requesting the retention fills out one of the forms and arranges for a colleague to fill out the other. Although from the form title one could infer that any physician can fill it out, only psychiatrists are permitted to do so within Office of Mental Health facilities.[6]

Usually two social workers are assigned to work on one ward. They may have Masters of Social Work or Bachelors degrees, their work titles and pay most often reflecting the education differential. Since the role of ward social

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[5] Documentation on incident reports is in addition to documentation in the record.

[6] Refer to chapter on Regulators and the Law for an expanded discussion.

worker is more ambiguous than the other occupations and professions discussed, describing a series of tasks and expectations will serve as explication. First, they are called "therapists" but that term has no official meaning and there is no consistent understanding of how that function should be performed. With two social workers on a ward, half the patients will be assigned to each. Social workers are expected to get to "know their patients". They are expected to learn about patients' past psychiatric and criminal incarcerations, family relationships past and present, educational level, and financial resources, as examples. One social work role then is "information gatherer" for the record. Another is "discharge expert", that is to know (or find out) where each of the patients could live upon discharge and what would be entailed to effect that discharge. Social workers are expected to engage in "legwork" such as accompanying patients on visits to residences for post-hospitalized psychiatric patients. Social workers are required to write monthly notes. As information gatherers they are expected to document that data in the core history and social assessments. They are expected to ensure the availability of all the paperwork needed for discharging patients on their caseload. Social workers are also most often assigned the task of writing treatment plans, a task, as I note elsewhere in this paper,

many of them see as an expression of how their profession "gets dumped on" unfairly.

A typical ward will be assigned a recreation therapist, one of several occupational titles under the aegis of the rehabilitation department. Recreation workers provide for a range of projects for patients who are restricted to the ward all or most of the time. Those projects include a standard assortment of activities such as crafts, exercise sessions, games and holiday celebrations. Recreation workers must write a month activities note and an annual activities assessment. Entries by rehab department workers must be present in the record but they are not usually closely evaluated qualitatively.

The clinical staff described above are members of "the treatment team" which is supervised by the Treatment Team Leader, a title combining administrative and clinical functions. The psychiatrist, however, is considered the leader of the clinical team for purposes of treatment decision making. The treatment team is expected to convene several times weekly for "rounds", (during which all ward patients should be discussed), at least weekly for administrative issues and training sessions, (a time when policies and forms are introduced or reviewed), at least three times weekly for "therapeutic community" ("T.C"), (meetings comprised of staff and patients), post "T.C.s",

(staff meetings to review the T.C. that just occurred), weekly discharge meetings, treatment planning sessions when annual comprehensive and quarterly reviews are due for each patient, special meetings called for case conference and special training conferences. It should come as no surprise that various staff groupings differ greatly with their interest in and capacity for compliance with meeting attendance, let alone keeping those meeting focused and "productive", but even the more involved staffs express exasperation at the number of meetings scheduled, especially those that serve administrative purposes. Pragmatic concerns may prevail in sanctioning staff absence from team meetings. For example medical specialists are not expected to attend routine meetings since they "cover" two wards.

The treatment team is not merely a utilitarian organizational format; it is a concept specifically stated in Health Care Financing Administration guidelines: "The patient and treatment team collaboratively develop the patient's treatment plan."[7] While effects of HCFA and treatment planning processes will be elaborated in other sections here attention is directed to an example of how that federal agency's influence is manifested throughout The Psychiatric Center. Many staffs are a disparate collection

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[7] Code of Federal Regulations: S482.61 (c)(1) Guidance

of individuals, some of whom have a fundamental disdain for the opinions of other "team" members. Nevertheless documentation in the record is expected to demonstrate a cohesive viewpoint. In the course of his study Barrett observed "Conflict between staff was never openly expressed in the case records, being fought out instead in the arena of spoken discourse which left no permanent record."[8] Barrett's use of "never" is an overstatement, at least from my vantage point. While it is rare for staff to use medical record documentation to express disapproval of other staff, it does happen, but there also may be consequences for the writer. For example after the death of an outpatient a social worker wrote a progress note which appeared to implicate a psychiatrist by documenting his lack of responsiveness to complaints. Since "death" records are always scrutinized the note, as was anticipated, came to the attention of administration, setting off an investigation. Because the social worker used the record for "whistle blowing" instead of following other avenues for reporting her observations and concerns, she was officially reprimanded.

When patients are discharged or terminated the record must be closed. A disposition report should be filled out

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[8] Barrett: 1988 p. 268

very soon after so that the medical records department can enter the event into a data bank. (That does not mean that if a disposition report is not sent, the medical records department and others would be uninformed of a discharge; there are also daily census sheets and nursing reports which require entries of all patient transactions.) The psychiatrist must complete a discharge summary and the social worker must fill out a service plan. Also several staff must write closing progress notes. A discharge can be planned or unplanned, the latter occurring when, for example, a voluntary patient leaves the facility without permission (perhaps not returning from a pass). Under those circumstances the patient must be discharged at the end of three days. Most patients who absent themselves do return (or are brought back by family members) within that time period, often having satisfied an urge to imbibe alcohol or get high on drugs. Patients who stay out longer, perhaps being brought back a week or two later (via an emergency room, most likely,) provoke irritation since their old records would have had to be closed and a new one opened, generating "all that paperwork". On the other hand unplanned discharges, while administratively frowned upon, do help reduce the census. Successful unplanned discharges, that is patients who stay out for several months or longer,

sometimes are inferred to be proof that staff had kept them too long and had avoided the efforts of a planned discharge.

Closing of the record is supposed to be completed within fifteen days of a discharge. Closing the record involves filling out the forms mentioned, completing any documentation that is missing and compiling and integrating all debrided material that had previously been culled; every ward has file cabinet space (most likely in the nursing station) allotted for their storage. Since many patients have been hospitalized for several years or more (some even for decades) there could be many folders of material that have to be placed into one record according to the file order form. Most likely this task will be done by secretarial staff. Rarely does the medical records staff accept the record as sent. That department lists missing or incomplete record materials on forms which are distributed departmentally and administratively.[9] Staff, if still available, will be asked to go to the medical records department, perhaps just to sign an assessment. Sometimes when the staff involved are long gone, or material cannot be located unit administrators write a memorandum requesting that the record be "administratively closed". On the other hand large chunks of records may be missing yet be

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[9] Appendix A: Nos. 1 and 2

overlooked. I have stumbled over a number of folders stuffed with materials that belonged with records that had long been closed yet had not been noticed as missing. No one knew quite what to do about those old files.

The above depiction of documentation assignments has frequently been phrased in terms of requirements and expectations but there are several factors which impede their fulfillment. First, there is a wide variation among staff inclination to do paperwork -- a significant number express distaste for the tasks entailed. This will be evident not only with documentation not being done (quantitative deficiencies) but also that which appears skimpy and incomplete (qualitative deficiencies). Second there is a wide variation among staff capacity to write clearly and fluently. I have mentioned earlier the difficulty many MHTAs have using written language. That also may be true of some members of the professions, perhaps because English is not their first or their primary language or perhaps due to backgrounds that de-emphasized writing skills.

A third factor hampering paperwork completion is inconsistency of staff presence. For example if one of the social workers assigned to a ward is on medical leave, possibly for several months, that staff member is not replaced. If the "regular" nurse is out for the same period

replacements will be sent to ward on a day to day basis since patients must receive prescribed medication (the hospital has a contract with a private agency that supplies needed nursing personnel) but that may not result in ensuring all nursing documentation is present. Absent psychiatrists are "covered" by psychiatrists from other wards, but only for services such as prescribing medication and emergencies. Vacations and short term sick leaves create added staffing gaps, all leading to an accumulation of missing documentation.

A fourth impediment to getting paperwork done is in the nature of the documentation required. Language, logic and ideology demands of treatment plans are discordant with thinking and writing processes of most staff. Monthly progress notes require statements recounting how many times for how many minutes each time the writer met with the patient, also stating that those meeting were purposeful and related to the treatment plan. Absence cannot be stated as a reason for lack of patient contacts since regulations require the hospital to have sufficient staff to provide treatment. But even if staff members are present for a full schedule, entered time allocations with patients vary between gross estimates and gross fictions. Many staff tell of the tension they experience because they cannot write

acceptable notes without attesting to events that did not occur.

Depicted above are documentation processes as they are likely to occur on an inpatient ward. Conceptions about various staff disciplines are intertwined with their documentation obligations; for example a social worker who has been assigned to work on a particular ward is expected to be ready to perform documentation tasks relegated to that profession. The psychiatric medical record has been shown to be a major focus of staff activity; for many staff it is their primary activity.

CHAPTER 5

AUDITS

I have shown that regulations established by certain organizations have an impact on psychiatric medical record documentation. Those organizations send surveyors to the facility to assess the degree of compliance with their regulations. Below I will describe audit processes, including stages of preparation for those events, emphasizing how they affect and are affected by the psychiatric medical record. There are three main auditing groups: the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Health Care Financing Administration (HCFA) and the Periodic Medical Review (PMR), a New York State review of every medical record. In addition pre-survey surveys occur; the Office of Mental Health may send in a team to assess the facility's readiness for prospective surveys. Further, other groups have the authority to conduct surveys, generally limited in scope. For example the Commission on Quality of Care may assess treatment and care of patients who have been the subjects of

major incidents, perhaps suspected abuse or neglect by staff.

Facilities almost always are given notice prior to the arrival of surveyors. Applications are made to JCAHO to conduct a survey. Accreditation, if not impeded by recommendations or conditions, is awarded for a period of three years. JCAHO arranges the survey times with health care organizations but has the option to conduct unscheduled surveys when a facility is suspected of engaging in deleterious practices. In 1993 the Joint Commission instituted a policy of conducting random, unannounced surveys for five percent of accredited organizations, a very unnerving prospect for facilities that had become dependent upon having time to prepare. HCFA, which will only audit hospitals accredited by JCAHO, conducts surveys approximately yearly but the specific time may not be made available until perhaps two weeks or so before they are to arrive. Since the outcome of HCFA surveys determines whether the facility will be able to claim third party reimbursements on behalf of Medicare eligible patients, much hinges on approval by both JCAHO and HCFA. PMR conduct its medical records audits yearly.

Outcomes of audits directly affect careers, perhaps even employment, of administrators. Positive outcomes can earn advancements if particular staff are believed to have

been instrumental in the result; negative ones most likely affect employees with titles lacking civil service protection. Administrators are expected to do what is necessary to pass audits, mainly getting others to do what is necessary. Pressures on top administrators reverberate through line and staff hierarchies with the ultimate goal of motivating every staff member for "the cause" whether by engendering an esprit de corps or through fear of humiliation and possible discipline. In the words of a psychiatrist who was head of a unit, "If HCFA wants us to jump up and down six times we jump up and down six times." Preparations for audits are periods of intensely focused, sometimes frenzied activity. Through organizational learning the hospital has evolved many techniques to become ready for surveys. Organizational learning is evident also among auditing groups when regulations are re-interpreted or changed.

"In God We Trust -- All Others Document" is a message taken from an in-house newsletter entitled "Preparation H'FCA". Prior to audits communiques are distributed with paychecks, a mechanism for getting the attention of all staff, and are posted in hallways and on wards. Handouts remind staff of rules that have been known to be violated. For example one flyer reiterated the dictum that "whiteout and erasures have no place in the medical record" (every

staff member is supposed to know that!), and explained the method one should use to make corrections (drawing a single line through the error and initialing and dating the change.) Another reminded about rules for debriding (thinning) charts. Still another educated staff about language proscriptions, providing a list of "Non Behavioral" terms that should be avoided, "interact", "coherent", "relevant", "appropriate", as examples, unless they were clarified with "as evidenced by" and a description of the behavior.[1]

Handouts are only one way to motivate and educate staff. Every unit and discipline supervisor is instructed to hold special training sessions with relevant staff. For example if there is reason to believe that the auditors will be questioning mental health therapy aides about their knowledge of procedures, unit administrators will be required to ensure that those workers have both the right information and the right attitude, primed to reflect well on TPC. Administrators may be given a list of questions (for example, "How do you handle a medical emergency?") to ask staffs from a number of different wards, reporting results to the central administration. Sometimes those training sessions are used by ward staff as an opportunity

[1] Appendix A: No. 3a-c

to let administrators know they didn't give a damn and if "auditors want to really know what's going on I'll tell them but you won't like it." Generally such remarks are not pursued but treated as letting off steam. If too much anger is evident prior to an audit there may be some attempt to mollify lower level staff, perhaps by increasing "positive feedback" or (rarely) increasing staff in some key areas. Auditors are expected to understand that every facility has a few malcontents but there is always fear of being undermined from the ranks. Handouts mentioned above exhort all staff to try to make good impressions on auditors.

But all staff are needed to be invested in the labor of impression management. Walls have to be painted, floors have to be scrubbed and day rooms have to be redecorated. Regulations about treatment rooms are reviewed. "Red Bag" disposables, those which have been in contact with bodily fluids, must be checked for proper placement and usage. Refrigerators in treatment rooms have to be cleaned and checked to ensure that staff do not have their own food in the one allocated for medication (a frequent violation.) Patient sleeping areas are cleaned and aired out. Bedrooms and dorms are checked to ensure that there are no more beds than allowed by regulations, which may necessitate moving some patients. Patients' wardrobes have to be checked to ensure they appear to have a supply of clean clothes. A

supply of clean sheets and bedspreads are made available for use on the day auditors arrive so they have little chance to get dirty. Amid the tensions and bickering about who is responsible for which of the tasks, cynicism and a measure of camaraderie may develop; someone recalls the time when the facility had displays of fake flowers which had been rented just for the period of the audit. Patients are very much aware of the pre-audit buzz of activity. Their "support" is generally solicited by making them part of the venture and preparing them for possible approach by "visitors". Long term patients get used to diminishment of staff attention during those times.

Medical records are a key focus of every major audit. Preparing those records so they appear to reflect existing policies, rules, regulations and laws with respect to documentation of psychiatric inpatient treatment is an undertaking that absorbs very substantial amounts of professional staff time and effort; it is, therefore, very costly. Accumulated paperwork requirements that have not been completed is a major organizational problematic. As organizational learning has taken place, and as "common sense" would dictate, keeping up with the work, getting it all done on time, would make audit preparation much less agonizing. That is easier said than done. Reasons (or

excuses?) for incomplete or missing documentation in the record were outlined in an earlier section.

The Psychiatric Center has instituted a stratagem of monthly reviews of each psychiatric record for quantitative deficiencies, i.e. the presence or absence of documentation. Monthly reports, called "ticklers" were devised to keep the administration apprised of the status of chart documentation with the hope of preventing an overload of work prior to audits.[2] The "tickler" is a form that lists every patient on a ward and which has spaces to enter the dates of the last assessments and progress notes written by members of each of the professions required to write them and for treatment plans and reviews due from the treatment team. The tickler form is expected to be filled out by Treatment Team Leaders who call attention to missing documentation by encircling those spaces. Copies of completed ticklers are widely distributed to the Quality Assurance Department, discipline supervisors and staff required to make entries. Deficiencies from all ticklers are collated and entered onto another form which is then presented to administrative and supervisory staff so that all can compare how they rate with respect to getting chart work done.[3]

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[2] Appendix A: No. 4

[3] Appendix A: No. 5

Prior to an audit a task force comprised of a number of staff from a variety of titles and positions will have portions of their time redirected toward audit preparations. The task force has additional forms for chart reviews, duplicating much of what appears on ticklers and additionally may review other aspects of the record.[4] Copies of the review forms filled out by the task force are sent to the Quality Assurance Department and to team leaders who are required to review and address deficiencies noted. It is expected that unit administrators will prod recalcitrant staff into completing documentation due.

Ticklers and reviews call attention to work that has to be completed but they do not get that work done. By the time auditors arrive all assessments, treatment plans, progress notes and essential medical data are assumed to be complete. Where there are documentation gaps not eliminated by the clinicians originally considered responsible for them, plans are put into place for the backlogged work to be accomplished. Staff must meet qualifications for documentation; for example only psychiatrists may write psychiatric notes. Unit supervisors can enter documentation under the discipline for which they have been credentialed, for example those who are Registered

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[4] Appendix A: Nos. 6, 7, 8 and 9

Nurses can do nursing notes and assessments and those with Social Work degrees can enter documentation due from social workers. Sometimes notes may be written by someone of another discipline if a "proper" signature can be obtained. Supervisory and unit administrative staff will enlist other staff or do the writing themselves since, they are told, they should not have allowed the backlog to develop in the first place. Amidst much conflict, it is with recriminations, resentment and resignation that the catch-up is achieved.

Many staff have learned how to construct adequate documentation for past due work in records without much or even any contact with the patients those records purport to represent. In fact unit administrators and discipline supervisors are expected to have acquired that skill while they were still line workers. Essentially one uses other available documentation, restating, with modifications, what has been written, taking care that dating and placement in the record match. Staff making back-dated entries may also be attentive to whether they were actually present at the time, and not, for example, on vacation.

While some staff refuse to take part in constructing back dated entries for work situations in which they had not participated, others rationalize that no harm is done since the caught up material only reiterates what is already

present in the record and what is being written about is the past and can no longer affect the patients. One Treatment Team Leader, now retired, told me that she would complete chart work due from others when "it became a choice of disciplining the employees or concentrating on treatment." She said she rationalized that she had to prioritize what she wanted to get from those employees in terms of their work with patients. She then reflected, saying that back-dating entries was an incremental process you got used to, comparing it to battered women's syndrome.

Unit administrators, discipline supervisors and/or task force staff are expected to conduct qualitative reviews so they can provide of the best charts from each ward. Those records are then scrutinized for possible sources of embarrassment such as inconsistencies. From that list a shorter "perfect charts" list is developed. Records are selected and ranked so that staff will know which ones they should present to auditors, should they be given an option. Copies of treatment plans from the selected records are sent for approval to the Quality Assurance Department which, in turn, returns them with corrections so they can be re-written. Before an audit all staff will be expected to have memorized their ward's perfect charts list since auditors are not supposed to know of its existence.

Inconsistencies uncovered in the record can be present for many reasons. For example when some staff write their monthly notes they might not read preceding ones written by other staff and then write statements that contradict what is already in the record. For instance a nurse documented that a patient was given an injection following an episode of "agitation" and the social worker note directly below said "no episodes of agitation this month." The social worker thus revealed that he is not performing his job since he is expected to, at a minimum, discuss the patient's perception of the event, perhaps to help prevent repetitions. Notes, assessments and/or treatment plans may reveal that some staff are unaware of medical conditions documented by the medical specialist. Another potentially embarrassing record would be one which reveals staff dislike of the patient with statements such as "He was his attention getting pesky self all night". If it is believed that problematic records are retrievable for the "best" list then efforts for correction will be made. For example, in the case of the contradictory note, all staff who wrote on that progress note sheet will be asked to rewrite their notes even though only one of the notes is problematic thus providing a series of seemingly uncorrected entries.

One of the newsletters mentioned above reminds staff that "appearance counts". Preparation for audits also

involves the presentation of the record as a physical entity. Because of their frequent handling record binders may become quite battered, some even broken. All of those will be replaced. Some unit administrators may choose to have all records re-labeled so that they look clean and uniform, a tactic meant to impress central administrators by the visibility of effort expended. Most importantly, the records will be debrided (thinned) in accordance with stipulated policies, for example removing progress notes that are more than six months old. (The thinned material is stored in designated file cabinets on the ward.) Material within the record is re-ordered, if necessary, to conform to the file order.

Audits vary in their progression and outcome even when conducted by the same group. If organizational learning is evident in how the psychiatric center readies for an audit, the auditing groups are also part of organizations that undergo changes based upon experiences and pressures, with some of those changes being effected through regulations and others by reinterpretations of regulations.

Every audit is different. First, of course, they are conducted by different organizations with different mandates. They each also occur at different points in the history of The Psychiatric Center and the history of the auditing organization. Auditing groups such JCAHO review

their policies frequently, publishing new manuals yearly. Over time TPC has developed some expertise at preparing medical records for audits, so that in contrast to earlier failures the facility tends to do well. Events that occur in one audit become part of the lore of TPC, influencing staff behavior for subsequent ones. For example in the mid 1980s the head of the Department of Psychology approached an auditor to, she told people later, say something about what an important contribution members of her department were making to the facility. The auditor, claimed that he was obligated not to engage in private discussions with staff and had to report any such approach to the Chief Executive Officer. Within weeks of the event the item of Head of the Department of Psychology was eliminated, effectively demoting her. It is doubtful that JCAHO auditors in the mid 1990s receive the same instructions but for TPC staff the lesson lingered.

A Case Example of an Audit

Following is a description of one audit process from the vantage point of my participation. I was, at the time, a Treatment Team Leader for two wards and therefore very invested in the activities described. This was a Periodic Medical Review (PMR) audit conducted in the Spring of 1994. Since PMR auditors are sent from New York State offices in

Albany there really is no danger of actual failure; as one staff member put it "The State is not going to shoot itself in the foot". A poor showing though could affect the reputation and possibly the employment of high level administrative staff. A PMR audit entails reviewing documentation in every medical record, using a check-off form listing the discrete categories to be evaluated. Copies of those forms had been used by the task force that conducted pre-audit reviews. Surveyors would also be using computer printouts listing names of all patients on each ward, so there was no opportunity to "hide" any records.

It was known that the auditors would be at the facility for four days, Monday through Thursday. Staff of each ward were told which day they were expected to have their charts "audit ready". One of the wards I was responsible for was slated for Tuesday, the other the next day. One ward's (ward A) records were more up-to-date so the choice of which of the wards went first was based on that, of course. On the less organized ward (ward B) a social worker had been out ill for four months, and had recently returned. Since not all of "her work" had been done there was still catching up to do; the day's delay would be helpful. At one point that social worker tearfully said "getting sick is like a punishment...no one does the paperwork while you're out". While her statement wasn't completely true it did express

how overwhelming the task of tracking a backlog of paperwork can be.

On Monday morning the first group of charts from another hospital unit was sent to a very large office area that was subdivided into about fifteen work stations. Present in that office were task force members, discipline supervisors, clinical department heads and several administrators. There the charts would again be reviewed by the TPC staff, in case something had been overlooked in previous reviews. If a missing signature was noted on a nursing assessment and the nurse who wrote it was not on the grounds, nursing supervisors already in the room were available to sign. Reviewed charts could then be brought to a nearby office where surveyors were located. Monday afternoon information was received that PMR auditors had completed one ward and had noticed a psychiatric assessment that had a 1992 date crossed out and 1993 written over it. It was clear that a new assessment had not been done. That could be considered evidence of fraud. The surveyors, we were told, were not in a good mood. Tuesday morning the charts for ward A were brought to the TPC reviewers' area. Nursing supervisors were clustered in one area, social work supervisors in another, utilization review staff were in several areas and many other professional staff were present or going in and out of the room. I learned then that the

surveyors were criticizing date spans between some progress notes. While we were all in the habit of okaying a monthly note if it had any date for that month, the surveyor were citing as deficiencies if, for example, social work notes were dated the 15th in February and the 25th in March, a period of more than four weeks.

In addition the surveyors had noticed crossed out dates on a number of assessments and treatment plans. All charts were being reviewed again by TPC staff for crossed out dates. It had been decided that assessments or treatment plans which appeared problematic would have to be re-written immediately and quickly before the auditors called for those records. There was now frenzy of reviewing and re-writing. Since there had been a changeover in form types six months earlier care had to be taken to use the correct forms. If, for example, re-writing was being done for an assessment due the past August old forms had to be located since the new forms weren't in use until October. Staff of various disciplines had to be summoned from other work areas for help with writing and signing. Supervisors would sign whatever was put before them. Suddenly the room got quiet and tense. It seems that one of the surveyors had come into the area to use the bathroom. There was fear that the re-writing would be discovered. Subsequently the door was kept

locked so that only those with hospital keys could enter at will.

Only half of the charts from ward A that were sent down on Tuesday had been reviewed by the surveyors. At the end of the day all charts went back up to the ward and those still needing PMR approval were sent back down early Wednesday. I was told that one of the charts in the second batch had been cited because the treatment plan was out of date; it had been due the day before. Had the chart been reviewed as scheduled all would have been well. One of the social workers in the room shook his head saying "It's the bureaucracy gone haywire."

That day also was the preparation for the review of charts from ward B. Several of the surveyors were also touring wards to view patients "in their environment." As with every audit there was preparation that activities for patients would be going on when surveyors come on the ward. Staff who had been called down to the TPC reviewers' work area so they could re-write or sign off on forms were called to report to the ward for the activity display. Those same staff were then expected to return to the chart preparation area to help with the re-writing. One of the most difficult aspects of the job I had was being in direct line of the anger, derision and challenges. One social worker I had called to make corrections said "I have a group to run now.

Are you saying I should not run my group?" While staff may engage in some form of verbal protests they also know that institutional forces overshadow individual perspectives.

On Thursday afternoon the surveyors addressed staff in an "exit" meeting. Their report was not as derogatory as many had expected. They said some complimentary things about patient care in general and medical care in particular. Among their criticisms were write-overs, emphasizing those on medication orders. The surveyors also stated there were problems with the way treatment plans and treatment plan reviews were written, but that was endemic throughout the state. The facility was then expected to develop a plan of correction for all issues on which they were cited.[5] Several months later I happened to be seated next to the Director of Quality Assurance. She was discussing preparations for an upcoming audit and, recalling the past one, said "PMR" really doesn't count; HCFA is the one we worry about." Prospective audits of course generate the most anxiety. Processes involved with audit preparations may not be without potential peril for administrators even when outcomes are successful. An administrator, having generated enmity among a number of

[5] Appendix A: Nos. 10 and 11

staff, became the target of an anonymous doggerel which included this stanza:

> Your directives were illegal
> Such as forged notes and plans
> You mandated staff write
> For surveyland

Freidson, in his study of a medical group's practices, was prophetic with his statement in a chapter aptly entitled "The Threat of the Medical Record":

> I have no doubt that, where it is required, records will be kept in such a way that an evaluator can find little to fault; what was a tool in the medical group at the time we studied it will become more of a cover. What will go on behind that cover is likely to be a somewhat different reality.[6]

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[6] Freidson: 1975 pp 184-185

CHAPTER 6

THE FORMS

This chapter focuses on forms that are contained in the psychiatric medical record. While each of the forms listed on the 1991 File Order Form will be discussed below (copies of each form will be found in appendix B), several have been selected for special attention because they are most illustrative of psychiatric medical record changes and the processes involved in effecting those changes. Those forms are: assessments, treatment plans and progress notes, which together comprise the Uniform Case Record (UCR) packet of forms and the File Order Form, which was designed to help manage the record and which will be the guide to write-ups about the other forms. Ensuing discussions of forms are not meant to even approach a recapitulation of all rules and regulations relevant to them; a facility publication, "Policy and Procedure Manual for the Uniform Case Record", issued in 1991, consists of 168 pages (slightly more than double that of the one issued in 1982,) is only one of the manuals that relate to medical record entries.

Assessments

Assessments, or evaluations, are generally specific to professions or occupations that have been mandated to fill them out, with the requirement that staff who do so are credentialed. For example, only those who can claim the title "Psychiatrist" are qualified to fill out a psychiatric assessment; only a Registered Nurse is qualified to fill out a nursing assessment. Assessments are designed to be relatively comprehensive evaluations. They are required to be done shortly after a patient is admitted and yearly thereafter.

Prior to distribution of the Uniform Case Record packet issued in 1981 there were no structured assessment forms, but professional departments within the facility proffered evaluation guidelines. Social workers at TPC wrote "psycho-social summaries", which were expected to be a compilation of a wide range of information about a patient, including family situation (past and present), work experience, medical and psychiatric histories, manner of relating during the interview and any other data the writer believed to be germane or of interest. Social workers were, and still are, the occupational group considered to have "expertise" at such information gathering. Structured four page social assessment forms might actually result in less data than psychosocial summaries they displaced but there was now a

format that all social workers in all New York State psychiatric centers were required to use.

Before UCR forms were put into effect psychiatrists would periodically write evaluations they entitled "Mental Status", which encompassed a series of observations about the patient such as memory, orientation to time place and person, mood, evidence of delusions or hallucinations and generally concluding with a statement as to whether the individual was "currently" considered dangerous to self or others[1]. Psychiatrists varied greatly with respect to how thoroughly they documented mental status examinations, often not writing more than just a few lines, referring to only a few categories. The four page UCR psychiatric assessment requested expanded documentation and contained spaces for diagnoses that met standards of the American Psychiatric Association, but believing that form allowed psychiatrists too much leeway the head of the department of psychiatry at TPC developed a psychiatric assessment form that was eight pages, each divided into several sections. Mental status categories were all listed, with spaces for psychiatrists to fill in.

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[1] Assessments of dangerousness are usually qualified by "currently", thus being non-predictive in an attempt to protect against repercussions due to future actions of a patient.

Designations of the form's sections serve as "reminders" about documentation needed. One psychiatrist, when shown the new, more detailed, assessment form commented sardonically, "Oh, good...now I don't have to remember how to do a mental status." Structured assessments make highly visible spaces that are left blank. Those who are responsible for filling out assessments become accountable for what is not filled in as well as what is (of course that is true for other forms as well.) Discretion about what is important or relevant can no longer be left to the judgement of the various professionals. All assessments have spaces for the writers to enter treatment recommendations appropriate for their respective professional expertise. It is those recommendations which are supposed to become bases for treatment plans.

Treatment Plans

Treatment planning is a commonsensical operational concept and is a well ingrained ideology of medical service delivery. There is a moral imperative to the concept of treatment planning based on a common value that those who "treat" others should reason in advance of performing any procedures why those procedures should be performed. Moreover, these choices should be readily explainable to and understood by others credentialed to make an evaluation.

Thus if a patient complains of certain types of persistent headaches, "Rule out frontal lobe tumor" would justify a physician initiating a series of diagnostic procedures. As I have noted elsewhere in this paper, until just a few decades ago "treatment" was not explicitly associated with mental hospitals since their primary function was custodial. When long term incarceration fell into disfavor and treatment was attempted there was a surfeit of theories about the causes of and modalities which purported to alleviate mental illnesses.

Comprehensive Problem-Oriented Treatment Plan forms, developed by TPC for its own use, were introduced in the mid 1970s. Previously there were no standards for documenting treatment planning. Should clinicians have chosen to write some statements of their intentions it might consist of one or two lines as exampled by: "Plan: Continue in day program, Continue on I.M. medication." Probably no treatments plans would have been found in most records. That had to change because a JCAH[2] audit in the early 1970s uncovered a paucity of treatment plan documentation, resulting in failure of the facility to be accredited. Problem-oriented treatment plans, introducing a major change and objected to

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[2] The Joint Commission on Accreditation of Hospitals (JCAH) changed its name to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 1987.

by staff, required relatively little writing compared to what would follow later with the introduction of UCR treatment plans.

Treatment plan processes have been referred to earlier as being particularly problematic for staff. Tri-part comprehensive treatment plans use an essentially behavioral management by objective model of treatment. Goals of treatment are expected to derive from observed behaviors that could be considered justifications for patients' continued hospitalization. Objectives, steps toward reaching those goals, must be stated in measurable behavioral terms with time allocations for them to be accomplished. Plans then require statements of methods to be used to attain each of the objectives, stating what each of the staff will do and how much time they will spend doing it each week. What about this progression is so problematic?

For many staff distinctions between goals and objectives and between objectives and methods are difficult concepts; some staff never do thoroughly grasp them. Sometimes those distinctions are elusive. For example one may come across an objective that states that the patient "will take medication to control his voices". But generally medication is considered a method and is entered that column. On the other hand if the patient is known to refuse

medication frequently then the objective would still need modification, perhaps providing two objectives, one for acknowledging the value of medication and one for diminishing the impact of voices, an example of the type of obsessing that treatment planning could entail. Many staff have difficulty finding terminology for goals and objectives because policies prohibit framing statements in the negative but it is patients' "negative" behaviors that are perceived to be the cause of hospitalization. For example if a patient has been known to suddenly strike others one cannot simply state as a goal the "the patient won't strike out at others" but will have to convert it to something like the patient "will be able to maintain self-control over his impulses to hit others." Much time in treatment planning is spent in deliberating about "how to say it".

Other aspects of writing objectives are also trying. For example one objective for this patient could be "he will report, in groups, that hurting others is wrong. three times a week for two months." These kinds of statements are written as staff either shrug or smile since everyone knows that no one is keeping track of everything any one patient said, let alone counting how many times s/he said it, even if one could really rely on a connection between what a patient may say and his or her actions. In the effort to get the writing job done staff search for any statement that

will pass as "measurable" and attach times to them. Highly literate staff may have as much difficulty making treatment plan entries as staff for whom writing is arduous. For the former, some of whom have private psychotherapy practices, minutiae of behaviorism are an anathema. To the right of the objectives column is another one for entry of a "target date", a time when that objective could be attained, but not more than six months ahead. Since it is very likely that objectives will not have been met during that time, especially on wards where more chronic patients reside, when period treatment plan reviews are due target dates are crossed out and a new ones entered.

Configuring methods are also troublesome. Methods are expected to be specifically related to specific objectives but effects of most staff inputs are speculations. Staff who fill out treatment plans are instructed to state activities that will transpire, their duration per week and names of the staff involved. For example an arts and crafts group led by a recreation therapist will be entered as a method to achieve one or more of the objectives on treatment plans for patients who attend, however infrequently. Methods statements are as prone to derive from what is already being done (i.e. recreation therapists still do the same type of work they have been doing for decades) as from treatment plan objectives but in the treatment plan writing

it should appear that the treatment activities are geared to meet each individual's treatment objectives. State psychiatric facilities must demonstrate that patients are involved in at least twenty hours of treatment weekly and if they refuse to participate attempts are made to engage them. Thus it becomes important to list every possible activity in the methods column, particularly for those patients who do not have privileges to attend off ward programs. Treatment plans which were strictly behavioral met with some criticism from auditors; then statements of "clinical rationales" for various treatments had to be added to the methods column. Clinical terminology which had been frowned upon and which staff had learned to eliminate while writing treatment plans then had to be re-introduced and squeezed in illogically in the methods section.

Writers of treatment plans are instructed to document that Registered Nurses involvement with patients' treatment extends beyond administering medication because HCFA's reimbursements for "procedures" performed are based upon Registered Nurses having key clinical roles. Therefore entries in the methods column must list some clinical activity for RNs, for example co-leading a medication education group with the psychiatrist. But many of the RNs who work at The Psychiatric Center, neither trained nor interested in running groups, become expert at making

themselves unavailable for that kind of patient contact. Cynical staff say "maybe the patient line-up for medication is really a group." Occasionally staff members are sticklers for how their own name appears in the methods column. One example is a recreation therapist who insisted that the times stated in the methods sections were exactly those he had displayed on his program schedule. Such line staff, particularly non-medical personnel, are considered to be obstructing progress toward getting the job of treatment plan writing done and are held in check by various supervisors.

All entries necessary for filling in the methods section creates additional problems when there are changes in a patient's treatment locale within the facility, i.e. transfer to a different ward. Since all staff names from the sending ward become obsolete they should be crossed out (white-outs or erasures are absolutely forbidden) and current staff names are inserted. All the crossing out and insertions can make methods sections take on a sloppy incomprehensible appearance; but no matter, it looks as if staff have worked on it. Writing a whole new treatment plan is a prospect staff tend to avoid even when they disagree with what is written, perhaps offering as a rationale: "We might as well delay all that work until the next comprehensive is due".

There are some staff who are both proficient and efficient at writing treatment plans, but for most it is a very time consuming, cumbersome and often vexing task. It is, therefore, a source of much conflict about who should do the writing and when. Generally treatment plan writing is assigned to social workers, or psychologists should one be assigned to the ward. Social workers insist it is an unfair burden: the team leader, the nurse or the psychiatrist could also do the writing, they claim. One social worker complained that psychologists should be hired to do them all since "they were trained in behavioral methodology but social workers were not." While that social worker was incorrect about the training of most of the psychologists who work at TPC she did express the uneasiness often heard about having to write plans about which one has no convictions. Resentments of staff may be gleaned from treatment plan contents. For example one social worker omitted objectives for medication prescribed by the psychiatrist. When questioned about this lapse the social worker said "How am I supposed to know what the medication does? If it's so important let the psychiatrist do the writing." Bickering ensues about whether treatment plans should be written during treatment planning meetings or delayed to be written after, or whether they can be done at all if key staff are absent, etc. During periods of audit

preparations all protestations tend to be set aside; somehow by someone each treatment plan must be completed. Treatment plans must be signed by the writer and the ward psychiatrist. It is customary for records to be piled, opened to treatment plans that need signatures and placed in front of psychiatrists; I have rarely seen them read treatment plans they sign, an exchange for being relieved of the writing process. It is also an indication that treatment plans, while understood to be administratively necessary, are not used by psychiatrists to affect the clinical course of patients' care.

Comprehensive treatment plans are filled out yearly with treatment plan reviews due every three months until the next comprehensive treatment plan is due, that is one comprehensive plan and then three reviews.[3] Treatment teams are expected to meet to discuss entries that should be made on reviews, a practice inconsistently adhered to. Before the uniform case record redesign reviews were regarded as tasks that could be dispatched with relative ease. With the aim of not having to bother making any changes in the comprehensive treatment plan progress notes

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[3] During the first year of an inpatient stay reviews are due after 10 days and every 2 months thereafter. Reviews are also due 10 days after patients are transferred from one ward to another.

for the past period would be perused (of course patients could be better, worse, the same or better in some ways and worse in others) and short statements written about each of the objectives, ending with "Objective continued". This practice was criticized since continuing treatment objectives, and implicitly methods to attain them, did not seem warranted when there was no documentation of improvement, particularly with a redesigned treatment plan review form that specified "outcomes". To avoid dealing with the comprehensive treatment plan staff sought other solutions, finding more wordy expressions of "Objective continued", for example "an additional time period will be allowed to see if objectives need to be revised."

Progress Notes

Regulations and situations requiring progress note entries by various staff was discussed in Chapter 4. The progress note section contains entries from representatives of all staff groups, professional and non-professional. To recap: psychiatrists, social workers, recreation workers, and registered nurses must write weekly notes for the first eight weeks after admission and monthly notes thereafter. Psychiatrists must write additional notes for any situations such as secluding a patient or incidents such as a patient being found missing or changes in legal status or

medication. Dieticians write on a schedule varying with patient's medical status, mental health therapy aides write notes about incidents when they occur and when they have to do "special observations". In addition progress notes should be written by various staff for a variety of circumstances such as admissions, transfers to and from medical facilities and discharges.

Progress note instructions inform prospective writers that notes should be "keyed" to goal numbers and objective letters on treatment plans. Progress notes are expected to be focused, addressing those goal and objectives specifically. As an example if a patient's treatment plan has a second goal pertaining to losing weight with a first objective of losing four pounds per month, a nurse's note should contain statements about weight changes and they would be keyed "2A". However if a treatment plan six months overdue (a not uncommon occurrence), is then written and backdated, progress notes could then appear to be incorrectly keyed. One can find progress notes keyed "3B" when a treatment plan has only two goals. Because flipping pages back to the treatment plan is distracting and time consuming many staff choose to leave those spaces blank until they gear up for audit preparations. When notes are written to document an unusual event instructions state that

the note should be keyed "O", thus indicating awareness that it does not refer to the treatment plan.

Progress note forms which were issued with the uniform case record are limitedly structured, but there is an implicit structure resulting from all the policies concerning progress note writing. Staff have had to learn to "DAP" their notes, i.e. to segment them into Data (D), Assessment (A) and Plan (P). That is not to say that some staff don't have trouble differentiating data and assessment, but even then notes do get sequentially labeled and ordered most of the time. Professional staff also have to write statements which state how much time they have spent with each patient per week, a discomforting aspect of note writing when entries constitute stretches of the truth. Psychiatrists' notes must comply with a number of additional policies. For example their notes must state the specific medications they are prescribing. In contrast to the above, progress notes "in the old days" might be written by a social worker every three months or so. In the past there were no note writing requirements for nurses or activities workers. "Mental Status" evaluations written by psychiatrists every few months also fulfilled their routine note writing obligations.

Filing Orders

The Filing Order is an expression of the facility's need to manage forms within its multi-source, multi-function patient medical records. Comparison among different issuances of that form provide illustrations of expansion in documentation requirements from the mid 1970s to the early 1990s. The earliest file order I could locate, from 1976, much less detailed and listing far fewer forms than later filing orders, seems to have been developed just after the first Comprehensive Treatment Plan was put into effect. A later example of increasing importance of forms in the medical record is the filing order issued in 1981 which listed forms for both inpatient and outpatient services on one sheet. Noteworthy also about this form is that the order is presented as it would be when records are closed, with forms related to discharge placed near the beginning of the record, a format that would be continued.

In 1986 an inpatient Filing Order was issued which served as the model for subsequent versions; it had become important enough to be a required part of each record. Each form listed on it has identifying numbers and/or letters which indicate their origins. For examples "MED" and "OMH" indicate forms have been issued by the Office of Mental Health and "TPC" indicates forms were designed at the facility, perhaps for its own use only or to modify one

issued by OMH, in which case it would have been approved by that agency. Filing Orders, used as an instructional device, for example reminding staff when progress notes and treatment plans become due, also organize: categories of forms listed on the Filing Order are the same as those on dividers used to separate sections. In late 1993 a revised Uniform Case Record packet of forms was put into effect and a revised Filing Order form was then developed to reflect those changes.

Following are descriptions of and discussions about each of the forms listed on the 1991 Filing Order. The write-ups will also include examples of how the 1993 changes affected usage of the forms on the 1991 Filing Order. As will become evident there is much variance among them with respect to their importance for the facility. Some forms are no longer used, some are used inconsistently and there is an example of a form that was never used. That forms which are not used get listed even on revised file orders may be due to the extent of the compartmentalization of knowledge at the facility.

Forms on the 1991 File Order

The "Notification of Escape Record"[4] form is placed in front of those records for which its use has been deemed necessary or advisable, its position functioning as an alert. The term "escape" must be applied when patients with certain court related legal statuses cannot be located during routine checks. For example all patients who have active Criminal Procedure Law (CPL) 330.20 designations, i.e: having been indicted for a felony crime and having been adjudicated not responsible by reason of mental disease or defect, must have this form in front of their record. The form may also be applied to other patients who do not have court related statuses but who have been assessed as a risk to others in the community, perhaps having targeted for harm a specific individual. A five page, highly detailed form, it provides spaces for filling in (where the information is not already provided) telephone numbers and locations of a wide range of administrators, agencies and individuals who could have concerns about the escapee's whereabouts.

This form is not part of general audit preparation processes, but because it could have very substantial legal and financial consequences it is subject to internal reviews by a designee of the forensic committee to ensure that the

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[4] Appendix B 1a, 1b, 1c, and 1d: (OMH 321)

form is in place, particularly for CPL cases. When there are escapes of "high profile" patients, those who have committed murder for example, staff are required to set in motion rapid alerts, including attempting to enlist the police in regaining custody of the escapee. Documentation of telephone calls, including times they were made, are required not only on progress notes and incident reports but on this form also. Worst case scenarios are patients who escape and then hurt someone in the community, leaving the State of New York subject to lawsuits and public outrage. Unit administrators are considered accountable for ensuring that the form is filled out properly since missing or incorrect information could result in delayed notifications when a patient has escaped. Consequences to administrators for any laxity with respect to this form will most likely depend upon outcomes. For example in the scenario stated above an administrator could face formal charges.

The "Face Sheet"[5] will be found at the front of the chart (unless there is a Notification of Escape form.) Triage Unit staff fill it out upon admission, but it then becomes the responsibility of ward staff. Face sheets should contain identifying patient data and contact sources of his/her "significant others". Most likely to receive

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[5] Appendix B 2: (TPC)

attention when there is reason for ward staff to contact family members quickly about a serious event such as an injury, missing or incorrect information on this form can provoke ire as records may have to be searched to enable completion of staff tasks.

The "Filing Order"[6] form, which was discussed earlier in this chapter, is placed in each record at the time of admission.

The "Release/Termination Summary"[7] form was one of those connected to "closing" a record. Closing a record must occur when a patient status is terminated because of discharge or death or because of release through one of several transfer arrangements. OMH policies state that all documentation for closing a record be completed within fifteen days of one of those events, a "deadline" that is infrequently met. Since auditors review samples of records of those recently discharged and all "death" records, documentation such as this form will become part of audit preparation processes. Prior to the development of the Uniform Case Record packet there were no forms that defined record closing. A progress note by a psychiatrist declaring that the patient no longer needed services might suffice.

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[6] Appendix B 3a and 3b: (TPC 6a)

[7] Appendix B 4a, 4b, 4c, 4d, 4e, 4f and 4g: (TPC 412)

The Release/Termination Summary that was distributed with the Uniform Case Record was headed by a set of instructions that listed categories of entries needed to complete the form, but otherwise it was unstructured. TPC developed and attained approval for an expanded version which outlined the categories into sections and subsections spread out over seven pages. While psychiatrists were considered responsible for filling out the entire form, it had become so elaborate and time consuming they would attempt to enlist social work staff to fill in historical data or would refer the reader to historical data entered in other sections of the record. When the Uniform Case Record was redesigned psychiatrists had only to fill out sections of a shortened two page Discharge Summary. The new form states recognition that historical information was already present in the record and if needed copies could be attached, thus eliminating the need to review and repeat that information.

The "Discharge Summary" form was redesigned to be able to be filled out fairly rapidly for transmission of information. Agencies to which the patient has been referred upon discharge often require copies of the filled out Discharge Summary form before they render services. Discharge diagnoses and medications often form the basis of admission to outpatient psychiatric outpatient services and patients might be denied needed treatment because of delays

in paperwork transmission. Changeover from Release/Termination Summaries to shortened Discharge Summaries can be viewed as an example of organizational responsiveness to internal and external pressures, albeit delayed.

The "Individual Service Plan"[8] form was another connected to closing a chart. The four page form has many sections of blanks to be filled in or boxes to be checked related to planning for the patient's aftercare, all of which might have some logic if the entries were made before discharge. In fact the Uniform Case Record manual states "The Individual Service Plan must be completed by the day of discharge/release" but most often it was filled out as part of the process of closing the record, after, sometimes long after, the patient was no longer present. When the Uniform Case Record was redesigned the Individual Service Plan form was re-conceived as the second part of the Discharge Summary form, shortened and retitled "Service Plan". Service Plans were designed to serve as instructions to patients being discharged, stating the service appointments made for and medications dispensed to the individual. As with the form it replaced the Service Plan generally is not completed by the time the patient is discharged. Its intent, therefore

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[8] Appendix B 5a, 5b, 5c and 5d: (OMH 6)

is not fulfilled. Service Plan completion is considered the responsibility of social workers.

The "Disposition Report"[9], which can be filled out by any unit staff member, is a carbonized tri-part form, one copy of which is forwarded to Medical Records department staff who use it as a basis for entry into computers connected to the Department of Mental Health Information Services (DMHIS) statistical data bank. Although due when discharge is effected, Medical Records Department staff often have to send "reminders" or exert other pressure to obtain a completed Disposition Report, a form relevant to New York State statistical compilations rather than audit processes.

The "Discharge Instruction"[10] form which was never put into use, was very difficult to locate; the only staff member who seemed to have any also recalled its origin. In preparation for major audits central offices in Albany sometimes send an "expert" to review and critique the status of facility's survey readiness. Staff prepares for the OMH reviews with less vigor than for the "real" audit but it is invested with making a good showing since those reports reach central offices directly. One OMH reviewer stated his

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[9] Appendix B 6a and 6b: (AHR 116)

[10] Appendix B 7a and 7b: (TPC 612)

belief that patients, upon discharge, should have a form which is addressed to them, providing information about aftercare arrangements. My source informed me that TPC developed the form to demonstrate compliance but there was much conflict about what should be put on it. For example the original version had blanks to list diagnoses, but some staff objected to having patients in possession of that information. The form states it should be filled out by the primary therapists, a term that could apply to any of the clinical professions. Intent of this form was ultimately accomplished by the Service Plan of the redesigned Uniform Case Record.

The "Admission/Screening Report"[11] is filled out by a triage staff member at the time of admission. It is at this time that the patient is assigned an identifying number if it is his/her first admission to the facility. Patients who have had previous admissions to The Psychiatric Center will retain numbers that were assigned in the past. While most of the information requested can be filled out by any staff member only a psychiatrist can enter the diagnoses. A copy of the form is sent to the Medical Records department for entry into the Department of Mental Health Information Services statistical data bank. Copies of this form and the

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[11] Appendix B 8a and 8b: (AHR 725)

Disposition form, the other data entry form, are forwarded to the Patient Resource department, a unit that tracks availability of funds that can accrue on behalf of patients.

The "Diagnosis Record"[12] is another form that the Medical Record department uses for entry into the DMHIS statistical data bank. Its function is limited to tracking changes in diagnoses made during the patient's hospital stay. Original diagnoses would have been entered into the statistical data bank from entries on the Admission/Screening form. When psychiatrists believe that one or more categories of diagnoses should be changed they document it on Psychiatric Assessments but unless Diagnosis Records are filled out and sent to the Medical Records Department the data bank remains unchanged. Not infrequently Diagnosis Records are overlooked by psychiatrists, missing data that most likely will remain unnoticed.

The "Screening/Admission Note"[13] was usually filled out by triage unit staff. The 1994 Filing Order form shows that it has been eliminated, substituted by an admission note in the progress note section. Essentially unstructured but headed by a set of instructions outlining documentation

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[12] Appendix B 9a and 9b: (15 MED)

[13] Appendix B 10: (139 MED)

categories, the Screening/Admission note was meant to elicit a rationale for admitting or, more rarely, not admitting an individual. Actually patients arrive at the inpatient triage unit based upon pre-arrangements with sending facilities such as psychiatric units of local medical hospitals. Prototype forms of the redesigned Uniform Case Record combine a Screening/Admission Note with a Psychiatric Assessment (see discussion of that form below) developing a new form which uses three pages out of six for a Screening/Admission evaluation by a psychiatrist.

The "Interim Treatment Plan"[14] is a form that was required to be filled out on admission. Since the Comprehensive Treatment Plan was due within 11 days after admission the Interim Treatment Plan then expired and objectives had to be canceled, making this form especially problematic since it was often not filled out on time. When audits were being prepared for and past due work was developed and back-dated, this form, seemed particularly irritating to open and cancel at the same time while trying to obtain applicable signatures. When redesigned the Uniform Case Record eliminated this form.

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[14] Appendix B 11a and 11b: (140 MED)

The "Voluntary Request For Hospitalization"[15] form consists of 4 pages but only one of either of two pages requires filling out as they each apply to mutually exclusive groups: either adults or minors (individuals under 18 years old). Patients must be both willing and eligible to sign the form, precluding those who have Criminal Procedure Law statuses, for example. It is a form that is presented to patients for signature at the time of admission or when they have been on involuntary status and are eligible to become voluntary. Attempts to obtain some verbal statements of acquiescence with containment in a psychiatric hospital, perhaps "the voices are driving me crazy" are required to be documented on the form. Preferably, individuals should make an entry in their own handwriting if they can. Another signature required is that of a psychiatrist who is thereby attesting to the need for psychiatric hospitalization for that patient. Recapitulated on the first two pages of this form are laws and regulations which refer to rights and responsibilities of patients and inpatient facilities. Patients are offered copies of the filled out forms but most often they are too disorganized or disinterested in accumulating paperwork.

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[15] Appendix B 12a, 12b, 12c and 12d: (OMH 472)

The "Application For Involuntary Admission On Medical Certification"[16] is a two page form, most of which is relegated laws and regulations concerning involuntary admissions. It requires a statement and a signature from a "petitioner", who may, for example, be a family member complaining that the individual has been physically violent. Involuntary admissions have additional regulations as will be evident below.

In almost all circumstances two filled out "Certificate of Examining Physician"[17] forms must accompany the preceding form in order to effect an involuntary psychiatric hospitalization. Although the form does not specify that the "physician" must be a psychiatrist, within New York State psychiatric centers only a member of that specialty is considered qualified to enforce an involuntary hospitalization. This form displays ample, unstructured space for statements to justify incarcerating a patient, that is documenting how the patient "poses a substantial threat of harm to him/herself or others".

Locating the "Certificate of Examination By Director of Community Services or Designee"[18] form took some

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[16] Appendix B 13a, 13b and 13c: (OMH 471)

[17] Appendix B 14: (OMH 471A)

[18] Appendix B 15: (OMH 471B)

persistence since no work group, including the office of the Director of Community Services, has any recollection of using it. A Director of Community Services would ordinarily not be a physician, but as the existence of the form demonstrates, under very limited circumstances a non-medical administrator could effect an involuntary hospitalization, albeit for a very limited time period (see the following).

The "Examination for 72 hour or 24 hour Conversion to Involuntary Admission on Medical Certification"[19] form was designed to be used in conjunction with the one preceding. It calls attention to requirements of concurrence by a psychiatrist that a patient admitted by a Director of Community Services (or a designated physician) warrants continued involuntary hospitalization. This form, similarly to the preceding one, has not been used at TPC, at least as far as anyone can recall.

The "Record of Emergency Admission"[20] form, consisting of two pages, is used when a psychiatrist assesses that a patient meets the criteria for involuntary admission under Section 9.39 of the Mental Hygiene and that hospitalization should not be delayed for a second psychiatric confirmation if one is not available. Page 2 of the form requires that

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[19] Appendix B 16: (OMH 471C)

[20] Appendix B 17a and 17b: (OMH 474)

confirmation by a second psychiatrist be documented within 48 hours. This is a form that was always used very infrequently. Since almost all emergency admissions have been taking place at psychiatric emergency rooms of local general hospitals its use has become a rarity.

Patients are entitled to be presented with "Notice of Status and Rights" forms which describe their statuses and the rights they have with respect to them. Since the status and rights of voluntary patients differ from those who are involuntary, there are separate forms for each of the groups: "Notice of Status and Rights - Voluntary or Minor Voluntary Status"[21] and "Notice of Status and Rights Involuntary Admission on Medical Certification"[22], respectively. Every 120 days computerized print-outs of Notices and Status and Rights are sent in batches to each of the wards on behalf of each of the patients on voluntary status. According to regulations both the ward psychiatrist and the patients concerned should sign those forms with one copy then becoming the property of the patient and another for placement into the record, a process often ignored. Patients rarely are interested in accumulating or even signing these notices, but knowledge of "rights" can be

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[21] Appendix B 18a: (OMH 460)

[22] Appendix B 18b: (OMH 471)

readily acquired through peer and staff contacts. Further, a "Notice of Status and Rights" is posted prominently on every ward.

Paperwork which designates legal statuses resulting from criminal charges is completed by court systems and arrives with the patient from the sending agency, most likely a secure care psychiatric hospital or a prison. The role of the facility with respect to these papers is to ensure that stipulations are adhered to.

The Notice Of Status And Rights discussed above addresses patients thus: "You may request your release from this hospital at any time." Every psychiatric facility must, within 72 hours of such a request, either release the patient or, as is more likely, file papers to convert his/her status to involuntary. Having decided that a patient needs continued hospitalization, the ward psychiatrist writes a clinical summariy which states his/her rationale, fills out a Certificate Of Examining Physician form, and arranges for a second psychiatric certification (see discussion on involuntary hospitalization.) Filled out paperwork is delivered to the medical record department which then files an "Application For Court Authorization To

Retain A Patient"[23] with the court so that a hearing can be scheduled.

The "Notice Of Application For Court Authorization To Retain A Patient"[24] form is generated by the previous one; it officially informs the patient who has submitted a "72 hour notice" of intention to retain him/her involuntarily pending a court hearing. Ward administrative staff arrange for the filled out form to be picked up from the Medical Records department, have one copy delivered to the patient, another filed in the medical record and a progress note entry made documenting that an attempt was made to give the patient a copy of the form (many patients refuse to accept it.)

The "Certification Of Examining Physician" form was discussed above relation to involuntary admissions. One of two forms listed twice on the Filing Order, it is repeated here to call attention to its being required to convert patients' statuses from voluntary to involuntary. As with involuntary admissions two certifications are required for conversions from voluntary status.

When patients have been remanded to the facility by the court under Criminal Procedure Law, at first they are placed

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[23] Appendix B 19: (OMH 470)

[24] Appendix B 20a and 20b: (OMH 470A)

under the most restrictive level of off-ward supervision. For example those patients may be allowed off a ward for medical treatments only and under conditions of constant observation by a staff person. In order to enable less restrictive conditions for such patients ward psychiatrists must fill out the "Application for Change of Status/Privilege"[25] form and forward it to a designated committee that oversees forensic issues.

The "Notice Of Meeting Re Application For Change In Status/Privileges"[26] form gives notice to ward psychiatrists, patients, Mental Health Legal Services and others, informing them when and where forensic committee members will meet to evaluate whether status/privileges increases are warranted.

The "Notice Of Change in Status/Privileges (CPL 730)"[27] form is restricted for use on behalf of patients who are remanded under Criminal Procedure Law 730, a classification indicative of involvement in misdemeanor level crimes. Patients who are admitted on a CPL 730 status must be converted to civil status within three days, thus removing them from court jurisdiction.

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[25] Appendix B 22: (OMH 495)

[26] Appendix B 23: (OMH 496)

[27] Appendix B 24: (OMH 497)

Filled out by the sending agency, the "Order of Transfer"[28] form accompanies patients whose loci of residence is changed from one facility to another.

The "Record System Notification"[29] form is designed to apprise individuals at the time of admission that a record concerning him/her will be developed, that the record is necessary for their treatment and that they have rights with respect to that record. Although the form states that each patient should be given a copy of it, invariably both copies will be found in the record. Patients rarely are interested in accumulating paperwork, particularly during the process of admission. Therefore not handing out a copy of the form is a realistic staff response.

The "Notice Of Rights To Medicare Or Champus/Champ VA Patients" [30] form is addressed to patients who may be beneficiaries of federal funding. While in effect those patients do not have special rights there are federally funded agencies, as stated on the form, which oversee treatment and funding for that treatment. As with the preceding form, copies are rarely distributed to patients despite it being stated as a requirement.

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[28] Appendix B 25: (119 DMH)

[29] Appendix B 26: (324 ADM)

[30] Appendix B 27: (ADM 401)

The "Nursing Assessment"[31] form is designed in two parts consisting of many subsections. A nurse on duty at the time a patient is admitted filled out the first part, which has spaces to describe the physical status of the patient. While the first part could be filled out by a Licensed Practical Nurse the second, due within 11 days of admission and which demanded more extensive evaluations and language skills, required a Registered Nurse to fill it out. The later Nursing Assessment, which is part of the redesigned Uniform Case Record, is divided into three parts (the first two due within 24 hours and the third due in seven days,) each of which must be filled out by a Registered Nurse. A most interesting aspect of the newer Nursing Assessment is the introduction of concepts of categories of "human responses" developed by the North American Nursing Diagnosis Association. For examples mobility and sleep patterns are subcategories of "moving (human responses related to activity)" and hallucinations and self-esteem are sub-categories of "perceiving" (human responses related to receiving/integrating information.) Here is an example of a professional group influencing form

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[31] Appendix B 28a, 28b, 28c and 28d: (154 MED)

development in order to promote a new conceptual framework.[32] Nursing assessments are one of the forms that auditors will use for their evaluations. All records are required to contain nursing assessments that appear to have been completed within regulated time frames. Nursing department supervisors are expected to ensure that any missing assessments are completed, back-dating as necessary, prior to any audit.

The "Abnormal Involuntary Movement Scale"[33] form is designed to ensure that the psychiatrist evaluates each patient for the presence of side-effects that have been known to be associated with the use of certain psychotropic medication. One page of the form provides instructions for conducting the examination, thus using the form as a training mechanism and also thereby documenting the training.

Parts of this discussion of "Psychiatric Assessment"[34] forms reiterates what has been said earlier in this chapter. The Uniform Case Record packet of forms issued in 1981

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[32] An Office of Mental Health publication, "Inpatient Uniform Case Record Prototype Forms, Highlights and Instructions" issued in March, 1992, states that the Nursing Assess "reflects the framework of the NANDA" (p.37)

[33] Appendix B 29a and 29b: (99 MED)

[34] Appendix B 30a, 30b, 30c, 30d, 30e, 30f, 30g and 30h: (TPC 512)

provided a Psychiatric Assessment that was four pages long with headings for the categories of information expected, but was essentially unstructured except for spaces allotted for the diagnoses. TPC developed an eight page form, issued in 1991, which consisted of numerous sections and sub-sections. The Psychiatric Evaluation developed by central offices in its redesign of the Uniform Case Record is similar to what had been developed earlier by TPC, delineating numerous categories to be addressed. As stated in the discussion of the Screening Admission Note above, that form was combined with a psychiatric assessment, resulting in a new form entitled "Screening/Admission Note and Psychiatric Evaluation (Integrated)," a slight modification of a redesign prototype. Developed also to demonstrate compliance with more recent regulations, categories were added to the redesigned new form. For example it allots space to document whether patients have been informed about "Advance Directives", such as a health care proxy form. Psychiatric assessments are one of the forms auditors are certain to evaluate when conducting surveys.

The "Psychiatric Assessment Supplement Specific to AIDS"[35] form is headed by instructions pertaining to

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[35] Appendix B 31: (42 MED)

categories of information viewed as relevant to psychiatric treatment of patients diagnosed with AIDS. Issued in 1987 it fell into disuse as treatment of patients with AIDS became geared to "normalization" within the context of a ward. As redesigned, Psychiatric Evaluations provide categories to document high risk sexual and/or drug use behaviors.

"Social Assessment"[36] forms consist of four pages of several sections, most of which are relegated to the patient's history and family situation; as the title of the form implies, it must be filled out by a Social Worker, the staff component designated as best qualified to compile such data. The form also provides space for a "psychosocial assessment" which was expected to be geared toward discharge criteria terminology. When it was revised the Uniform Case Record separated aspects of the Social Assessment into a "Core History" form and a "Core Evaluation, Psychosocial Functioning" form. The Core History is an elaborate five page form with many sections and subsections related to the patient's history; it is expected to function as "the history" in the record, eliminating obligations for other staff to devote time to developing histories on other forms. Through its categories the Core History draws attention to

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[36] Appendix B 32a, 32b, 32c and 32d: (145 MED)

aspects of patients' backgrounds that might have been bypassed on earlier forms, legal entanglements for example[37]. Added also are categories related to ethnicity and religion, in keeping with an ideologic stance of promoting "cultural awareness".

"Psychological Assessment/Psychological Testing"[38] forms are rarely used at TPC. When psychologists do assessments or testing they use departmentally specified formats for their reports, but not on forms.

The "Psychological Referral"[39] form was developed by the Psychology Department for ward staff to request assessment or testing of specific patients. Copies of the form in the record provide documentation of the request. Prior to audits unit administrators are expected to peruse records for referral forms not attached to completed reports since that could provide evidence that TPC staff do not follow through on recommendations. TPC record reviewers might then pressure Psychology Department staff for a report or remove the referral form and replace it with an updated one.

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[37] New York State Psychiatric centers have gained access to "rap sheets" of patients under its jurisdiction. However that information has been inconsistently relayed and often difficult for staff to interpret.

[38] Appendix B 33: (143 MED)

[39] Appendix B 34: (TPC)

The "Activities Assessment"[40] form consists of two pages with three main sections. Staff with different titles, recreation therapist or occupation therapists as examples, under the aegis of the Rehabilitation Department may fill out this form. The redesigned Uniform Case Record eliminated the activities assessment, developing instead a form that is the second part of the Core Evaluation (see the discussion on social assessments above), the Rehabilitation Screening. Conceptually it was an attempt to induce rehab staff to write evaluations that indicate knowledge of the patient's history and are related to discharge planning. Instead staff simply separate parts of the Core Evaluation and make entries on the one that pertains to their discipline, in effect bypassing the redesign's intent. Activities evaluations have been more specifically emphasized by JCAHO standards in its 1995 manual.

Patients who have been granted "honor cards", which allow them "privileges" of leaving wards for designated time periods, are often referred to one of the programs operated by the Rehabilitation Department. Staff are expected to use the "Rehabilitation Services Referral"[41] form when they want patients to participate in one of those programs.

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[40] Appendix B 35a and 35b: (147x MED)

[41] Appendix B 36: (TPC)

Rehabilitation department staff are not consistent with demands that the form be completed, allowing, at times, verbal agreements to suffice.

The "Nutritional Assessment"[42], a two page multi-sectioned form was replaced by a Nutritional Evaluation when the Uniform Case Record was redesigned. Staff from the dietary department who are assigned medical record documentation tasks, having to cover several wards, use documentation already in the record to construct their entries. Nutritional Assessments or Evaluations are required but not focused upon by auditors.

"Vocational Assessments"[43] are rarely found in records since there are no current programs that access employment opportunities directly. The Rehabilitation Services Referral (see above) was the form that staff used to refer patients to existing "work for pay" programs. The redesigned Uniform Case Record guidebook indicates that the Rehabilitation Screening part of the Core Evaluation eliminates the need for a Vocational Assessment.

State regulations require that certified teachers evaluate education levels of every patient under 22 years and provide appropriate services. TPC only accepts patients

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[42] Appendix B 37a and 37b: (148x MED)

[43] Appendix B 38a and 38b: (146x MED)

who are at least 18 years old; therefore the "Educational Assessment"[44] was applicable to very few patients. This form also has become obsolete with the Rehabilitation Screening form changeover.

The "Assessment/Assessment Continuation Sheet"[45] is an essentially unstructured form, designed to be used when other assessments did not provide enough space.

Comprehensive Treatment Plan & Reviews: Treatment plans and the processes they entail have been discussed earlier in this chapter and in other sections of this paper. Here the forms will be described as they appear on the Filing Order form. When the Uniform Case Record was redesigned treatment plan forms were modified to display more prominently compliance with auditing group standards. For example when HCFA first required that diagnoses be entered on treatment plans, staff were instructed as to where to transcribe those diagnoses on the earlier version. The later one has spaces allotted for that purpose. More prominence in the newer version is given for patients and/or their family members to sign treatment plans, with specific spaces allotted for that purpose.

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[44] Appendix B 39a and 39b: (157 MED)

[45] Appendix B 40: (149 MED)

The "Comprehensive Treatment Plan" - Part I[46], was entitled "Discharge Plan" to introduce a practice of considering every patient as prospectively dischargeable. Part II[47], entitled "Goal Plan", was extensively discussed in an earlier section. Filling it out is experienced by staff as perturbing due to its detailed language constraints and requirements. The redesigned treatment plan has an almost identical goal plan form. Part III[48] entitled "Treatment Team Conference Note" is essentially unstructured, allowing two pages for a narrative composition expected provide the rationale for the treatment plan constructed. The title is designed to reinforce the concept that treatment planning must be a "team" enterprise. The redesigned treatment plan allots space for a team conference note, but it is confined to a half page.

The "Periodic Treatment Plan Review"[49] form has a proscribed schedule listed on the file order. While its second page is unstructured, staff are instructed to address each of the goals, objectives and methods listed in the Comprehensive Treatment Plan.

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[46] Appendix B 41a and 41b: (150 MED)

[47] Appendix B 42a and 42b: (150A MED)

[48] Appendix B 43: (150B MED)

[49] Appendix B 44: (151 MED)

The "Patient Care Monitoring"[50] form was designed to document results of patient care consultations provided by a staff member from one work unit to the staff of another unit. Consultations may be requested because the treatment a particular patient is receiving seems to be ineffective, perhaps that patient appears intractably engaged with auditory hallucinations. A ward psychiatrist might choose (or feel pressured) to call upon a respected colleague who could document concurrence with treatment being rendered or suggest alternatives. Consultations at times may be mandated by facility policy, perhaps, for example, a patient has been placed in seclusion frequently.[51] In effect the form documents "a second opinion". Space on the form is allotted for unit staff to document how the patient responded to the consultant's recommendations. Instructions state that copies of the filled out form be sent to various levels of administration, a policy that is complied with inconsistently, particularly if the consultant's recommendations were never followed.

The "Medical Summary Sheet"[52] form, developed at the facility, opens the medical and laboratory report section of

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[50] Appendix B 45a and 45b: (TPC PCMR)

[51] Episodes of patient seclusions are sometimes tracked through Nursing Department reports.

[52] Appendix B 46: (TPC-52)

the record. Designed to highlight the most salient medical issues rapidly, it is filled out by the medical specialist assigned to the ward.

Prior to the issuance of the "Physical Examination and Assessment"[53] form there had been a physical assessment form in the assessment section and a physical examination form in the medical report section; however this six page form is structured with many more categories for medical specialists to fill in, is lengthier than the other two combined. Time frames for filling it out these forms are most likely to be adhered to at TPC, perhaps because of special vulnerabilities created by missing data concerning patients' physical statuses.

The "Physical Addendum"[54] form, originated at the facility, requests increased specificity than the preceding one with respect to the section that evaluates cranial nerves. Noting that the Physical Examination and Assessment was developed before the addendum, one could predict that future versions of the former would incorporate the latter.

"Gynecological Chart"[55] forms are filled out by specialists who are generally not part of TPC staff but work

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[53] Appendix B 47a, 47b, 47c, 47d, 47e, 47f : (34 MED)

[54] Appendix B 48a and 48b: (TPC 11)

[55] Appendix B 49: (36A MED)

for the facility on a consultation basis. Ward medical specialists fill out Consultation Request forms (see below for discussion) for all female patients shortly after admission and yearly thereafter. Referrals for gynecological examinations must also occur on as needed basis for women who are pregnant or have gynecological problems.

The "Immunization Record"[56] is form is filled out at the time of the first physical examination and subsequent immunizations are noted on the same form. TB testing and their results are also documented on this form. In preparations for audits every chart will be reviewed to ensure that documentation on this form displays that immunization and TB testing schedules comply with regulations.

The "Weight Chart"[57] form states that all patients are to be weighed at least monthly,[58] a task assigned to Mental Health Therapy Aides. When audit preparations are in process, missing weights are filled in, with weights taken and recorded and missing dates and weights approximated for

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[56] Appendix B 50a and 50b: (9 MED)

[57] Appendix B 51: (TPC 53)

[58] When patients have medical and/or mental illnesses for which more frequent weight monitoring is ordered a separate Weight Chart is used.

months missed. When weights are recorded but inconsistently it is more difficult to "correct" since there may not be blank spaces to enter overlooked data. Two professions, a nurse and a doctor, must indicate by their initialing that they have viewed the weights.

The preceding paragraph concerning weights is also applicable to the "Monthly Blood Pressure"[59] since missing data is easily highlighted. If patients refuse to have their blood pressure taken there must be a notation of that refusal. Note the NSG as part of the identifying number; the form was designed by the nursing department.

The "Clinical Chart"[60] form was very difficult to locate; no staff could relate it to its name and it was not available by number in the forms storage unit but copies were found accidently in a treatment room desk drawer. It was designed to be filled in by nurses to monitor body temperatures and pulse rates during periods when patients were experiencing acute medical illnesses. While the Clinical Chart form is not in use, the Vital Signs Monitoring form (not listed on the Filing Order) is one used instead; nevertheless the Clinical Chart is still the one listed on the 1994 File Order form.

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[59] Appendix B 52: (NSG 2)

[60] Appendix B 53: (26 MED)

The "Diabetic Control Record"[61] form has been applicable only to patients who have diabetes and whose condition warrants frequent urine testing. Most likely this form will become obsolete and a new one developed as blood monitoring becomes the standard.

The "Seizure Chart"[62] form, applicable to patients with seizure disorders, has many small box spaces to indicate dates when seizures occurred and what type they were. It was designed to provide a rapid overview of whether seizure activity has been increasing or decreasing. Evidently the Seizure Chart is a form that is not taken seriously as one may find these forms in records with no entries on them despite staff having witnessed seizures and then documenting them elsewhere in the record. Nurses are responsible for filling out form.

The "Intake & Output Record" form was not available in any of the areas searched. One can surmise that it had been used during periods that measurement of fluids were medically advisable or necessary. Perhaps the form may have been used when the hospital still had a Medical/Surgical ward, a section that closed in the 1970s. Patients who

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[61] Appendix B 54: (TPC 126)

[62] Appendix B 55: (216 MED)

require such high level medical monitoring would most likely be transferred to a general hospital.

The "Laboratory Report"[63] form has not been in use for many years. It is a form that reflects outmoded methods of compiling, evaluating and documenting results of blood and urine tests. At one time the hospital had its own laboratory but now blood and urine are drawn at the facility and analyzed at outside laboratories. Laboratory reports are available on familiar computerized data sheets which highlight results outside normal ranges. Every laboratory report must be signed by a medical specialist who thus indicates having viewed it; out of range data must be noted as either non-significant or needing follow-up. Blood and urine tests are done yearly for all patients, additional testing is done as warranted or as stated in regulations. Patients who take certain psychotropic medications, lithium for example, must have blood levels evaluated with proscribed frequencies. When testing results are significantly out of range the laboratory will call to report the data, making sure to document to whom they spoke. Staff taking that information are required to report such data verbally immediately and write a progress note in the chart.

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[63] Appendix B 56: (82 MED)

"EKG Reports" which state results of electrocardiograms, generally are performed at the facility. The report itself will appear in the chart attached to an evaluation.

The "X-Rays Request Report"[64] form , comprised of four parts, is designed to provide tracking of follow-up when an X-Ray is ordered by the medical specialist who fills out the top half. Nurses arrange for X-Rays, sending three of the four parts (leaving the pink copy in the chart) to the X-Ray department. A radiologist fills in the report section, returning the top white copy back to the ward for filing in the patient's record; the pink copy can then be thrown away. A pink copy in a chart that contains no completed white copy is an alert that an order may not have been followed. During audit preparations pink copies of X-Ray requests should initiate a search for documentation of a rationale for missing reports, patients' refusal to have chest X-Rays, for example. Worse, of course, is locating an X-Ray request with all parts intact and no report, indicating slippage in following doctors' orders. Such questionable incomplete forms are removed from records prior to audits, part of the process of "cleaning up the record".

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[64] Appendix B 57: (82.13 MED)

The "Consultation Report"[65] form, similarly to the preceding one, is comprised of four parts, but its applicability has a much wider range. Consultations are used for many types of requests for services not available on the ward, such as optometry, ophthalmology, dentistry, neurology and transfers to the Secure Care unit. When patients require services of "outside" medical facilities, perhaps for medical emergencies or for clinic follow-up of medical conditions a Consultation Request form accompanies the patient. Those outside medical agencies may avail themselves of the form to enter their findings and recommendations or they may attach their own forms.

"Other Medical Reports" are statements from outside agencies which frequently cannot be confined to the space allocated on the consultation report form or those agencies may have their own format of reporting. Generally those statements would be placed in this section of the chart.

The "Dental Chart"[66] form is used by the hospital dentist to specify, on diagrams, dental treatment needed or given. Often this form is attached to Consultation Reports which requested dental examinations.

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[65] Appendix B 58: (36 MED)

[66] Appendix B 59: (122 MED)

"Medical Progress Notes"[67] forms are the same progress note forms as those used in the progress note section but once they are placed in this section entries should be made by medical specialists only. Errors, of course, do occur, since other staff sometimes absentmindedly or mistakenly make entries in this section. The frequency and type of progress notes required of medical specialists differ from that of other staff; when patients have no medical conditions or have had no situations requiring such treatment (an injury from a fight, for example,) a notes need to be written every three months.

The "Doctor's Order Sheet"[68] form, actually entitled "Physician's Orders", is pivotal to the record since, as the form instructions state, it must contain all medication and treatment orders. Physicians, both psychiatrists and medical specialists, when writing an order for medication, must specify its dosages, frequency, method (pills, liquid or injection) and the time period over which it should be dispensed. Essentially the Physician's Orders functions as a series of prescriptions. "Treatment orders" covers a wide range of stipulations in addition to medication, such as the circumstances under which the

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[67] Appendix B 60: (152 MED)

[68] Appendix B 61: (89 MED)

patient may be allowed off the ward, orders for seclusion, special observations, dietary indications and, of course, discharge. Each of the orders are restricted by a wide range of policies, regulations, laws and practices which are expected to be known by those who are responsible for carrying them out. Nurses, who arrange for the pharmacy to get copies of medication orders, must sign that they have noted and transcribed them onto other forms and thereby take a measure of responsibility for them. For example if the physician did not enter a valid stop date for a medication, the nurse would be expected to have the physician rectify the order. Should that be overlooked by the nurse, the pharmacist would be required to withhold dispensing medication. Almost every questionable event concerning a patient will trigger a review of entries on the form, scrutinizing the orders written and comparing them with how they were followed in an attempt to locate a possible culprit. Since Physician's Orders are routinely reviewed by surveyors, prior to an audit the forms will be scanned by nurse administrators for any conspicuous missing entries such as a nurse's signature. But back tracking and back dating physicians orders would be extremely risky and difficult to accomplish, particularly because it could entail collusion among a number of staff.

Restraint (physical containment of the patient) and seclusion (placing the patient in a locked room by him/herself) are reactive solutions to situations which are perceived to pose a threat. Processes of restraining or secluding patients can be in itself a source of injury (or worse!) to patients and/or staff and there is a potential to use those mechanisms to control and/or punish patients. Therefore restraint and seclusion of patients are the subjects of policy issuances which constrain its use as evidenced by development of the "Restraint or Seclusion Order Sheet"[69] form[70]. Within fifteen minutes of such confinement it must be filled out by a psychiatrist who writes a general description of the patient's general physical condition and a justification for his/her being restrained or secluded, thus taking responsibility for the patient being able to sustain the confinement. The psychiatrist must also make entries on the Physician's Order form and in the progress note section.

In the discussion of the Physician's Order form it was stated that a nurse must sign off ("pick up" is the term used) on all medications and treatments entered. That nurse

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[69] Appendix B 62: (TPC 1)

[70] For example seclusions may be ordered for periods of no more than two hours. To extend that period a psychiatrist would have to fill out another Restraint or Seclusion Order Sheet at the end of the two hour period.

then enters those medications on the "Medication/Treatment Record"[71], called the "Medex". Nurses dispense all medications (except under the rare circumstances that physicians do) and are required to record whether patients received medication or refused them by entering their initials in spaces allotted on the form. When a question arises as to whether a patient received medication as ordered the medex form is reviewed. Prior to an audit medication/treatment records are scanned for missing entries. Blank spaces, where medications should have been noted as dispensed or refused, are filled in by the ward nurse or nurse administrators, thus indicating that patients did indeed receive them.

The "Restraint or Seclusion Monitoring Record"[72] is a two page form used in conjunction with the Restraint or Seclusion Order Sheet discussed above. During the process of being restrained or secluded patients can sustain injuries (sometimes self-inflicted,) or become seriously ill. A patient locked in a small seclusion room might, for example, become dehydrated and need medical attention. The function of the form is to document that the patient has been periodically observed (at least every fifteen minutes)

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[71] Appendix B 63a and 63b: (223A MED)

[72] Appendix B 64a and 64b: (TPC 7)

during the period of restraint or seclusion. Mental Health Therapy Aides, the staff who are assigned to do the monitoring, must fill in the spaces requesting the time of observation, the condition of the patient at that time and then signing to attest to their statements.

"Progress Note"[73] documentation regulations and processes have been discussed in this and other chapters of this study.

The "Inpatient Hospital & Extended Care Administrative Billing & Release of Information"[74] form is applicable only to those patients who are "Medicare eligible", about 15% of the inpatient population. "Medicare Payment Request and Authorization To Release Information" the form's actual title, is initiated by the Bureau of Patient Resources, the agency which follows sources of funding available, its function is to obtain signatures from patients so that information can be released to federal agencies which release Medicare reimbursements.

Confidentiality protection for patients has been enacted in New York State law and is the subject of a separate manual outlining policies surrounding it. As its

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[73] Appendix B 65: (152 MED)

[74] Appendix B 66: (BPR 1453)

title implies, the "Consent For Release Of Information"[75] form is used to obtain patients' permission to provide information, generally from the record, to individuals and/or organizations not part of the Office of Mental Health. Among the reasons for information "sharing" are attempts for discharge to residences, referrals for post-hospitalization treatment and obtaining "entitlements". Although the form should be completely filled out, specifying what information will be released, to whom and why, very often the patient is presented with a blank form and the other entries made later. Patients can resist discharge by refusing to sign this form. Bypassing its use is permitted during certain situations, medical emergencies for example.

The "Consent For Release Of Information To A Community Support System Agency"[76] form is no longer in use. It had applied to the Community Support System, a concept of outpatient treatment programs with special mandates, funding and administrative channels, all of which were discontinued in 1982. That this form is listed on the 1991 and 1994 Filing Order forms is another example of irrelevant,

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[75] Appendix B 67a and 67b: (OMH 11)

[76] Appendix B 68a and 68b: (OMH 144)

outdated information being perpetuated because it is easier to list the form than ascertain if has any meaning.

"Correspondence" placed here would expected to be related more to administrative, financial and contacts with family members rather than clinical matters.

Hospital policies state that staff are required to document each visit to a patient, who it was and when it occurred, the purpose for which the "Record Of Visits"[77] was designed. However the form was rarely used. During a period of gathering this data I questioned staff about their own use of the form and was told by some that they often forgot to use it, others said they wrote the information in the Communication Book and still others mentioned a special book set aside to record visits, but they couldn't locate it. As it turns out the "Policy and Procedure Manual" states that each ward should have a special book to record visits. After an incident of a visitor being suspected of providing a patient with contraband, attention to the visitors record book was reactivated, but its use remained inconsistent. Despite the fact that the form is not in use and policies require other methods of recording visits, the form continues to be listed on File Orders.

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[77] Appendix B 69: (3 ADM)

At times some patients may be asked if they wish to participate in projects which could result in public exposure, a documentary for example, or in research being conducted, testing the efficacy of a new medication for example. A "TPC Consent Form"[78] is specially designed for each of the projects, outlining their parameters and stating how rights of patients will be protected. All research projects and the forms they use must have administrative approval.

The "Record Of Patient's Property Forwarded To Business Office"[79] is a form designed to list patients' property, such as jewelry, that is being held by the facility's business office. It is rare to find this form in patient records but a business office staff person insisted it is being used. It may be that the form is applicable to a small percentage of patients because most are impoverished.

The "Patient's Personal Clothing Record"[80] form is designed to record articles of clothing the patient had at the time of admission and those subsequently added through purchases from the patient's funds or those brought by relatives. It is a form, however well intentioned, that

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[78] Appendix B 70: (TPC)

[79] Appendix B 71: (67 BUS)

[80] Appendix B 72: (72 ADM)

rarely fulfills its purpose. Keeping track of and recording clothing used and stored by and for 35 severely mentally ill patients is unrealistic, particularly since no staff are specifically assigned to the task. Patients who are psychotic may have a diminished capacity to take care of their clothing as they may even have difficulty differentiating between what belongs to them and others. At times certain patients will destroy whatever is at hand. Entries into the clothing record are seldom made after a patient's admission. Most charts do not even have the form. Since some families register complaints when clothing they have bought is missing, records of those patients will tend to note.purchases of mcre expensive items. This form is not the focus of surveyors. They do, however, inspect closets to assess if patients appear to have sufficient supplies of clean clothing.

The "Inventory of Patients Personal Property Maintained on Living Unit"[81] form is designed to keep track of patients' property other than clothing, radios, for example. Much of what has been said about the Clothing Record is applicable here. Patients who have items such as radios may get into the habit of holding onto their property at all times. This form is rarely seen in records.

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[81] Appendix B 73: (72A ADM)

The "Agreement For Leave" form[82] form was not located despite substantial effort to do so. There was a similar form entitled, "Permission To Leave Grounds", and that too did not appear to be in current use. The form has been eliminated from the 1994 Filing Order form list.

The "Independent Team Medicaid Certification"[83] form is applicable only to those patients under age 22 and who are Medicaid Eligible. Essentially it requests signatures that hospitalization is necessary. The form is filled out at the point of referral of the patient.

Similarly to the preceding form the "Treatment Team Medicaid Certification"[84] form also is a certification of the need for psychiatric hospitalization of patients under 22 years old, but this form is signed by designated facility staff. Utilization Review staff ensures that this form is in place and filled out prior to audits, especially those conducted by the Health Care Financing Administration, the agency that oversees federal reimbursements.

The "Medicare Certification And Recertification"[85] form specifies time frames (up to 168 days) for

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[82] Appendix B 74: (55 MED)

[83] Appendix B 75: (528 MED)

[84] Appendix B 76: (529 MED)

[85] Appendix B 77: (70 MED)

psychiatrists to attest to medicare eligible patients' need for hospitalization. Prior to audits the Utilization Review staff enters dates for physicians to sign the form.

The "Medicaid Certification"[86] form specifies that psychiatrists sign every sixty days to attest, for patients over 65 years, that psychiatric hospitalization is needed. As with the preceding forms the Utilization Review unit ensures that all signatures are "caught up" prior to audits.

Utilization review is the process of determining whether the medical record verifies that patients' conditions meet the standards for need of inpatient psychiatric treatment. "Utilization Review Documentation"[87] is the form that Utilization Review department staff, who must periodically examine every medical, uses to enter their approval or disapproval. That work group teaches staff which types of statements are most likely to make patients' continued hospitalization appear questionable and which statements ensure approval. For example staff are cautioned against writing statements such as "the patient maintains his improvement" unless there are active discharge plans in process. Instead, staff are told, statements about improvement should include statements about

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[86] Appendix B 78a and 78b: (75 MED)

[87] Appendix B 79: (UR 3)

ways patients remain too sick to be discharged. Utilization Review Documentation is always found in the record.

The "Notification Of Referral For Service"[88] form is applicable only to patients who have been hospitalized for more than five years and who are being discharged. That group of patients is eligible for enriched aftercare funding, transportation to and from day programs for example. The work unit that arranges entitlements generally ensures that this form is filed when necessary.

The "Certification Of Need For Treatment"[89] form is no longer in use, having been replaced by certification forms 528 MED and 529 MED discussed above.

The "Adverse Drug Reaction Report"[90] form was designed, as its title states, to report adverse drug reactions to the pharmacy. Very problematic is the criteria for assessing a drug reaction as sufficiently adverse that filling out this form is warranted. Psychiatrists are reluctant to fill out this form every time a patient has some type of suspected or known adverse drug reaction (a not uncommon occurrence,) since it could reflect more negatively upon their competence than the drug. The form was

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[88] Appendix B 80: (OMH 5)

[89] Appendix B 81: (527 DMH)

[90] Appendix B 82: (72 MED)

eliminated from the 1994 Filing Order form since it was recognized that documentation that could trigger investigations, similarly to incident reports, should not become part of the medical record.

Patient deaths set in motion investigations, some quite extensive. It is expected that the administrators of units attempt to enlist cooperation from family members by encouraging them to sign a "Permission for Autopsy"[91] form when autopsies are warranted.

Autopsies are not performed at the facility but by the Medical Examiner. Copies of "Autopsy Reports"[92] are obtained by the Chief Medical Specialist.

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[91] Appendix B 83: (20 MED)

[92] Appendix B 84: (103 MED)

CHAPTER 7

CONCLUSIONS

In chapter 1 it was made clear that documentation processes are not merely passive by-products of bureaucracy. They were shown to be: mechanisms to evaluate productivity of workers, declarations to categorize individuals as defective, expressions of control over those defective individuals, means to promote professional status, influences in molding professions and their members, indicators of organizational change, purveyors of organizational change, arenas of non-face-to-face interaction, avenues to procure resources, and vehicles to display legitimacy and cultural values. Of particular interest were documentation changes as they affected developments in psychiatric medical records, the focus of this research. Emphasized were rationales for replacing unstructured narratives with structured forms.

Chapter 2 identified a number of regulatory and legal determinants of documentation requirements. Policies developed by The Psychiatric Center and forms for use in those records were shown to address specific regulations and

laws, often incorporating them verbatim. Also described are legal processes which circumscribe and/or foster patients' liberty, and which entail documentation of any changes in their status. Noted further is the added pressures of societal trends toward litigiousness, provoking writers to be wary as they make their entries in the record. Psychiatry is portrayed as the medical specialty most impacted by regulation.

Chapter 3 situated The Psychiatric Center, the site of this research, as an organization under the aegis of the New York State Office of Mental Health. As a complex organization, TPC uses many hundreds of forms, so many that their management is in itself problematic. TPC is subject to a multitude of pressures, one of which is ongoing demands from the Office of Mental Health to reduce its census by discharging patients to approvable habitats even when the environment is unwelcoming and those patients are resistive. Psychiatric services, characterized as having a limited technology with unclear values of staff inputs, had been evaluated based upon staff activities (processes) as documented in patient records. Since 1996 the Health Care Finance Administration has been instructing their surveyors to rate psychiatric organizations based upon outcomes of treatment for patients, a change indicating that organization's questioning its own past processes.

Chapter 4 situated psychiatric medical records, in tandem with patients they represent, at the locus of writers on an inpatient ward. Functional roles and documentation obligations are described for each of the writers' occupations and professions, including their collective, the treatment team. Explanations are proposed for the difficulties in achieving documentation requirements and expectations.

Chapter 5 situated TPC in the throes of preparation for audits. Since surveyors focus heavily on medical records all of them receive several internal reviews. Forms are developed to record the presence or absence of required documentation on medical record forms to uncover deficiencies. By cajoling, pressuring, and/or intimidating staff to ensure that there are no missing entries when auditors arrive, administrators and supervisors induce a catch-up process which includes producing back-dated progress notes, assessments, and treatment plans, procedures which result in cynicism, resentment, and/or concerns for possible repercussions for participating in questionable activities. An audit was recounted to convey those tension laden events as performances during which staff are expected to display obeisance to administrative behests, however inane.

Chapter 6 Describes and discusses forms that comprise psychiatric medical records at TPC, using those listed on the 1991 File Order form. Write-ups, combined with copies of the actual forms in appendix B, illustrate how documentation trends, regulations, laws, and surveyors' requisites impact the medical record. Through a historical review of selected forms, it was made evident that during the period of the mid 1970s to the mid 1990s there was a proliferation of documentation mandates requiring display on forms to be placed in the medical record.

Proliferation of documentation on forms in psychiatric services is a reflection of increased reliance on documentation on forms in society. This is true not only for organizations but also for the individuals with whom those organizations interact as employers, insurers, educators, health carers, funders of entitlements, bankers, licensers and tax assessors as examples. Commonly voiced is anxiety about social security numbers being used as identification for so many, maybe almost all, of the organizations with which the individual has need to relate. Over time organizations have been gaining more expertise in collecting and collating data, and perhaps also use that expertise to befuddle some and intimidate others. Filling out forms as an acknowledged source of psychic stress is evidenced when HMOs attempt to increase enrollment by

advertising that its subscribers will be freed from that bothersome paperwork.

To understand changes in recording expectations one must examine changes outside of any one organization or even any group of organizations. Complexities of health care organizations such as hospitals make them subject to interacting influences of legal decisions, potential malpractice suits, the economy, public attitudes toward accountability, standards set by auditing groups, demands of financial resource groups such as insurance companies or governmental funders, technological advances in fields of medicine, power positioning among the various occupational groups that staff the institution and current philosophies of health care. During the 1970s there was a convergence of interacting factors which contributed to the proliferation of documentation requirements. Entitlement legislation passed in the 1960s would later result in regulations to display controls of the disbursement channels, which meant establishing overseeing mechanisms. Further, consumerism, civil rights movements and a growing societal litigiousness fostered a defensive stance by public organizations.

As is evident, organizations are the most likely designers and producers of forms. Through forms organizations can reify or perhaps re-establish their boundaries. By implementing Uniform Case Record forms the

Office of Mental Health exerted its authority to intrude in the medical record documentation practices of the psychiatric centers under its jurisdiction. As was noted earlier, that change was initiated after it became apparent that left to their own devices New York State psychiatric centers constructed medical records that were deemed deficient by accreditors, resulting in a loss of federal funds. Similarly TPC exerts pressures on its units by extracting crucial data from forms developed for reporting purposes; examples are forms used to monitor discharge rates and documentation deficiencies. Forms are designed to diminish options of staff mandated to fill them out.

Processes involved with psychiatric medical records documentation entail enormous financial expenditures since it is mainly relatively high paid professionals who are documenters, supervisors and reviewers. An article, "The War on Paperwork",[1] located in a publication issued by central office administrators to promulgate their image and programs, expressed these concerns openly, stating: "Paperwork -- estimated to gobble up a third or even half of clinical staff's time -- has been a longstanding concern in

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[1] This one-page article apprised OMH employees of a then projected and ultimately realized "Redesign of the Uniform Case Record."

the Office of Mental Health."[2] Verifiable assessments of costs of medical record documentation are extremely difficult, perhaps impossible, to acquire. Many activities surrounding medical records are beyond the purview of those outside the organization and are expected to remain so. Many meetings attended by supervisors, unit chiefs, team leaders and department heads are convened to thrash out which category of staff should be responsible for writing treatment plans and under what circumstances, an example not only of costs in staff time but also in the depletion of energy and attention. During audit preparations large segments of clinical staff spend almost all of their time preparing records for surveyors, resulting in suspension of many patient related activities, the very activities which they may be documenting to get charts audit ready.

Paperwork requirements change relationships among staff and the nature of their work. Those who demonstrate paperwork skills and supervisors who demonstrate ability to get others to complete paperwork are highly valued by the organization, but for the workers, the documenters, those values de-emphasize the value of their "real work". Supervisors may be empathic with those who express antipathy toward paperwork, perhaps identifying with the inclinations

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[2] Barrins: 1990 p. 12

for "people work" expressed by clinicians who seek employment in mental health services. Sometimes it is with embarrassment that supervisory staff reprimand those who are not "caught up" or whose documentation do not fulfill all regulations, particularly if those supervisees can be relied upon to advocate for patients' needs. The relative value of professions changed due to the importance of their documentation for the medical record. For example because there are no HCFA requirements that psychologists write monthly notes in every inpatient record the facility employs many fewer members of that profession than in the past and very few are assigned to inpatient wards.

In public psychiatric services documentation has developed both a centrality and cumbersomeness that is in large measure due to uncertainty of technology and product.[3] The citation in chapter 1 from Ryback, Longabaugh and Fowler warrants repetition here: "Psychiatry more than any other area in health care delivery needs a structured logical approach to document its thinking so that it may find out what it's doing or not doing."[4]

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[3] The history of mental health services is rife with concepts once accepted as bases for treatment but now discredited. "The schizophrenegenic mother" and the patient as "acting out the illness of the family" are two examples of training perspectives that were available to clinical staff at TPC in the 1970s and early 1980s and which were discontinued.

[4] Ryback et al: 1974 p. 4

Documentation developed by psychiatric services provide descriptions and justifications of staff activities although underlying there may be meager understanding about their effectiveness or even a consistent definition of effectiveness. While uncertainty tends to result in increased documentation, that uncertainty is not to be exposed in records. Staff entries should impart that those activities were what the patients needed.

Behavioral models of treatment presuppose that specific staff inputs directed at specific patient behaviors will result in specific symptom abatement. It is a progression though that defies staff experience, perhaps because the facility is unable effect the consensus of staff and consistent control over their activities that the behavioral model requires or perhaps because the model has limited applicability for transformation of patients with severe psychiatric illnesses. Determining that certain staff activities change patients' behaviors is extremely difficult. Notwithstanding, documentation displayed on medical record forms must be developed as if the writers have convictions about their statements and they have achieved concordance with others on "the team."

Through its forms and the instructions that accompany them staff are indoctrinated with treatment perspectives and practices sanctioned by the organization since questions to

be addressed on forms indicate parameters of expected replies. For example treatment plan forms mandate entries using behavioral terminology and as staff enter their responses they are at the same time being inculcated with behavioral rhetoric. Staff who are of the opinion that psychiatric illnesses are best alleviated with psychodynamic treatment methods have almost no opportunity to express those viewpoints; their documentation is required to adhere to the operant behavior model.[5]

When in 1996 HCFA changed from a process based to an outcome based evaluation it was an implicit critique of its own past audit practices of focusing on what staff did rather than on how patients were affected by what staff did; psychiatric hospital staff would have to document effects of their activities on patients. But, as was illustrated in the previous chapter's discussion of treatment plans, staff activities at TPC did not change but how they worded treatment plan review entries did; more elaborate and ambiguous ways were found to say why treatment was not changed even though the patient had not improved. Documentation is often analogous to strategic game-playing.

Little has been said in this study about the subjects of the psychiatric medical records, the patients. They

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[5] A number of staff maintain part-time psychotherapy practices.

necessarily would have to be relegated as background when documentation processes were highlighted. But, as has can be inferred from the foregoing, involvement with medical record documentation may in fact diminish attention to patients; sometimes they become irritants that hinder getting chart work done. Medical records can seem more substantive than the individuals whose names they bear. HCFA decided that as of 1996 it was time for them to view actual patients as well as their records. Effects of the change is not evaluated here because it took place when this study was near completion.

A number of issues I have raised will be illustrated in the following vignette: Professional, paraprofessional and administrative staff involved with direct inpatient care from all the psychiatric centers within the city were ordered to attend a day long meeting held at one of those facilities. In order not to totally deplete each hospitals clinical staff employees were given an option of attending either of the two days on which the meeting was held in late 1994. Bear in mind then that several hundred of the higher paid employees (aides and cleaners were excluded, for example) were provided with transportation, lunch (however sparse), and, most important, time away from their regular tasks. Bear in mind also that the order had to have come from someone with hierarchical level above that of director

of a hospital, that is someone with centralized authority, an OMH official. The main purpose of the meeting was to introduce a new form and train staff how to use it.

What was so compelling about this form that would induce such a large expenditure of resources? It consisted of eight pages with question and response areas designed to display an assessment of a potential for dangerous behavior. Several months prior to this training session there had been a couple of instances of murder having been committed by individuals who had been treated in one or more of the state psychiatric centers. During one of these episodes a woman was thrown onto a subway track, an event that received widespread media coverage. State psychiatric centers were also being castigated in the media because of a discharged patient who was considered a menace by residents of a particular community. The Office of Mental Health was being called upon to "do something" about the perceived threat to the safety of citizens.

The very concreteness of the form lends itself to a display of resolution despite intrinsic complexities with which the questions grapple. A continuing dilemma of inpatient state psychiatric services is how to reduce populations of its hospitals without incurring untoward reactions as noted above. Another dilemma is how to fulfill the legal requirement to provide the least restrictive

treatment setting by helping eligible patients gain "privileges" to leave wards unattended while recognizing those same patients may use "privileges" as an opportunity to elope. Responsibility for decisions for discharge or privileges falls mainly on psychiatrists, but there should be evidence in the record of "input" by the "team". Those decisions are expected to be documented on medical record forms described and discussed in earlier chapters. Psychiatrists often and in many contexts, including during the meeting under discussion here, expressed apprehension about being targets of punitive action should they put their signature on a permission for leave or discharge for a patient who then commits a major misdeed. The alternative of cautiously withholding privileges and discharges would not only jeopardize patients' civil rights, but was also unacceptable when there was an urgency to reduce costs.

The form presented at the meeting was designed to address both imperatives. Questions on it were geared to establish whether patients met criteria for potential dangerousness. If they did then the form would be forwarded for a second step review by and signature from selected supervising psychiatrists. It was explained that this review would, by spreading potential liability among several levels of authority, induce ward psychiatrists to be

less reluctant to consider referring some of the riskier patients to residences.

When first presented with copies of the eight page form those in the auditorium responded with groans. Complaints, as usual, were heard about being inundated with paperwork. The presenter stated his total agreement with a position that objects to the number and types of forms that he knew to be part of the medical record. In fact, he stated, he had been soliciting recommendations for modifying or even eliminating many of the forms that were bogging them down uselessly. But this form, he said, was purposeful and practical and should, therefore, be distinguished from those that caused rightful staff resentment. That stance is repeated frequently at TPC as administrators fume at being bogged down with following paperwork yet simultaneously introduce forms that they believe can track some problematic factors.

Ultimately the forms distributed at the meeting were not put into effect. The leader of the meeting was, as it turned out, leaving his position shortly after. Although there was no pressure to institute a form developed by someone no longer in charge, in lieu of that one each facility was ordered by the Office of Mental Health to devise a method to document knowledge about and control over patients whose future actions could elicit media attention

and/or law suits. The Psychiatric Center decided to institute a risk assessment form for each patient and to require three signatures, -- a psychiatrist, a supervising psychiatrist and a unit administrator, on progress notes prior to increasing privileges for patients designated as high risk. Therefore while an individual was instrumental in generating a particular form, his displacement did not do away with needs of the system to attempt to manage the census and mollify the media at the same time. Should something go wrong, for example should staff sign to privileges for a patient who proceeds to inflict harm someone in the community, highest level administrators can be shielded as they hone in on staff who can be held accountable.

The form described in the vignette above was designed to guide decisions about possible future behavior of people who have histories (assuming those "histories" are available, factual, complete and clearly interpretable, - a chancy presumption) of having committed at least one act that was sufficient to warrant incarceration based upon mental illness. I have overheard and engaged in countless discussions which entailed evaluations of patients' current conditions as improved or not, if improved, why and if not, why not, the likelihood of decompensations and under what circumstances, reinterpretations of past events, questioning

whether certain individuals should be incarcerated as criminals rather than as mental patients, how crazy the patient can be and still be discharged, how crazy the patient is entitled to be and still be discharged, as examples. Much of what is said are speculations.

Perhaps from the foregoing one could infer that my intent is to deprecate bureaucratic processes. As Beetham said, "Bureaucracy is something we all love to hate...there is almost no evil that has not at some point been debited to its account." [6] But I am not proposing that staff, freed from the fetters of paperwork loads and the regulations they address, would necessarily use their time to spend with patients who would, therefore, be better cared for. I had observed and participated in too many situations not to be suspect of such claims. There is no doubt that many regulations, along with documentation to display they have been complied with, have played a major role in improved patient care.

Audit preparations can result in the average level of care being raised. An audit group reviews yearly each and every psychiatric medical record for the presence or absence of documentation of numerous aspects of patient care, including medical examinations and treatments. One

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[6] Beetham: 1987. p. 1

requirement is that records contain reports which indicate patients have been examined, and treated if necessary, by the dentist within the year. If patients refuse there should be both referrals and progress notes by medical specialists to indicate efforts at getting patients to "cooperate". True, prior to an audit the dentist will be inundated with referrals, no doubt more than can be handled at that time, but at least some attention will probably have been paid to all patients. I am not suggesting here that documentation should be equated with actual rendering of services or that really shoddy work won't be concealed by prudent writing. This paper has presented many examples of documentation practices which are nothing more than misleading displays of staff activity. But bureaucratic practices can also be lauded for preventing or uncovering potential neglect, particularly for certain types of documentation such as noting the rendering of very specific medical examinations or treatments which are relatively easy to assess and risky to tamper with.

An example of the hazards of unregulated, undocumented treatment is from my experience working in one of the state psychiatric outpatient clinics in the early 1970s. Mental Health Therapy Aides, employees who rarely have more than a high school education, would pour prescribed medications from large containers into smaller ones which they would

hand over to patients. Use of several of those medications (Valium, for example) would later become highly controlled, but in those days batches would "walk" and no one could or would ascertain why the pills were missing. Worse yet, there was often no documentation that patients actually received their medications as visits were often unrecorded. Further, there was inadequate follow-up of how patients actually used the large number of pills they were given. Today medication is packaged and dispensed at the pharmacy where patients are required to sign for what they receive. When these changes were instituted they were viewed by many as intrusive and causing inconvenience to patients.

Shortly after I started to work at the outpatient clinic mentioned above word came that there was to be an audit of clinic records, a great many of which had no or few progress note entries. After the clinic director assembled staff for a "chart party", we wrote statements, perhaps "patient reports no problems", in records at random, without knowledge of those individuals' actual conditions. I relate this tale with some uneasiness because I still can have twinges of embarrassment and relief that there were no repercussions. When a new director instituted a form that would check off dates and services for patients' visits he was derided as an autocrat. Poor records evidently existed at one of the facility's other outpatient clinics. Several

years later a clinic director was discovered to have stashed piles of patient records in the trunk of his car to avoid having those most ill prepared subject to an audit. Endeavors to resist and outwit bureaucratic encroachments bestowed an aura of heroics, but those tactics now are far too crude in times when computer print-outs are the standard to track patients and their records.

In conducting this study it was not my intent to produce one more diatribe against bureaucracy. In addition to presenting some effects of its excesses I have taken care to describe results of inadequate documentation processes. Merely disparaging bureaucratic processes in effect repudiates the need for accountability measures, a stance that could not maintain credibility. It is important to examine how and why irrationalities of controls through documentation become entrenched so that their effects can be moderated.

While many of the stated observations about forms have general applicability, public psychiatric hospitals exhibit special problems. Legal, regulatory, and financial pressures demand compliance with their standards but uncertainties of inpatient psychiatric services discussed above make them resistive to rationalization. Conflicting mandates of discrete segmented categories while portraying "the whole person" results in documentation that tends to be

unwieldy, disjointed, and time consuming. Psychiatric patients are difficult to encapsulate into a series of defined blank spaces.

In this research I have demonstrated how administrative forms are used as mechanisms to exert various types of control by organizations. I have shown that they design and modify forms in reaction to external and internal pressures; over time there is a non face-to face but nevertheless dialogic quality to form development and processes as administrators review responses on a set of forms and subsequently make changes on the next set, perhaps to counteract possible evasiveness by the respondents. Further, I have illustrated how forms are not only generated out of conflict they also generate conflict for those who are responsible for their entries. Controls through administrative forms warrant particular attention since those who must participate by signing generate their own vulnerabilities for self-incrimination.

APPENDIX A

EXAMPLES OF AUDIT PREPARATION MATERIAL

1. Medical Records Department follow-up of records of discharged patients.

2. Medical Records Department follow-up of missing documentation in records of discharged patients.

3. Several newsletters priming staff with respect to medical records documentation during audit preparations.

4. Tickler for reporting chart documentation deficiencies of a ward.

5. Hospital-wide summary of deficiencies displayed on ticklers.

6. One version of a record review form.

7. Another version of a record review form.

8. Utilization Review Department review of one record.

9. Periodic Medical Review form filled out by internal staff as part of audit prepartation.

10. Two page memorandum summarizing the Periodic Medical Review report for their 1994 audit.

11. Two page memorandum summarizing the Periodic Medical Review report for their 1995 audit.

Appendix A 1
Request for records of discharged patients:

[redacted] CENTER

MEDICAL RECORDS DEPARTMENT

DATE 12/4/89

TO: [redacted]

FROM: [redacted]
Supv. Med. Rec. Admin.

RE: OVERDUE RECORDS

All closed-out records are due in Medical Records within fifteen (15) days of discharge.

Below is a listing of discharge records from your unit which we have not received and are overdue:

CONS. #	NAME	DATE	ACTION	COMMENTS
[redacted]	[redacted]	4/14/89	Disch.	
	[redacted]	4/7/89	Disch.	

It is the responsibility of the Discharge Unit to notify Medical Records if any of the above records have already been returned.

Thank you for your cooperation.

CC: [redacted]

Appendix A 2
Follow-up of missing documentation for discharged patients:

[redacted] Center
Medical Records Department
TO: Nursing Ward [redacted]
FROM: [redacted]
Director, Medical Records Dept.

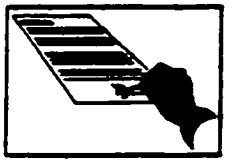
CODES: M - Missing
I - Incomplete
S - Signature

CHART#	NAME	WD	DATE OF DISCHARGE	CODE	DEFICIENCY	DATE MED'D SENT
[redacted]	[redacted]	32	4/8/93	S	Weight + Blood Pressure	4/30/93
						5/14/93
						5/28/93
						6/4/93
						6/14/93
						6/18/93
						6/25/93
						7/2/93
						7/9/93
						7/16/93
						7/23/93
						7/30/93

Appendix A 3a
Newsletter preparing staff for audits:

Treatment Planning Tips: · Completing the Behavior Box

The behavior box is the most important section both for individualizing the patient's treatment plan and for setting up the Goal and Objectives. The behavior box should conceptualize the problem to be addressed, and illustrate how this problem is exhibited behaviorally by the patient. For example:



The patient has a schizophrenic thought disorder. The patient has auditory hallucinations of a woman's voice telling him he is no good, the patient is isolated and does not participate in group activities or make eye contact when spoken to, and the patient has poor ADL skills (unshaven, uncombed hair, refuses to change his clothes).

Note that the behavior box statement is a succinct and concise statement of the problem with individualized behavioral components. As is demonstrated below, it leads naturally to the goal statement and the measurable objectives. It does not contain redundant or unnecessary statements about the patient's psychiatric history - e.g., "This patient has several psychiatric hospitalizations since 1967, ..."

The task is to conceptualize the problem clearly and accurately describe what characterizes the problem. When this is done well, the rest of the Goal Page falls into place.

The Goal Statement:

The goal need not be measurable - only observable. A general statement of the patient's problem is acceptable. For example, it should read something like: The manifestations of schizophrenic thought disorder will be controlled or alleviated to the point that the patient will be able to reside in a structured outpatient setting.

Objectives:

The objectives need to be measurable and should relate directly back to the behavior box. The above behavior box should result in three objectives, each addressing one of the behavioral concepts, auditory hallucinations, isolation and poor ADL. Additionally, the objectives should have a precise benchmark which will allow the team to assess if it has been attained. For example, one possible objective might read: "Upon staff prompting, the patient will respond verbally in group discussions 2X per week for one month."

SURVEYORS EVALUATE ACTIVE TREATMENT BASED ON DOCUMENTATION CONTAINED IN THE MEDICAL RECORD. BE SURE YOU GIVE YOURSELF CREDIT FOR THE SERVICES YOU ARE PROVIDING.

Is it a problem or a disability??????

A problem is an issue for the patient that is (at least theoretically) able to be ameliorated or improved, while a disability is an issue for the patient that cannot be corrected. All patients have problems, that's why they are here, however not all patients have disabilities.

Appendix A 3b
Newsletter preparing staff for audits:

Progress is Measured One Note At A Time

HCFA surveyors measure movement toward goal attainment by reviewing the progress notes. At the least, weekly notes are required from each discipline for the first eight weeks of the hospitalization. Thereafter, notes are entered at least monthly.

In these notes you should "recap" the services provided to the patient since the last monthly (weekly) note, assess the patient's progress in meeting the goals set out in the treatment plan and indicate how you will continue to treat this patient over the subsequent month (or week).

At the Bronx, we require that all providers "DAP" their progress notes. That is, each note is divided into three sections which

D = Describe the services provided and the patient's response to it. This is the data. Be as specific as possible. If the patient attended your "Art Appreciation" group twice during the month and stayed each time for 45 minutes, say so. Be specific. This is the billing section of the medical record. Also document patient's response to your treatment. If the patient is resisting treatment, document your efforts to engage the patient in the plan.

A = The assessment section of the progress note should begin with a statement as to the change, if any, in the patients condition. The first line of this section should read, "The patient's condition (is better, is worse, remains the same) followed by your more detailed clinical assessment.

P = In the plan section, you should explain how you are going treat this patient over the next month/week. If the patient is compliant with the treatment plan and the patient is progressing towards the goals set, you might note that you will continue treatment according to the plan. If the patient is not compliant, or not responding to the treatment, you should describe how you will either change the treatment or engage the patient in the treatment.

Appendix A 3c
Newsletter preparing staff for audits:

We are judged by our behavior...

...box, that is. The following are examples of the content of "real" behavior boxes. One example falls into the category of the "best," while one is not quite so good. You review the narratives, and you decide which is which. Remember, a good behavior box describes observable behaviors, does not include patient history, focuses on current behavior, refrains or clarifies diagnostic labels and clearly states how the behavior interferes with the patient functioning.

Example A: Pt. has been continuously hospitalized since 1984 and received unescorted grounds privileges 2 months ago. As patient is a CPL case he needs to demonstrate the capacity to function independently on grounds before we can approach the DA regarding discharge.

Example B: Pt. sits in the corner of the dayroom with a frightened expression on her face, looking dischevelled and often smelling unwashed. Pt. states that she tries to be a "honest girl" but staff does not take good care of her, leaving her at the mercy of "bad people" on the ward. Patient denies that she has any problems, blaming everything on "men who want to do bad things to her." In groups, she will alternately be supportive or critical of the others.

Ed. Note: Because the behavior box used in example B was so detailed, it was extensively paraphrased and some details changed. This behavior box in its original form would have definitely allowed someone to identify this patient. This is key to a good behavior box.

Moving???

When patients are transferred between wards, there is a mandate for certain documentation to be included in the chart. Upon leaving a ward, notes are required from the psychiatrist, nurse and physician. The psychiatrist, nurse and physician on the receiving ward must also write a note upon the patient's arrival. Additionally, the treatment plan must be reviewed (PTPR) or rewritten by the receiving team, as appropriate. Please refer to the policy regarding patient transfer in the BPC Uniform Case Record (UCR) manual (pp. 39 - 41) for complete information.

HAVE NO PLACE IN THE MEDICAL RECORD.

Correct the medical record by drawing a single line through the error and adding your initials and the date of the modification.

Appendix A 3d
Newsletter preparing staff for audits:

Know Your Role in the Treatment Plan

In some ways the treatment plan is like a script, it defines each treatment team member's individual role and presents an integrated team approach to patient treatment. It is important that <u>all</u> staff review the treatment plans for patients in their care and reflect the treatment rendered in the monthly (or weekly) progress note.

This is especially important for staff who are assigned to multiple wards, such as dieticians. It is the responsibility of the principal therapist to ensure that these staff are informed when they are included in the patient's treatment plan, so that the appropriate progress notes can be entered and keyed.

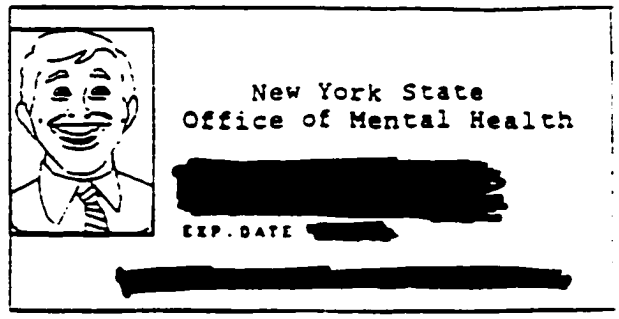
It is also time to start thinking about some of the areas which will be covered by the surveyors when they tour the wards. For example, they may ask you about the patients in your unit, the treatment goals of each unit and how your ward/unit fits into the overall structure of the hospital. Over time, we tend to become very involved in the "micro" level of care and do not think about some of these larger, and relevant issues.

Over the next few weeks, administrative staff will be touring the wards and "role playing" the content of the ward tours with you. This is being done to help you prepare for the critical ward tours. As has been said before, and can't be repeated too often, the ward tour sets the tone for the ensuing record reviews. So as they say in show biz...

Knock-'em dead,

figuratively, of course.

What's Wrong With This Picture?



Look at the expiration date on the I.D.

RENEW AND WEAR YOUR I.D.
FOR THE SAFETY OF PATIENTS & STAFF

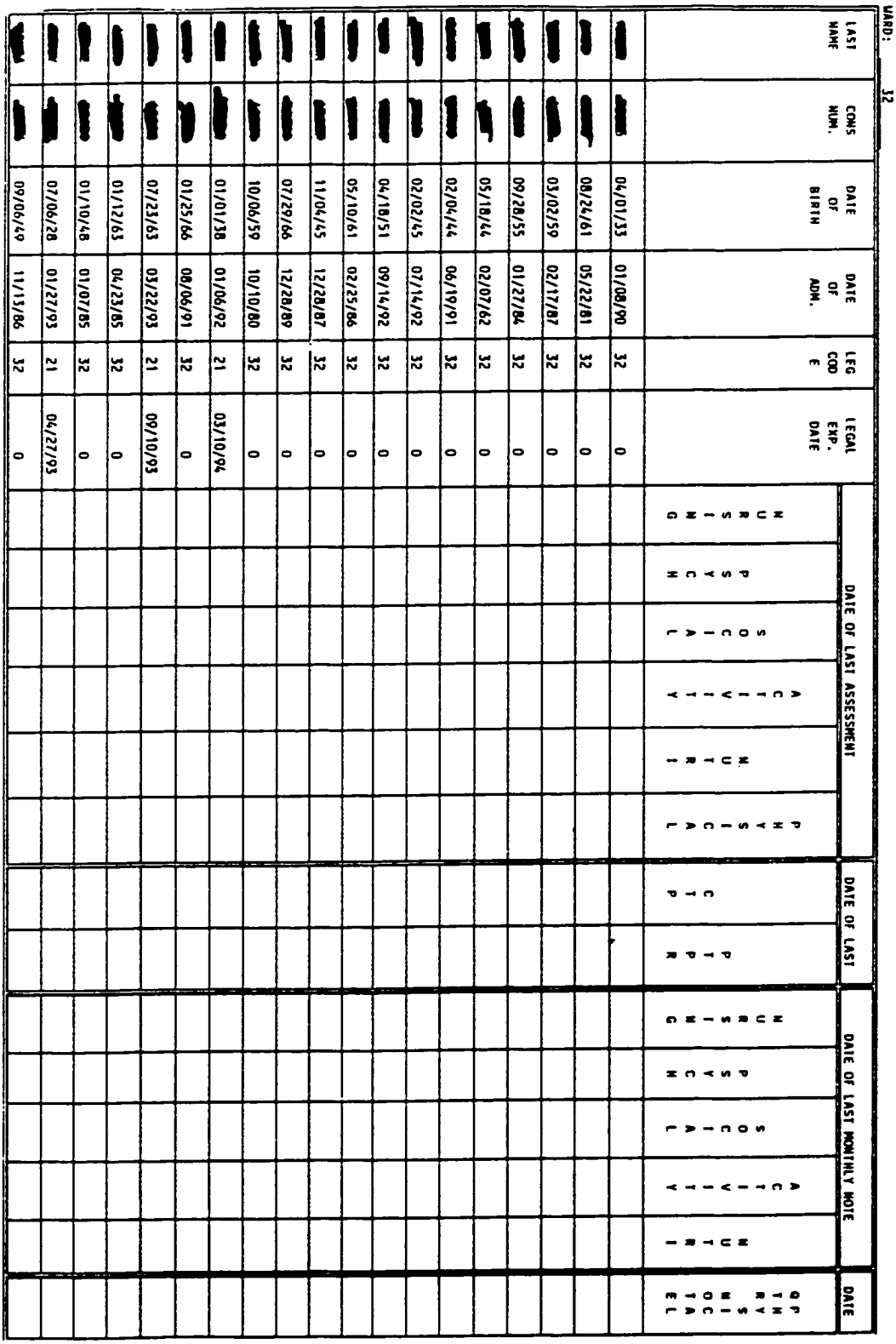
Watch Your Language

Words mean different things to different people. For example, what is "appropriate" behavior in one person's eyes, may be "inappropriate" in another's. The following non-behavioral terms should be avoided or used only if they are further defined:

interact	coherent
actively	agitated
relevant	socialize
calm	willingly
participate	normal
cooperate	

If used, these words should be accompanied with an "as evidenced by," "as manifest by," or "as indicated by" followed by a description of the behavior.

Appendix A 4a
Tickler, page 1:



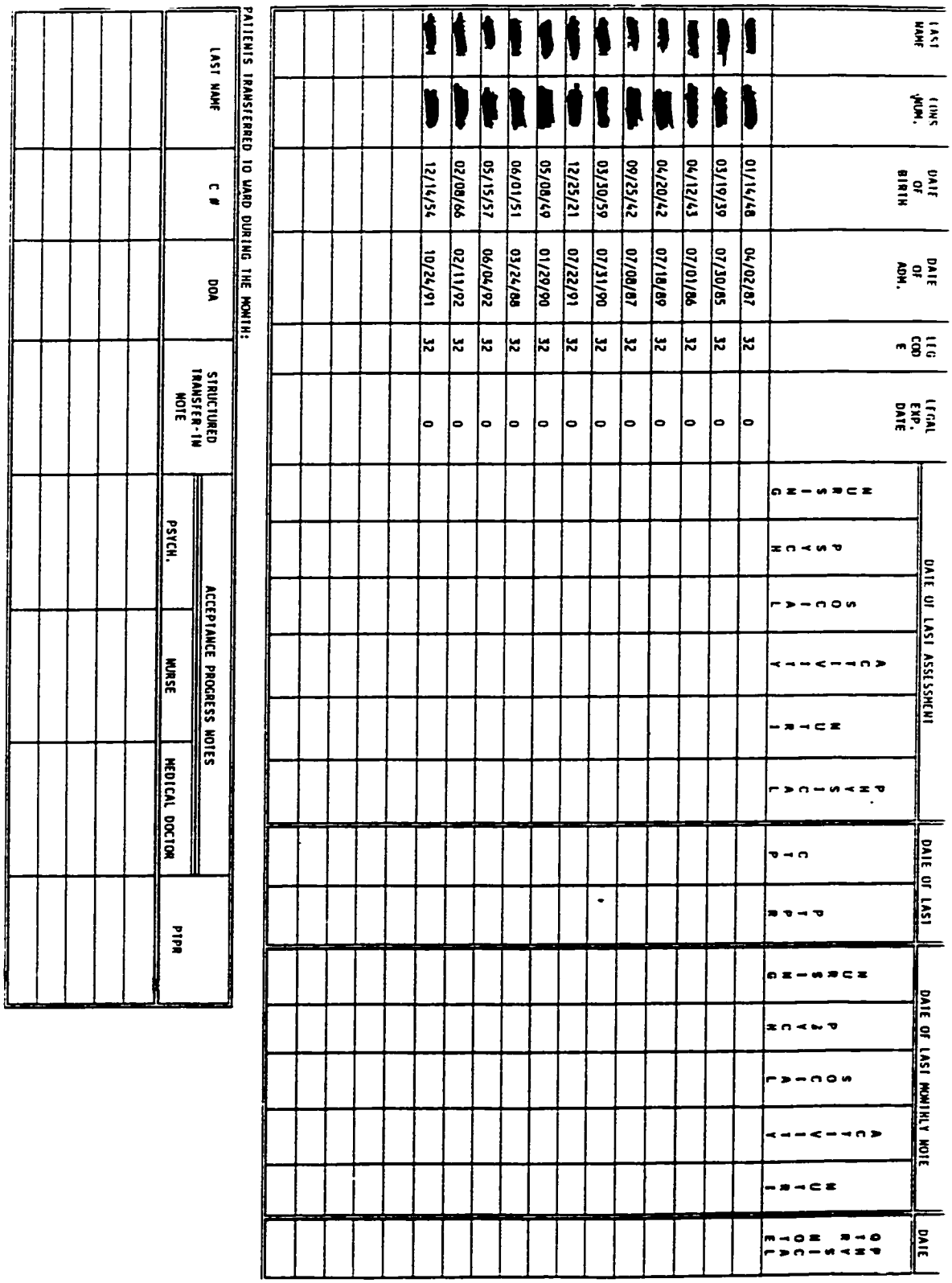
[redacted]

MEDICAL RECORD DOCUMENTATION STATUS
FOR THE MONTH OF: MARCH 1993

WARD: 12

LAST NAME	CONS NUM.	DATE OF BIRTH	DATE OF ADM.	LEG CODE	LEGAL EXP. DATE	DATE OF LAST ASSESSMENT: NURSING	PSYCH	SOCIAL	ACTIVITY	NUTRITION	PHYSICIAN	DATE OF LAST: PPR	CIPP	DATE OF LAST MONTHLY NOTE: NURSING	PSYCH	SOCIAL	ACTIVITY	NUTRITION	DATE: OPTHRAY	MISC-DOCUMENTAL
[redacted]		04/01/33	01/08/90	32	0															
[redacted]		08/24/61	05/22/81	32	0															
[redacted]		03/02/59	02/17/87	32	0															
[redacted]		09/28/55	01/27/94	32	0															
[redacted]		05/18/44	02/07/62	32	0															
[redacted]		02/04/44	06/19/91	32	0															
[redacted]		02/02/45	07/14/92	32	0															
[redacted]		04/18/51	09/14/92	32	0															
[redacted]		05/10/61	02/25/86	32	0															
[redacted]		11/04/45	12/28/87	32	0															
[redacted]		07/29/66	12/28/89	32	0															
[redacted]		10/06/59	10/10/80	32	0															
[redacted]		01/01/38	01/06/92	21	03/10/94															
[redacted]		01/25/66	08/06/91	32	0															
[redacted]		07/23/63	03/22/93	21	09/10/93															
[redacted]		01/12/63	04/23/85	32	0															
[redacted]		01/10/48	01/07/85	32	0															
[redacted]		07/06/28	01/27/93	21	04/27/93															
[redacted]		09/06/49	11/13/86	32	0															

Appendix A 4b
Tickler, page 2:

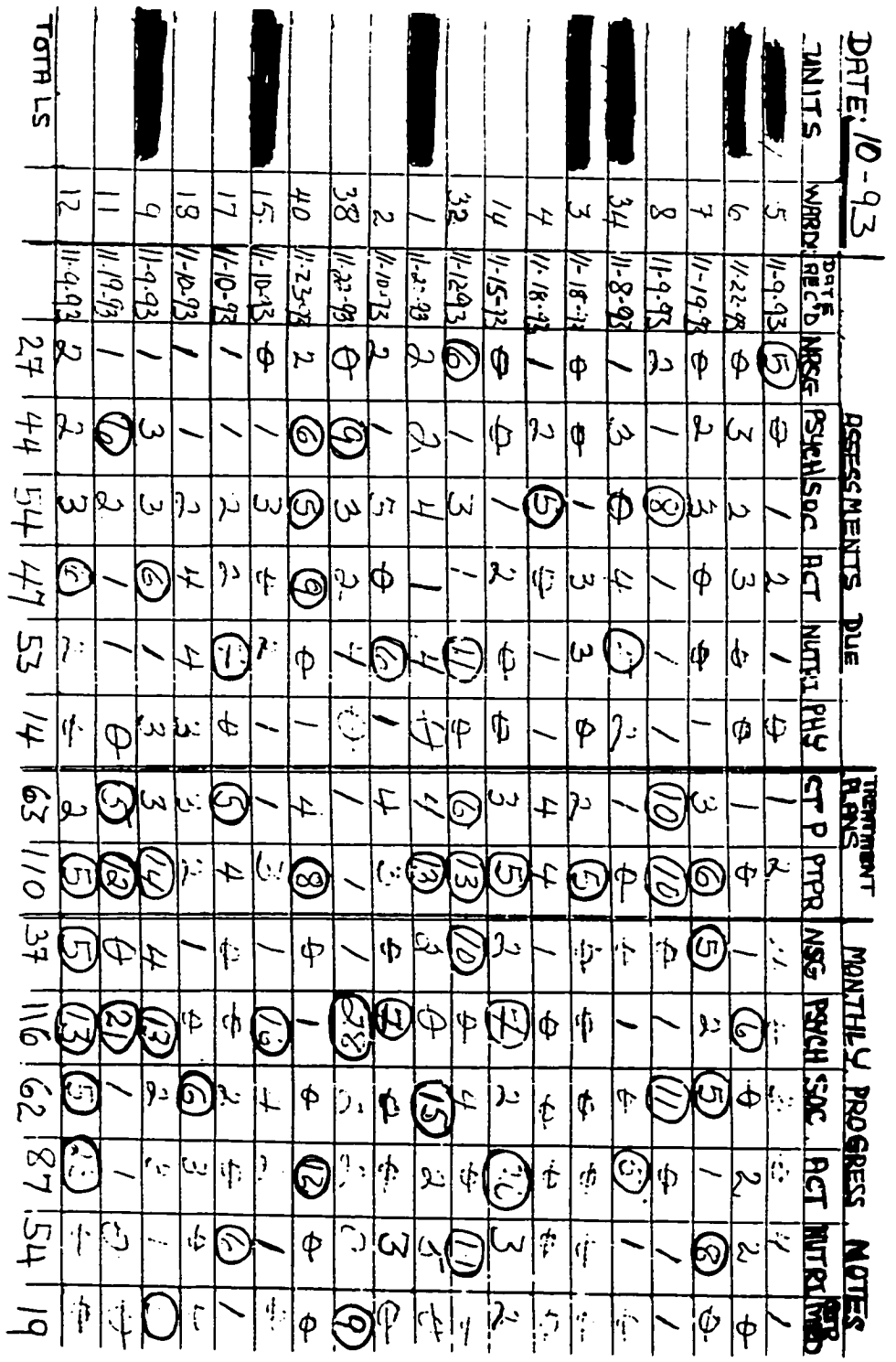


LAST NAME	UNIT NUM.	DATE OF BIRTH	DATE OF ADM.	LEG CODE	LEGAL EXP. DATE	DATE OF LAST ASSESSMENT: NURSING	PSYCH	SOCIAL	ACTIVITY	NURSING	PHYSICAL	DATE OF LAST: CIPP	PIPR	DATE OF LAST MONTHLY NOTE: NURSING	PSYCH	SOCIAL	ACTIVITY	NURSING	DATE OF MEDICAL
[redacted]	[redacted]	01/14/48	04/02/87	32	0														
[redacted]	[redacted]	03/19/39	07/30/85	32	0														
[redacted]	[redacted]	04/12/43	07/01/86	32	0														
[redacted]	[redacted]	04/20/42	07/18/89	32	0														
[redacted]	[redacted]	09/25/42	07/08/87	32	0														
[redacted]	[redacted]	03/30/59	07/31/90	32	0														
[redacted]	[redacted]	12/25/21	07/22/91	32	0														
[redacted]	[redacted]	05/08/49	01/29/90	32	0														
[redacted]	[redacted]	06/01/51	03/24/88	32	0														
[redacted]	[redacted]	05/15/57	06/04/92	32	0														
[redacted]	[redacted]	02/08/66	02/11/92	32	0														
[redacted]	[redacted]	12/14/54	10/24/91	32	0														

PATIENTS TRANSFERRED TO WARD DURING THE MONTH:

LAST NAME	C #	DOA	STRUCTURED TRANSFER-IN NOTE	ACCEPTANCE PROGRESS NOTES: PSYCH.	NURSE	MEDICAL DOCTOR	PIPR

Appendix A 5
Hospital wide summary of documentation deficiencies:



DATE: 10-93

UNITS	WARD	DATE REC'D	ASSESSMENTS DUE NRSG	PSYCH/SOC	ACT	NUTRI	PHYS	TREATMENT PLANS CT P	PTPR	MONTHLY PROGRESS NOTES NSG	PSYCH/SOC	ACT	NUTRI	PHYS
[redacted]	5	11-9-93	(5)	Φ	1	2	1	Φ	1	2	1	1	2	1
[redacted]	6	11-22-93	Φ	3	2	3	Φ	Φ	1	Φ	1	(6)	Φ	2	2	Φ
	7	11-19-93	Φ	2	3	Φ	Φ	1	3	(6)	(5)	2	(5)	1	(8)	Φ
	8	11-9-93	2	1	(8)	1	1	1	(10)	(10)	Φ	1	(11)	Φ	1	1
[redacted]	34	11-8-93	1	3	Φ	4	(1)	1	1	Φ	1	1	Φ	(3)	1	1
[redacted]	3	11-18-93	Φ	Φ	1	3	3	Φ	2	(5)	Φ	Φ	Φ	Φ	Φ	Φ
	4	11-18-93	1	2	(5)	Φ	1	1	4	4	1	Φ	Φ	Φ	Φ	Φ
	14	11-15-93	Φ	Φ	1	2	Φ	Φ	3	(5)	2	(7)	2	(10)	3	2
	32	11-29-93	(6)	1	3	1	(1)	Φ	(6)	(13)	(10)	Φ	4	Φ	(11)	1
[redacted]	1	11-22-93	2	2	4	1	4	1	4	(13)	3	Φ	(15)	2	2	1
	2	11-10-93	2	1	5	Φ	(2)	1	4	1	Φ	(7)	Φ	Φ	3	Φ
	38	11-22-93	Φ	(9)	3	2	1	1	1	1	1	(28)	2	2	1	(9)
	40	11-23-93	2	(6)	(3)	(9)	Φ	1	4	(8)	Φ	1	Φ	(12)	Φ	Φ
[redacted]	15	11-10-93	Φ	1	3	2	1	1	1	(5)	1	(9)	4	2	1	1
	17	11-10-93	1	1	2	2	(1)	Φ	(5)	4	Φ	Φ	2	Φ	(6)	1
	18	11-10-93	1	1	2	4	4	2	2	2	1	Φ	(6)	3	Φ	1
[redacted]	9	11-9-93	1	3	3	(6)	1	3	3	(4)	4	(12)	2	1	1	0
	11	11-19-93	1	(9)	2	1	1	Φ	(5)	(12)	Φ	(21)	1	1	2	Φ
TOTALS	12	11-9-93	2	2	3	(5)	2	2	2	(5)	(5)	(13)	(5)	(5)	1	Φ
			27	44	54	47	53	14	63	110	37	116	62	87	54	19

Appendix A 6a
Record review I, page 1:
RECORD REVIEW FORM

Pt's Name_____ C#_____ Unit Name_____ Ward_____

Reviewer_____ Date of Review_____ Admission Date_____ DOB_____

	COMMENTS
1. Was an interim TX Plan developed on admission? Yes___ No___ NA_____	
2. Is there a current legal status? Yes_____ No_____	

A. ASSESSMENTS:

	Phy	Psych	Soc	Act	Nursing	Other
3. Is there an assessment within 7 days of admission? (psy - 2 days) (nsg - 8 hours) (phy-24 hours)	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___
4. Is it signed with title and date?	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___
5. Are problems strengths disabilities specific and individualized?	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___
6. Are recommendations included in Tx. Plan?	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___	Yes___ No___ NA___

FOR THE PSYCHIATRIC ASSESSMENT:

7. Does it include the patient's chief complaint? Yes_____ No_____
8. Is medical history summarized? Yes_____ No_____
9. Does the memory and intellectual functioning report include a description of the tests performed? Yes_____ No_____

B. TREATMENT PLANS

10. Is there a Comp. TX Plan Part I present and completed? Yes_____ No_____
11. Is an RN, SW and Psych. listed as participating team members? Yes_____ No_____
12. Are family or significant others involved, or, if not, attempts to obtain participation documented? Yes_____ No_____
13. Is tentative discharge date current? Yes_____ No_____
14. Are criteria for discharge observable Yes_____ No_____
15. Does discharge plan state address patient's anticipated needs on discharge? Yes_____ No_____
16. Does the discharge plan state specific residential setting needed on discharge? Yes___ No____
17. Is there Comp. Tx. Plan II present? Yes____ No____
18. Is there a specific and individualized description of the patients's behavior in the Behavior Box? Yes_____ No_____
19. Does the goal relate to the behavior box? Yes_____ No_____
20. Are all target dates current? Yes_____ No_____

Appendix A 6b
Record review I, page 2:

21. Is there at least one treatment modality for each objective? Yes_____ No_____

22. Are the criteria for discharge addressed in the Goals and Objectives? Yes_____ No_____

23. Are all objectives observable and specific? Yes_____ No_____ If no, which ones are not?

_____

24. Do all methods indicate the name and title of the responsible person? Yes_____ No_____

If no, which ones are deficient?_____

25. Do all methods indicate the frequency and duration of intervention? Yes_____ No_____

26. If medication is a method, is the Dr's Order Sheet referenced? Yes_____ No_____ NA_____

27. Does the nurse provide individual and/or group therapy? Yes_____ No_____

28. Does the psychiatrist provide individual and/or group sessions? Yes_____ No_____

29. Is there a CTP Part III present? Yes_____ No_____

30. When objectives show revised target dates is a satisfied rationale documented PTPR? Yes__No__

31. Is the DSM-III-R Axes I-V listed on Part III? Yes_____ No_____

32. Does Part III give a rationale for the Treatment Plan Yes_____ No_____

33. Is part III signed or co-signed by MD? Yes_____ No_____

34. Are all identified problems and recommendations either incorporated in Objectives and Methods, or appropriately deferred in the rationale? Yes_____ NO_____

If no, which ones are not? _____

35. If alcohol or drug abuse has been identified as a problem, is it addressed in the Tx. Plan? Yes_____ No_____

C. TREATMENT PLAN REVIEWS

Directions: Review most recent Tx Plan update. If this is a recent admission and no update is due, MARK 36 NA and proceed to question #42.

36. Is there a current PTPR? (within 30 days of initial CTP; then every 60 days for 1st year; every 90 days thereafter; every 30 days under 22) Yes_____ No_____ NA_____

37. Does the PTPR state patients progress or lack of progress toward treatment objectives? Yes_____ No_____

38. Does the PTPR indicate whether or not changes should be made in the treatment goals, objectives, or modalities? Yes_____ No_____ NA_____

39. If the patient is not progressing, does the PTPR indicate how treatment should be changed, or why continuing current treatment is justified? Yes_____ NO_____ NA_____

40. Does the PTPR discuss change/lack of change in patients discharge plans? Yes____ No___ NA___

41. Is the PTPR signed or co-signed by an MD? Yes_____ No_____

D. MEDICAL SECTION

42. Is there a current physical exam in the chart? Yes_____ No_____

43. Was each of the bodily systems reviewed by a physician? Yes_____ No_____

44. Are all the cranial nerve systems addressed and was an attempt made to describe the tests used? Yes_____ No_____

45. Are abnormal findings appropriately followed up or justified by the attending physician? Yes_____ No_____

46. Was A TB skin test done on this patient? Yes_____ No_____

a. If positive, was a follow-up X-Ray done? Yes_____ No_____ NA_____
b. If negative, was there a subsequent test every two years? Yes_____ No____ NA_____

Appendix A 6c
Record review I, page 3:

COMMENTS

47. Is the patient's weight recorded monthly? Yes_____ No_____

48. Is the patient's blood pressure recorded monthly? Yes_____ No_____

49. Are unusual weight fluctuations addressed in the Treatment Plan, PTPR, or notes?
Yes_____ No_____ NA_____

50. Was a CBC, FBS, BUN and urinalysis done in the past year? Yes_____ No_____

51. Is there evidence that orders for medical consultation have been carried out and properly followed up? Yes_____ No_____ NA_____

52. Has the patient had a dental examination within the past year or as indicated? Yes___ No___

53. Is the Medication/Treatment Record present? Yes_____ No_____

54. Is the 223 MED free of white out and erasures? Yes_____ No_____

E. PROGRESS NOTES

	PSY.			NURSE			SW			RT OR OT		
	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
55. Are there weekly notes for the first 8 weeks?												
56. Are there monthly notes thereafter?												
57. Is there a precise assessment of the patients's progress in accordance with the TX Plan (better, worse, same)?												
58. Do Notes indicate what worker did; or that treatment modalities are delivered as specified in CTP?												
59. Do Notes describe what patient did in response to treatment and what workers assesment of that is?												
60. Do Notes contain recommendations for revision in the Tx Plan as indicated?												
61. Are progress notes keyed to the CTP?												
62. Are progress notes in a D-A-P format?												

63. Is there a Drs. progress note giving the rational for orders? Yes_____ No_____

64. Is there a note by the clinical physician within the last three months? Yes_____ No_____

65. If special dietary needs have been identified, have corresponding orders been written?
Yes_____ No_____

Appendix A 7a
Record review II, page 1:

[redacted] CENTER - RECORD REVIEW FORM

PATIENT NAME [redacted] C#: [redacted] DATE OF BIRTH: 3/1/44 DATE OF ADMISSION: 9/12/94 WARD: ___

REVIEWER: [redacted] DATE OF REVIEW: 11/29/94 LEGAL: C/c CURRENT LEGAL DOCUMENTS IN CHART: Y/N

YES	NO	NA	SEE COMMENTS	
			☐	**ASSESSMENTS:**
			☐	**CORE HISTORY:**
CH1. ☐	☑	☐	☐	**CH1.** History is completed within 5 days of admission. on 10/- started 9/23 - completed 9/29
CH2. ☑	☐	☐	☐	**CH2.** All areas of the history are addressed.
CH3. ☑	☐	☐	☐	**CH3.** Core history is signed, titled and dated by a Social Worker.
			☐	**NURSING ASSESSMENT:**
NA1. ☑	☐	☐	☐	**NA1.** Parts I & II are completed within 24 hours of admission and Part III is completed within 7 days of admission and updated annually within seven days of the anniversary of admission.
NA2. ☑	☐	☐	☐	**NA2.** All parts (as appropriate) are signed with title and date.
NA3. ☑	☐	☐	☐	**NA3.** All sections are complete.
NA4. ☑	☐	☐	☐	**NA4.** The assessment contains individual problems, strengths and disabilities.
NA5. ☑	☐	☐	☐	**NA5.** The assessment contains treatment recommendations.
			☐	**PSYCHIATRIC ASSESSMENT:**
PA1. ☑	☐	☐	☐	**PA1.** The assessment was completed within 48 hours of admission (or updated on the patient's anniversary date of admission).
PA2. ☑	☐	☐	☐	**PA2.** The form is signed, including title and date.
PA3. ☑	☐	☐	☐	**PA3.** The reason for admission is stated in pt's. own words.
PA4. ☑	☐	☐	☐	**PA4.** All sections are complete (N.B., A review of the physical health history and current health status must be included.)
PA5. ☑	☐	☐	☐	**PA5.** A current diagnosis, reflecting all five axes, is present.
PA6. ☑	☐	☐	☐	**PA6.** Specific tests used to determine cognitive functioning and the patient response to these tests is included.
PA7. ☑	☐	☐	☐	**PA7.** The assessment contains individualized problems, strengths and disabilities.
PA8. ☑	☐	☐	☐	**PA8.** The assessment contains treatment recommendations.
			☐	
			☐	**CORE EVALUATION:**
CE1. ☑	☐	☐	☐	**CE1.** The evaluation is completed within 10 days of admission and updated annually within ten days of the anniversary date of admission.
CE2. ☑	☐	☐	☐	**CE2.** Part I is completed by the primary therapist and is signed, with title and date. Which discipline completed Part I: _____
CE3. ☑	☐	☐	☐	**CE3.** Part I contains individualized problems, strengths and disabilities.
CE4. ☑	☐	☐	☐	**CE4.** Part I contains individualized treatment recommendations.
CE5. ☑	☐	☐	☐	**CE5.** Part II is completed within 10 days of admission and updated annually within ten days of the anniversary date of admission.
CE6. ☑	☐	☐	☐	**CE6.** Part II is completed by rehab staff and is signed, with title and date.
CE7. ☑	☐	☐	☐	**CE7.** All sections are complete.
CE8. ☑	☐	☐	☐	**CE8.** If additional evaluations are requested, these evaluations are complete and present in the chart within 10 days of request. checked [illegible] but not requested

Appendix A 7b
Record Review II page 2:

PATIENT NAME: [redacted]

PAGE 2

MEDICAL SECTION:

MS1. A current physical exam is complete and in the chart. For patients admitted within the past year, the medical exam is completed within 24 hours of admission.

MS2. The form is signed, with title and date.

MS3. Each bodily system was reviewed.

MS4. The physical addendum is present and complete. If neurological problems are noted, a complete neurological exam is ordered.

MS5. Abnormal findings are followed-up or justified by the attending physician.

MS6. The physical exam contains recommendations for treatment.

MS7. The patient's weight is recorded monthly.

MS8. The patient's blood pressure is recorded monthly.

MS9. The chart contains evidence that a urinalysis, CBC, FBS and BUN were done within the past year.

MS10. The patient has had a dental examination within the past year.

MS11. Orders for medical consultation have been carried out.

MS12. The most recent 223 MED is free of white-out, erasures and/or blanks.

MS13. The chart contains a progress note by the clinical physician within the past three months.

TREATMENT PLAN:

TP1. The treatment plan is present and was completed within the past year.

TP2. It is signed by the Psychiatrist.

TP3. There is evidence of patient, family involvement, or an explanation for non-participation.

TP4. The discharge date is current.

TP5. The discharge criteria are observable.

TP6. The residential setting for discharge is specific.

TP7. The psychiatrist, RN and SW are listed as participating team members.

TP8. The behavior box (Problems/Issues) contains a clear description of the patient's behavior.

TP9. The strengths/assets are specific to the behavior to be addressed.

TP10. The goal(s) is (are) directly related to the behavior box.

TP11. All recommendations from the assessments (including from the physical exam) are addressed or deferred.

TP12. Objectives are observable and specific (measurable).

TP13. Target dates are current.

TP14. Methods include clinical focus, duration, frequency, and responsible staff.

TP15. The psychiatrist, RN and SW each provides individual or group sessions.

TP16. A Team Conference Note is present.

TP17. The Team Conference Note includes a statement regarding patient programming.

TP18. The treatment plan includes all five DSM III-R axes.

TREATMENT PLAN REVIEWS (PTPR): (Review the most recent treatment plan review.)

PR1. The PTPR is current. However - need an accepting transfer PTPR

PR2. It addresses the patient's progress toward the treatment objectives.

PR3. If the patient is <u>not</u> progressing, it indicates why the treatment objectives are being continued <u>or</u> indicates how treatment will be changed.

PR4. The PTPR specifically includes a review of the patient's discharge plan.

PR5. The PTPR specifically addresses the patient's ability to participate in 20 hours of programming.

PR6. The PTPR is signed by the psychiatrist.

Appendix A 8a
Utilization Review of a record, page 1:

Form UR-6 (8M) (12-79) State of New York — Office of Mental Health

PSYCHIATRIC UTILIZATION REVIEW SCREENING REPORT

☐ Reverse ☐ Typewriter

Facility Name	Facility No.	Patient	Chart No.
[redacted] Center OPC	021	[redacted]	[redacted]

Ward No.	Admission Date	Date of Birth	Review Type	Date of Next Review
[redacted]	10-3-83	5-15-44	☐ ADM ☐ ICS ☒ SCS 3	10-26-89

Name of Attending Physician	Primary Psychiatric Diagnosis	Diag. Code
[redacted]	Schiz Undiff type Chr.	295.02

I **FIRST STEP**

Admission/Continued Stay Review: Answer all questions in this section. Refer all cases which do not meet criteria for admission/continued stay to Second Step.

	YES	NO	Documentation exists to substantiate:
1a.	☐	☐	a) A principle, admission or provisional diagnosis of mental disorder with psychotic features as specified by DSM III or ICD 9-CM, or
1b.	☐	☐	b) A principle, admission or provisional diagnosis without psychotic features as specified by DSM III or ICD 9-CM and substantiation of a functional deficit caused by the disorder, or
1c.	☐	☐	c) That client has been discharged from psychiatric inpatient care within the preceeding 30 days with a plan for aftercare services that included the provision of services in an OP program.

FOR CONTINUED STAY

2a.	☑	☐	a) Documentation of continued care in this program is provided in progress notes and treatment plan review, and
2b.	☑	☐	b) Patient is functioning at level which cannot be managed at an alternate program.

3. Screening Determination: ☑ 1st Step Satisfactory ☐ Refer to 2nd Step

Comments

Progress Notes for Oct missing

Signature of 1st Step Reviewer	Print Name Signed	Date of Review
[redacted]	[redacted]	11-20-89

Appendix A 8b
Utilization Review of a record, page 2:

II SECOND STEP

1. Check all criteria elements met during second step review: (corresponds to above criteria)

01a or 01b or 01c 02a and 02b

	YES	NO		
2a.	☑	☐	a)	Is client appropriate for admission or continued stay in this type of OP program? If no, complete UR-6 and answer the following:
2b.	☐	☐	b)	What type of service/program would provide the most appropriate level of care for this client?
2c.	☐	☐	c)	Is this type of service/program available?

Where? _____

3. Comments: _____

Signature of 1st Reviewing Physician	Signature of 2nd Reviewing Physician	Date of Revie
[redacted]	[redacted]	[redacted]

DoA 1-8-90

PERIODIC MEDICAL REVIEW

REVIEWER'S NAME [redacted] Reviewer's Code

PATIENT'S NAME [redacted] AGE

DISCIPLINE: 2 MD 3 Social Work 5 Rehab; 2 RN 4 Psychology 6 OT/RT 7 Other

DATE OF REVIEW: 01 20 93 (Mo Day Year)

"C" NUMBER [redacted] FACILITY NUMBER: 021 WARD NUMBER: 031

MEDICAID CERTIFICATION

	YES	NO	N.A.
Form 75 MED or equivalent or a statement that it is medically necessary for a patient to continue in treatment on an inpatient level is in the record	1	2	3✓
Form 75 MED or equivalent is signed every 60 days by a physician	1	2	3✓

PHYSICAL EXAMINATION

	YES	NO	N.A.
Form 34 MED or other equivalent physical examination form is present in the record	1✓	2	
The physical examination was conducted within the last 12 months	1✓	2	3
Documentation shows that each of the bodily systems was reviewed	1✓	2	3
Abnormal findings documented in the physical exam have been appropriately followed up or justified by the attending physician.	1✓	2	3
The physical examination contains recommendations based on the findings in the examination	1✓	2	3

PSYCHIATRIC ASSESSMENT

	YES	NO	N.A.
A psychiatric assessment is present in the record	1✓	2	3
The psychiatric assessment was completed or updated in the last 12 months	1✓	2	3
The psychiatric assessment or update includes a description of the patient's psychiatric problems, strengths and disabilities	1✓	2	3
The psychiatric assessment contains recommendations based on the findings in the assessment	1✓	2	3

SOCIAL ASSESSMENT

	YES	NO	N.A.
A social assessment is present in the record	1✓	2	3
The social assessment was completed or updated within the last 12 months	1✓	2	3
The social assessment or update contains a description of the patient's psycho-social problems, strengths and disabilities	1✓	2	3
The social assessment contains recommendations based on the findings in the assessment	1✓	2	3

LAB RESULTS

	YES	NO	N.A.
There is evidence that a complete blood count (CBC) has been done within the last 12 months	1	2✓	
There is evidence that a Urinalysis has been done within the last 12 months	1	2✓	
Abnormal findings on laboratory reports have been followed up or justified by the attending physician	1✓	2	3

TUBERCULOSIS TESTS 4/1/93

	YES	NO
There is evidence that a TB skin test or chest x-ray was done within the past 24 months	1✓	2

TREATMENT PLANNING 4/19/93

	YES	NO	N.A.
For patients admitted within the past year, an interim treatment plan was developed at the time of admission	1	2	3✓
The comprehensive treatment plan is present in the record	1✓	2	3
The comprehensive treatment plan is based on the findings and	1✓	2	3

K. PERIODIC TREATMENT PLAN REVIEW due 4/19

	YES	NO	N.A.
1. The Periodic Treatment Plan Review (Form 181 MED or equivalent) was completed within the last 90 days (30 days for persons under age 22) and is present in the record	1	2	3✓
2. The review takes into consideration the patient's progress toward treatment objectives	1	2	3✓
3. The review indicates whether or not changes should be made in the treatment goals, objectives or modalities	1	2	3✓
4. The review indicates how treatment should be changed, or justifies continuing present treatment	1	2	3✓
5. The review documents efforts made to address patient's expected needs on release or discharge	1	2	3✓

L. PROGRESS NOTES AND DISCIPLINE NOTES

	YES	NO	N.A.
The record contains EITHER the note specified in Item L1:			
1. An interdisciplinary team note indicating the participation of a physician, nurse, social worker and other significantly involved disciplines	1✓	2	3
OR the notes specified in each of the following 4 items (L2-L5):			
2. Physician's note	1✓	2	3
3. Nurse's note	1✓	2	3
4. Social Worker's note	1✓	2	3
5. Notes by other significantly involved disciplines	1✓	2	3
6. The progress notes in the record are related to the stated goals and objectives in the treatment plan and specifically reflect progress or a lack of progress toward these goals and objectives	1✓	2	
7. The progress notes indicate that treatment modalities (services) are being delivered as specified in the treatment plan	1✓	2	

M. MEDICATION ORDERS

	YES	NO	N.A.
1. The doctor's order sheet (Form 89 MED or equivalent) is present in the record	1✓	2	
2. Medication orders have a start date and a stop date	1✓	2	3
3. Medication orders are signed by a physician	1✓	2	3
4. The frequency, dose, or kind of medication specified on the Medication/Treatment Record (Form 223 MED or equivalent) is consistent with that entered on the doctor's order sheet.	1✓	2	3
5. The initial key on Form 223 MED (or equivalent) is completed	1✓	2	3
6. Medication orders have been signed by a physician within the last 30 days	1✓	2	3

N. DIETARY ORDERS

	YES	NO	N.A.
1. Have any special dietary needs been identified in the patient's record?	1✓	2	
If 'YES', then:			
2. Orders for a special diet or dietary supplement have been written	1✓	2	3
3. There is evidence that special dietary orders have been followed	1✓	2	3

O. CONSULTATIONS AND INTERVENTIONS

	YES	NO	N.A.
1. Has the need for any medical consultation or intervention been identified in the patient's record?	1✓	2	
If 'YES', then:			
2. Doctor's orders for appropriate medical intervention or consultation have been written	1✓	2	3
3. There is evidence that orders for medical consultation or intervention have been carried out and properly followed up	1	2✓	3

P. WEIGHT STATUS

	YES	NO	N.A.
1. The patient's weight is recorded on a monthly basis	1✓	2	
2. Unusual fluctuations in weight are addressed in the treatment plan	1	2	3✓

The psychiatric assessment or update includes a description of the patient's psychiatric problems strengths and disabilities — 1 ☑ 2 ☐ 3 ☐

The psychiatric assessment contains recommendations based on the findings in the assessment — 1 ☑ 2 ☐ 3 ☐

SOCIAL ASSESSMENT — YES / NO / NA

- A social assessment is present in the record — 1 ☑ 2 ☐ 3 ☐
- The social assessment was completed or updated within the last 12 months — 1 ☑ 2 ☐ 3 ☐
- The social assesment or update contains a description of the patient's psycho social problems strengths and disabilities — 1 ☑ 2 ☐ 3 ☐
- The social assessment contains recommendations based on the findings in the assessment — 1 ☑ 2 ☐ 3 ☐

LAB RESULTS — YES / NO / NA

- There is evidence that a complete blood count (CBC) has been done within the last 12 months — 1 ☐ 2 ☑
- There is evidence that a Urinalysis has been done within the last 12 months — 1 ☐ 2 ☑
- Abnormal findings on laboratory reports have been followed up or justified by the attending physician — 1 ☑ 2 ☐ 3 ☐

TUBERCULOSIS TESTS 4/1/93 — YES / NO

- There is evidence that a TB skin test or chest x-ray was done within the past 24 months — 1 ☑ 2 ☐

TREATMENT PLANNING 4/19/93 — YES / NO / NA

- For patients admitted within the past year an interim treatment plan was developed at the time of admission — 1 ☐ 2 ☐ 3 ☑
- The comprehensive treatment plan is present in the record — 1 ☑ 2 ☐ 3 ☐
- The comprehensive treatment plan is based on the findings and recommendations contained in the assessments or updates — 1 ☑ 2 ☐ 3 ☐

DISCHARGE PLANNING — YES / NO / NA

- A discharge plan (Form 150 MED or equivalent) is present in the record — 1 ☑ 2 ☐ 3 ☐
- The discharge plan states a projected release or discharge date — 1 ☐ 2 ☐ 3 ☐
- The discharge plan includes criteria for release or discharge — 1 ☐ 2 ☐ 3 ☐
- The discharge plan states the likely residential setting needed on release or discharge — 1 ☑ 2 ☐ 3 ☐
- The discharge plan states the support services needed upon release or discharge — 1 ☑ 2 ☐ 3 ☐

GOALS AND OBJECTIVES — YES / NO / NA

- The patient's strengths are stated in a manner that allows for their use in formulating treatment goals objectives and modalities — 1 ☑ 2 ☐ 3 ☐
- Objectives are stated in behavioral terms and are measurable — 1 ☑ 2 ☐ 3 ☐

TREATMENT MODALITIES AND RESPONSIBILITY — YES / NO

- At least one treatment modality is identified for each treatment objective — 1 ☑ 2 ☐
- The frequency and duration of each treatment modality is clearly specified — 1 ☑ 2 ☐
- The name and title of the staff member responsible for delivering each treatment modality are stated — 1 ☑ 2 ☐

Ho Name | Ward No | "C" No

M. MEDICATION ORDERS — YES / NO / NA

1. The doctor's order sheet (Form 89 MED or equivalent) is present in the record — 1 ☑ 2 ☐ 3 ☐
2. Medication orders have a start date and a stop date — 1 ☑ 2 ☐ 3 ☐
3. Medication orders are signed by a physician — 1 ☑ 2 ☐ 3 ☐
4. The frequency, dose, or kind of medication specified on the **Medication/Treatment Record** (Form 223 MED or equivalent) is consistent with that entered on the doctor's order sheet — 1 ☑ 2 ☐ 3 ☐
5. The initial key on Form 223 MED (or equivalent) is completed — 1 ☑ 2 ☐ 3 ☐
6. Medication orders have been signed by a physician within the last 30 days — 1 ☑ 2 ☐ 3 ☐

N. DIETARY ORDERS — YES / NO / NA

1. Have any special dietary needs been identified in the patient's record? — 1 ☑ 2 ☐
   If 'YES', then:
2. Orders for a special diet or dietary supplement have been written — 1 ☑ 2 ☐ 3 ☐
3. There is evidence that special dietary orders have been followed — 1 ☑ 2 ☐ 3 ☐

O. CONSULTATIONS AND INTERVENTIONS — YES / NO / NA

1. Has the need for any medical consultation or intervention been identified in the patient's record? — 1 ☑ 2 ☐
   If 'YES', then:
2. Doctor's orders for appropriate medical intervention or consultation have been written — 1 ☑ 2 ☐ 3 ☐
3. There is evidence that orders for medical consultation or intervention have been carried out and properly followed up — 1 ☐ 2 ☑ 3 ☐

P. WEIGHT STATUS — YES / NO / NA

1. The patient's weight is recorded on a monthly basis — 1 ☑ 2 ☐
2. Unusual fluctuations in weight are addressed in the treatment plan — 1 ☐ 2 ☐ 3 ☑

Q. UTILIZATION OF SERVICES — YES / NO / NA

1. Documented patient complaints regarding treatments or services have been acted on and followed up in a timely manner — 1 ☑ 2 ☐ 3 ☐
2. Treatment modalities and services recommended for the patient to attain treatment objectives and goals are being provided or the reason they are not being provided is documented — 1 ☑ 2 ☐
3. Special arrangements for services to be provided outside the facility are justified in the record — 1 ☑ 2 ☐ 3 ☐
4. Does the patient have any documented physical disabilities? — 1 ☐ 2 ☑
   If 'YES', then:
5. Physical disabilities are addressed with a program of services or the reason they are not addressed is documented — 1 ☐ 2 ☐ 3 ☑

R. PATIENT OBSERVATION — YES / NO / NA

Observe all patients under 22 years. Also observe patients over 64 years old whose physical, psychiatric, or social assessments have not been completed. For those observed patients check YES or NO. For all other unobserved patients check NA.

1. The environment is such that the patient is not likely to suffer harm through accident or neglect (e.g., fire safety precautions; windows properly secured, etc.) — 1 ☐ 2 ☐ 3 ☑
2. The environment is such that the patient is not likely to cause harm to himself or others (e.g., protective devices applied, adequate staff supervision, etc.) — 1 ☐ 2 ☐ 3 ☑
3. The patient's general appearance for cleanliness—skin hair fingernails clothes etc — is satisfactory — 1 ☐ 2 ☐ 3 ☑

S. ALTERNATIVE CARE DETERMINATION — YES / NO

1. The present level of care is appropriate — 1 ☐ 2 ☐
2. A facility alternative care determination has been made — 1 ☐ 2 ☐

wer's Comments:

Pt. refuse CBC w/ndiffs
EKG Dental

3. PTPR due 4/19/93
4- 0-3 pt results of Consultations

E-3

- Objective Methods missing dates

5. Pt refuses all Consultations.
EKG Dental Gyn Routine annually Blood Work

6. Need urinalysis

E TO FACILITY STAFF: If any of the shaded items above are checked 'NO', immediate ective action is required. A report on action taken must be sent to the facility Director for lity Assurance

Appendix A 10a
Summary of Periodic Medical Review report for 1994, page 1:

MEMORANDUM

July 8, 1994

TO: All Clinical Staff
All Quality Assurance Staff

FROM: [redacted]

RE: **PMR Report**

We have received the official PMR report. Five standards were noted to be out of compliance and require a plan of correction. Two of the five items (M4 & K5) are relatively easy to correct and simply require our attention to paperwork practices. A comprehensive training program has been developed to deal with the other three items. The survey details are as follows:

The Item M4, **the frequency, dose or kind of medicine entered on the Medication/ Treatment Record is consistent with that entered on the Doctor's Order Sheet** was deficient because there were write-overs or crossouts in an inappropriate format. Specifically, dates and dosages were often written over on the Doctor's Order Sheet. To correct an error, the procedure is as follows: draw a single line through the entry and initial and date the correction. The only modification with this practice is with dates. Dates are corrected with a single line and an initial only. You do not need to date a date change. It makes it too confusing.

A second deficiency was item K5, **the review addresses patient's expected needs on release or discharge.** As has been the practice at [redacted] the treatment plan review indicates that the discharge plan was reviewed and remains the same (if that is the case). This in prior years had been acceptable to the reviewers. This year the PMR auditors wanted the review to be more specific and refer directly to the discharge placement. From now on, PTPR must include a

reference to the discharge plan with the exact anticipated residence upon discharge i.e., the discharge plan has been reviewed and remains the same. Patient will be discharged to [redacted] with follow-up care provided [redacted]

Appendix A 10b
Summary of Periodic Medical Review report for 1994, page 2:

-2-

The remaining three deficiencies concerned me most. They were: **objectives are stated in behavioral terms and are measurable, the [PTPR] review indicates how treatment should be changed, or justifies continuing the present treatment and the discharge plan includes criteria for release or discharge.**

A comprehensive training program is being implemented to deal with the above deficiencies. Using a team training approach, each team will undergo extensive retraining during regularly scheduled treatment plan meetings on the ward. Active charts will be utilized and CTPs and PTPR completed on schedule. Training modules will be given in no less than three sessions to assure thorough a knowledge of the treatment planning process. Sessions will be led by [redacted] PhD and all wards will be scheduled by the end of the summer.

I want to thank you for your continued attention to documentation requirements. I am confident that ongoing efforts and a more focused preparation will again result in the exceptional survey reports that reflect the high quality of care we provide.

[redacted]

cc: Cabinet

Appendix A 11a
Summary of Periodic Medical Review Report for 1995, page 1:

MEMORANDUM

June 20, 1995

TO: Unit Chiefs
Department Heads
Team Leaders
Medical Records Review Committee

FROM: [redacted]

RE: PMR Survey Results

I wanted to share the Periodic Medical Review Survey results and thank you for your ongoing efforts in maintaining the medical records at [redacted]

During the survey, we received some citations not previously noted. However, the area we focused on viz., Periodic Treatment Plan Reviews vastly improved and almost reached the 80% requisite compliance rate (K4 = 64% and K5 = 75%).

Members of the Medical Records Review Committee deserve special merit for their continued assistance despite responsibilities elsewhere in the hospital. I'd also like to extend my gratitude to [redacted] who adeptly monitored the process during the four-day survey.

[redacted]

cc: Cabinet

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

Appendix A 11b
Summary of Periodic Medical Review Report for 1995, page 2:

PMR Comparisons

1995 v. 1994

ITEMS UNDER 95% COMPLIANCE - 1995

		DEFICIENCIES	
		1995	1994
C3:	Psych Assessment - Problems, Strengths, Disabilities	71	37
C4:	Psych Assessment - Recommendations	91	33
D4:	SW - Recommendations	180*	53
H3:	TP - Discharge Criteria	229*	263
H5:	TP - Suppport Services Needed at D/C	32	90
I2:	TP - Measurable Objectives	112	155
K3:	PTPR - Changes in Tx. Goals/Objectives	40	66
K4:	PTPR - Justification for Chg/Continuation	167*	366
K5:	PTPR - Expected needs on Discharge	117*	270
M4:	Med Orders - 223 Meds including error correction on Dr's Order Sheet	124*	110

PRESENCE/ABSENCE ITEMS

E1:	CBC	14	11
E2:	Urinalysis	24	18
F1:	PPD	12	11

* Items requiring Plan of Correction.

Appendix B 1991 File Order, page 1

Disch. Date:_____

INPATIENT MEDICAL RECORD

FILING ORDER

Facility Name

The following is the filing order to be used for both the active and inactive inpatient record.

			FORM NUMBER	REQUIRED
I.	1	A. Notification of Escape Record	OMH 321	A/I
	2	B. Face Sheet (Blue)	PC	ALL
	3	C. Filing Order	PC 6a	ALL
II.		TO BE FILED IN FRONT OF ADMISSION/SCREENING REPORT (within 15 days of disch.)		
	4**	A. Release/Termination Summary	PC 412	ALL
	5	B. Individual Service Plan	OMH 6	ALL
	6	C. Disposition Report	AHR 116	ALL
	7	D. Discharge Instruction Form	PC 612	ALL
III.		ADMISSION & EVALUATION DATA*: (Completed within 24 hours of admission)		
	8	A. Admission/Screening Report	AHR 725	ALL
	9	B. Psychiatric Diagnostic Record	15 MED	A/I
	10	C. Screening/Admission Note	139 MED	ALL
	11	D. Interim Treatment Plan	140 MED	ALL
IV.		LEGAL & ADMINISTRATIVE DATA*: (Completed within 24 hours of admission)		
	12	A. Voluntary or Minor Voluntary Admission	OMH 472	A/I
	13	B. Involuntary Admission	OMH 471	A/I
	14	Certificate of Examining Physician (Mental Illness)	OMH 471A	A/I
	15	Certificate of Exam. by Dir. of Comm. Svc./Designee	OMH 471B	A/I
	16	Examination of 72 hrs. Conversion to 2PC	OMH 471C	A/I
	17	C. Record of Emergency Admission	OMH 474	A/I
	18	D. Notice of Status & Rights	OMH 46C	ALL
	—	E. Criminal Procedure Law Retention Papers		A/I
	19	F. Application for Court Auth. to Retain a Patient	OMH 470	A/I
	20	Notice of Application for Auth. to Retain a Pt.	OMH 470A	A/I
	21	Certif. for Exam. Physician (for Court Auth. Procedure)	OMH 471A	A/I
	22	G. Application for Change of Status/Privilege	OMH 495	
	23	Notice of Meeting re-Applic. for Change in Status/Priv.	OMH 496	
	24	Notice of Change of Status/Privilege	OMH 497	
	25	H. Order of Transfer	119 DMH	A/I
	26	I. Record System Notification	324 ADM	ALL
	27	J. Notice of Rights to Medicare or Champus/Champ VA Pts.	401 ADM	ALL
V.		PAST RECORDS:		
	—	Abstracts or Summaries from Other Hospitalizations		A/I
VI.		ASSESSMENTS*		
	28	A. Nursing Assessment (Completed within 8 hrs. of Adm.)	154 MED	A/I
	29	B. Abnormal Involuntary Movement Scale (AIMS)	99 MED	ALL
	30	C. Psychiatric Assessment (Completed within 8 hrs. of Adm.)	PC 512	ALL
	31	D. Psychiatric Assessment Supplement Specific to AIDS	42 MED	A/I
	32	E. Social Assessment	145 MED	ALL
	33**	F. Psychological Assessment/Psychological Testing	143 MED	A/I
	34	G. Psychological Referral	PC	A/I
	35	H. Activities Assessment	147xMED	ALL
	36	I. Rehabilitation Services Referral	PC	A/I
	37	J. Nutritional Assessment	148xMED	A/I
	38	K. Vocational Assessment	146xMED	A/I
	39	L. Educational/Assessment (required for pts. under 22)	PC	A/I
	40	M. Assessment/Assessment Cont. Sheet (addenda & other Assess)	149 MED	A/I

ALL - Required for ALL Patients
A/I - As Indicated
* - These records cannot be thinned from the chart
** - These records need to be typed

Appendix B 1991 File Order, page 2

VII.	**COMPREHENSIVE TREATMENT PLAN & REVIEWS***		
	A. Comprehensive Treatment Plan (Completed within 11 days of admission)		
41	Part I Discharge Plan	150 MED	ALL
42	Part II Goal Plan	150A MED	ALL
43	Part III Treatment Plan Conference Note	150B MED	ALL
B.44	Periodic Treatment Plan Reviews	151 MED	ALL
	REVIEW SCHEDULE: 72 hours of admission 40 days after admission Every 60 days for first year Every 90 days after first year For patients under 22 years of age, every 30 days		
45	C. Patient Care Monitoring	BPC-PCMR	A/I
VIII.	**MEDICAL & LABORATORY REPORTS:**		
46	A. Medical Summary Sheet	BPC 5	ALL
47	B. Physical Exam & Assessment (within 24 hrs. of adm.)	34 MED	ALL
48	C. Physical Addendum	BPC 11	ALL
49	D. Gynecological Chart	36A MED	ALL
50	E. Immunization Record (Completed within 24 hrs. of adm.)	9 MED	ALL
51	F. Weight Chart	BPC 53	ALL
52	G. Blood Pressure Chart	NSG 2	ALL
53	H. Clinical Chart	26 MED	A/I
54	I. Diabetic Control Record	BPC-126	A/I
55	J. Seizure Chart	216 MED	A/I
—	K. Intake & Output Record	BPC	A/I
56	L. Laboratory Reports	82 MED	A/I
—	M. EKG Reports		ALL
57	N. X-Rays Request Reports	82.13 MED	A/I
58	O. Consultation Reports	36 MED	A/I
—	P. Other Medical Reports		A/I
59	Q. Dental Chart	122 MED	ALL
60	R. Medical Progress Notes	152 MED	ALL
XI.	**TREATMENT & MEDICATION RECORDS:**		
61	A. Doctor's Order Sheet	89 MED	ALL
62	B. Restraint or Seclusion Order Sheet	BPC 1	A/I
63	C. Medication/Treatment Record	223 MED	ALL
64	D. Restraint or Seclusion Monitoring Record	BPC 7	A/I
X.	**PROGRESS NOTES**		
65	A. Progress notes - weekly 1st 2 months, monthly thereafter Nursing to also include a note, each shift, 1st 3 days	152 MED	ALL
XI.	**MISCELLANEOUS**		
66	A. Inpat. Hosp. & Extended Care Adm. Billing & Rel. of Inf.	BPR 1453	A/I
67	B. Consent for Release of Information	OMH 11	ALL
68	C. Consent for Release of Information to CSS Bus. Office	OMH 144	A/I
—	D. Correspondence		A/I
69	E. Record of visits	3 ADM	A/I
—	F. Correspondence Sheet	4 ADM	A/I
70	G. BPC Consent Form	BPC	A/I
71	H. Record of Patient's Property Forwarded to Bus. Office	67 BUS	A/I
72	I. Patient's Personal Clothing Record	72 ADM	ALL
73	J. Inventory of Client's Prop. Maintained on Living Unit	72A ADM	ALL
74	K. Agreement for Leave	55 MED	A/I
75	L. Independent Treatment Team Medicaid Certification	528 MED	A/I
76	M. Treatment Team Medicaid Certification	529 MED	A/I
77	N. Medicate Certification and Recertification	70 MED	A/I
78	O. Medicaid Certification	75 MED	A/I
79	P. Utilization Review Documentation	UR-3	ALL
80	Q. Notification of Referral for Service	OMH 5	A/I
81	R. Certification of Need of Treatment (Pts. under 22)	527 DMH	A/I
82	S. Adverse Drug Reaction Report	72 MED	A/I
83	T. Permission for Autopsy	20 MED	A/I
84	U. Autopsy Report	103 MED	A/I

Appendix B 1a: (OMH 321)

Form OMH 321 Mar 4-84

STATE OF NEW YORK
OFFICE OF MENTAL HEALTH

NOTIFICATION OF ESCAPE RECORD

This form must be completed for all patients admitted pursuant to Article 730 or Section 330.20 of Criminal Procedure Law (CPL), and may be utilized for other OMH patients

INSTRUCTIONS:

1. Enter the information in Part II and in Part IV as soon as possible after admission, updating as necessary
2. Upon each update or review of the form
   (a) Enter the date of review and signature of the reviewing staff member in Part I
3. Upon escape of the patient
   (a) Update and complete Part IV
   (b) Notify the appropriate persons and agencies in the order indicated in Part III
   (c) Enter the following in Part III
      1. Name of the person contacted and directly notified of the patient's escape
      2. Means, date, and time of notification
      3. Initials of person making the notifications
      4. Name, signature, and initials of the person making the notifications
4. Upon return of the patient to the facility
   (a) Notify the persons and agencies previously notified of the patient's escape
   (b) Enter name, signature, and initials of person making the notifications if not previously entered

Part I - Upon each review of this form to ensure complete and up-to-date information, the reviewer should enter the date and his/her signature below.

Review		Review	
Date	Signature	Date	Signature

Significant Status Change/Privilege

Effective Date	Status, Privilege Granted

Significant Status Change/Privilege

Effective Date	Status, Privilege Granted

Appendix B 1b: (OMH 321)

Form OMH 32[illegible]-83)

STATE OF NEW YORK
OFFICE OF MENTAL HEALTH

NOTIFICATION OF ESCAPE RECORD

Patient's Name (Last, First, Middle)

Part II - The following information should be obtained as soon as possible after admission and updated as necessary.

LAW ENFORCEMENT AGENCIES	Telephone No.	Address
Superintendent of State Police	Day: 518-457-0557 Night: 518-457-6811	State Office Bldg. Campus Public Security Bldg. Albany, N.Y. 12226
Local Sheriff (Where facility is located)		
Local Police (Where facility is located)		
Other Law Enforcement Agencies *(if indicated)* District Attorney - Bronx County	Day: 590-2120 (Mon-Fri)	Assistant D.A. Seth Marvin Appeals Bureau - 3rd Floor 215 E. 161st Street Bronx, NY 10451

RELATIVES, POTENTIAL VICTIMS, OTHERS	Relationship	Potential Victim	Telephone No.	Address
Immediate Family/Nearest Relative *(living)* 1.				
2.				
3.				
4.				
Other Persons who may be in danger 1.				
2.				
3.				
Others				

COURT/ATTORNEY	Telephone No.	Address
District Attorney of County of Commitment	Day: Night:	
Patient's Attorney		
Court Designee (If Applicable)		
Court of Commitment/Judge (330.20 only)		
MHIS (330.20 only)		

OMH/FACILITY STAFF		Telephone No.
Bureau of Forensic Services	44 Holland Avenue Albany, New York 12229	(518) 474-7275
Chief Executive Officer		Ext. 2261, 2262
Administrator on Call		Switchboard
Clinical Director & Director for Inpatient Operations		Ext. 2264 & 2819
Unit Chief or Treatment Team Leader		Switchboard
[redacted] Medical Administrator		Ext. 2267, 2268
Facility Safety Department		Ext. 2222, 2573

Appendix B 1c: (OMH 321)

NOTIFICATION OF ESCAPE RECORD

Patient's Name (Last, First, Middle)

PART III - The following information should be recorded as each person is notified of the patient's escape and return.

	PEOPLE/AGENCIES NOTIFIED (indicate name of person contacted)	Notification of ESCAPE — Means:	(✓)	Notified on: Date	Time	By: Initials	RETURN — Notified on: Date	By: Initials
LAW ENFORCEMENT	Facility Safety Department	Telephone						
	Superintendent of State Police	Telephone						
	Local Sheriff (Where facility is located)	Telephone						
	Local Police (Where facility is located)	Telephone						
	Other Law Enforcement Agencies District Attorney - Bronx County	Telephone 590-2120 (M-F,Day)						
POTENTIAL VICTIMS	PERSONS WHO MAY BE IN DANGER 1	Telephone Telegraph Police						
	2	Telephone Telegraph Police						
	3	Telephone Telegraph Police						
	4	Telephone Telegraph Police						
OMH/FACILITY	Unit Chief or Treatment Team Leader	Telephone						
	[redacted] Medical Administrator	Telephone						
	Clinical Director & Dir. for Inpt. Operations	Telephone						
	Administrator on Call	Telephone						
	Chief Executive Officer	Telephone						
	Bureau of Forensic Services (518) 474-7275	Telephone Telegraph						
COURT/ATTORNEY	District Attorney of County of Commitment	Telephone Telegraph						
	Patient's Attorney	Telephone Telegraph						
	Court Designee (If Applicable)	Telephone Telegraph Police						
	Court of Commitment Judge (330.20 only)	Telephone Telegraph						
	MHIS (330.20 only)	Telephone Telegraph						
RELATIVES	Immediate Family/Relative (not listed above) 1	Telephone Telegraph Police						
	2	Telephone Telegraph Police						
	3	Telephone Telegraph Police						

Name of Person(s) making notifications: Name—Printed or Typed	Signature	Initials

Appendix B 1d: (OMH 321)

NOTIFICATION OF ESCAPE RECORD

Patient's Name (Last, First, Middle)

Part IV - The following information is to be provided to those being notified of the patient's escape.

A. ALL PERSONS/AGENCIES

1. **Your identity:** **Name and title**
   A member of the _____ **Psychiatric Center's staff.**
2. The following statement: **THIS IS AN ESCAPE NOTIFICATION AS REQUIRED BY THE NEW YORK STATE CRIMINAL PROCEDURE LAW.**
3. The patient's full name and legal status (CPL Section) _____
4. A description of the patient at the *time of escape*.

Description of the Patient:

Age _____ Sex _____ Ethnic Group _____ Height _____

	CHANGES IN PHYSICAL APPEARANCE				
	AT ADMISSION Date	Date	Date	Date	Date	**AT ESCAPE** Date
Weight						
Hair—color						
—length						
Eyes—color						
glasses						
contact lens						
Complexion						
Facial Hair						

Existence of noticeable/identifying:

Scars _____

Features _____

Description of Clothing Patient was last seen wearing:

Shirt/Blouse _____

Pants _____

Skirt _____

Dress _____

Shoes _____

Jacket/Coat _____

Hat/Scarf _____

Other _____

5. Last known whereabouts of the patient: Time _____ AM PM Place _____
6. Destination if known or suspected _____

B. LAW ENFORCEMENT AGENCIES/FACILITY STAFF *ONLY*

1. Other information police/facility staff should know during apprehension of the patient (escapee).
   a. Charge(s):
   b. Danger Profile

Appendix B 2: (TPC)

Face Sheet

A. Patient's Name:_____AKA(if any)_____
Case #:_____Date of Admission:_____Ward_____
Address:_____Catchment Code:_____
(List address changes below and cross out old address)
_____
Telephone#_____Telephone Belongs to_____
Date of Birth:_____ Sex____Social Security #:_____
Place of Birth_____Marital Status____Maiden Name_____
Medicare #:_____Medicaid #:_____
Other Insurance (specify:_____
Legal Status:_____Expiration Date:_____
If CPL Status, List charges_____
CSS Eligible: YES ( ) NO ( )
Emergency Contact:
Name:_____Relationship to Patient_____
Address:_____
Telephone #:_____(List Address Change below and cross out old address)
1. _____
2._____

****

B. Release/Termination - (To be completed at time of termination)
Discharge Date: _____Discharge Ward_____
Type of Discharge:
/ / Termination, No Further Services
/ / Transfer to Clinic/Program, (specify):_____
/ / Permanent transfer to (other institution):_____
/ / Placed in Family Care
/ / Placed on Convalescent Care
/ / Discharge from LWOC
/ / Death
/ / Discharged/referred to other agency/professional, (specify, including address and telephone #):_____
_____
CSS Eligible: YES ( ) NO ( )

Appendix B 3a: (TPC 6a)

Disch. Date:_____ INPATIENT MEDICAL RECORD FILING ORDER

Facility Name

The following is the filing order to be used for both the active and inactive inpatient record.

		FORM NUMBER	REQUIRED
I.	A. Notification of Escape Record	OMH 321	A/I
	B. Face Sheet (Blue)	TPC	ALL
	C. Filing Order	TPC 6a	ALL
II.	TO BE FILED IN FRONT OF ADMISSION/SCREENING REPORT (within 15 days of disch.)		
	**A. Release/Termination Summary	TPC 412	ALL
	B. Individual Service Plan	OMH 6	ALL
	C. Disposition Report	AHR 116	ALL
	D. Discharge Instruction Form	TPC 612	ALL
III.	ADMISSION & EVALUATION DATA*: (Completed within 24 hours of admission)		
	A. Admission/Screening Report	AHR 725	ALL
	B. Psychiatric Diagnostic Record	15 MED	A/I
	C. Screening/Admission Note	139 MED	ALL
	D. Interim Treatment Plan	140 MED	ALL
IV.	LEGAL & ADMINISTRATIVE DATA*: (Completed within 24 hours of admission)		
	A. Voluntary or Minor Voluntary Admission	OMH 472	A/I
	B. Involuntary Admission	OMH 471	A/I
	Certificate of Examining Physician (Mental Illness)	OMH 471A	A/I
	Certificate of Exam. by Dir. of Comm. Svc./Designee	OMH 471B	A/I
	Examination of 72 hrs. Conversion to 2PC	OMH 471C	A/I
	C. Record of Emergency Admission	OMH 474	A/I
	D. Notice of Status & Rights	OMH 460	ALL
	E. Criminal Procedure Law Retention Papers		A/I
	F. Application for Court Auth. to Retain a Patient	OMH 470	A/I
	Notice of Application for Auth. to Retain a Pt.	OMH 470A	A/I
	Certif. for Exam. Physician (for Court Auth. Procedure)	OMH 471A	A/I
	G. Application for Change of Status/Privilege	OMH 495	
	Notice of Meeting re-Applic. for Change in Status/Priv.	OMH 496	
	Notice of Change of Status/Privilege	OMH 497	
	H. Order of Transfer	119 DMH	A/I
	I. Record System Notification	324 ADM	ALL
	J. Notice of Rights to Medicare or Champus/Champ VA Pts.	401 ADM	ALL
V.	PAST RECORDS:		
	Abstracts or Summaries from Other Hospitalizations		A/I
VI.	ASSESSMENTS*		
	A. Nursing Assessment (Completed within 8 hrs. of Adm.)	154 MED	A/I
	B. Abnormal Involuntary Movement Scale (AIMS)	99 MED	ALL
	C. Psychiatric Assessment (Completed within 8 hrs. of Adm.)	TPC 512	ALL
	D. Psychiatric Assessment Supplement Specific to AIDS	42 MED	A/I
	E. Social Assessment	145 MED	ALL
	**F. Psychological Assessment/Psychological Testing	143 MED	A/I
	G. Psychological Referral	TPC	A/I
	H. Activities Assessment	147xMED	ALL
	I. Rehabilitation Services Referral	TPC	A/I
	J. Nutritional Assessment	148xMED	A/I
	K. Vocational Assessment	146xMED	A/I
	L. Educational/Assessment (required for pts. under 22)	TPC	A/I
	M. Assessment/Assessment Cont. Sheet (addenda & other Assess)	149 MED	A/I

ALL - Required for ALL Patients
A/I - As Indicated
* - These records cannot be thinned from the chart
** - These records need to be typed

Appendix B 3b: (TPC 6a)

VII.	**COMPREHENSIVE TREATMENT PLAN & REVIEWS***		
	A. Comprehensive Treatment Plan (Completed within 11 days of admission)		
	Part I Discharge Plan	150 MED	ALL
	Part II Goal Plan	150A MED	ALL
	Part III Treatment Plan Conference Note	150B MED	ALL
	B. Periodic Treatment Plan Reviews	151 MED	ALL
	REVIEW SCHEDULE: 72 hours of admission 40 days after admission Every 60 days for first year Every 90 days after first year For patients under 22 years of age, every 30 days		
	C. Patient Care Monitoring	TPC-PCMR	A/I
VIII.	**MEDICAL & LABORATORY REPORTS:**		
	A. Medical Summary Sheet	TPC 50	ALL
	B. Physical Exam & Assessment (within 24 hrs. of adm.)	34 MED	ALL
	C. Physical Addendum	TPC 11	ALL
	D. Gynecological Chart	36A MED	ALL
	E. Immunization Record (Completed within 24 hrs. of adm.)	9 MED	ALL
	F. Weight Chart	TPC 53	ALL
	G. Blood Pressure Chart	NSG 2	ALL
	H. Clinical Chart	26 MED	A/I
	I. Diabetic Control Record	TPC-126	A/I
	J. Seizure Chart	216 MED	A/I
	K. Intake & Output Record	TPC	A/I
	L. Laboratory Reports	82 MED	A/I
	M. EKG Reports		ALL
	N. X-Rays Request Reports	82.13 MED	A/I
	O. Consultation Reports	36 MED	A/I
	P. Other Medical Reports		A/I
	Q. Dental Chart	122 MED	ALL
	R. Medical Progress Notes	152 MED	ALL
XI.	**TREATMENT & MEDICATION RECORDS:**		
	A. Doctor's Order Sheet	89 MED	ALL
	B. Restraint or Seclusion Order Sheet	TPC 1	A/I
	C. Medication/Treatment Record	223 MED	ALL
	D. Restraint or Seclusion Monitoring Record	TPC 7	A/I
X.	**PROGRESS NOTES**		
	A. Progress notes - weekly 1st 2 months, monthly thereafter Nursing to also include a note, each shift, 1st 3 days	152 MED	ALL
XI.	**MISCELLANEOUS**		
	A. Inpat. Hosp. & Extended Care Adm. Billing & Rel. of Inf.	BPR 1453	A/I
	B. Consent for Release of Information	OMH 11	ALL
	C. Consent for Release of Information to CSS Bus. Office	OMH 144	A/I
	D. Correspondence		A/I
	E. Record of visits	3 ADM	A/I
	F. Correspondence Sheet	4 ADM	A/I
	G. BPC Consent Form	BPC	A/I
	H. Record of Patient's Property Forwarded to Bus. Office	67 BUS	A/I
	I. Patient's Personal Clothing Record	72 ADM	ALL
	J. Inventory of Client's Prop. Maintained on Living Unit	72A ADM	ALL
	K. Agreement for Leave	55 MED	A/I
	L. Independent Treatment Team Medicaid Certification	528 MED	A/I
	M. Treatment Team Medicaid Certification	529 MED	A/I
	N. Medicate Certification and Recertification	70 MED	A/I
	O. Medicaid Certification	75 MED	A/I
	P. Utilization Review Documentation	UR-3	ALL
	Q. Notification of Referral for Service	OMH 5	A/I
	R. Certification of Need of Treatment (Pts. under 22)	527 DMH	A/I
	S. Adverse Drug Reaction Report	72 MED	A/I
	T. Permission for Autopsy	20 MED	A/I
	U. Autopsy Report	103 MED	A/I

Appendix B 4a: (TPC 412)

Form TPC 412 (Rev 5/91) — Office of Mental Health

RELEASE/TERMINATION SUMMARY

Admission Date	Event	Date of Event

SECTION A

I. Identifying Information: *(Age, Sex, Ethnicity, Marital Status, Religion, Legal Status)*

II. Presenting Complaints Upon Admission: *(Including Medical Complaints)*

Appendix B 4b: (TPC 412)

RELEASE/TERMINATION SUMMARY	Patient's Name (Last, First, M.I.)

SECTION A (Continued)

III. Mental Status Upon Admission: *(Include Level of Psycho-social Functioning)*

IV. Admission Diagnoses:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

PAGE 2

Appendix B 4c: (TPC 412)

Form TPC 412, Rev. 6/97 — Office of Mental Health

RELEASE/TERMINATION SUMMARY	Patient's Name (Last, First, M.I.)

SECTION A (Continued)

V. Past Psychiatric and Medical History:

Appendix B 4d: (TPC 412)

Form TPC 412 Rev 5/91 — Office of Mental Health

RELEASE/TERMINATION SUMMARY	Patient's Name (Last, First, M.I.)

SECTION B

I. Treatment Plan:

For each significant problem indicate Treatment Therapy provided and patient's response to Treatment *(Include Medical Problems)*

PAGE 4

Appendix B 4e: (TPC 412)

Form TPC 412 Rev 5/9[illegible] Office of Mental Health

RELEASE/TERMINATION SUMMARY	Patient's Name (Last, First, M.I.)

SECTION B (Continued)

II. Patient's Course During Hospitalization/Outpatient Treatment:

III. Special Problems of Hospitalization/Outpatient Treatment: *(i.e., Medical, Violence, etc.)*

Appendix B 4f: (TPC 412)

RELEASE/TERMINATION SUMMARY	Patient's Name (Last, First, M.I.)

SECTION C

I. Condition and Mental Status Upon Discharge:

II. Describe Participation of Patient, Family, Significant Others In Aftercare Plan:

Appendix B 4g: (TPC 412)

RELEASE/TERMINATION SUMMARY	Patient's Name (Last, First, M.I.)

SECTION C (Continued)

III. Patient's Address on Discharge:

_____

_____

_____

IV. Aftercare Plan:

Names and Addresses of Aftercare Provider(s) (Medical and Psychiatric):

NAME	ADDRESS	MEDICAL/ PSYCHIATRIC

Date of First Appointment: _____

Discharge Plans: Medications with Dose and Frequency/Diet/Activity Limits

Final Diagnoses:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

SIGNATURE:	TITLE:	DATE:
APPROVED/UNIT CHIEF		PAGE 7

Appendix B 5a: (OMH 6)

Form OMH 6 (6-82)
(Part One)

State of New York
Office of Mental Health

INDIVIDUAL SERVICE PLAN	Patient's Name (Last, First, M.I.) "C" No. Unit/Ward No. Facility Name

Referred by:

OMH Facility _____

OMH Liaison _____

Telephone No.: _____

Date the Plan was Completed: _____

Social Security No.: _____

Primary Patient Contact (Person the Patient or Service Agency should contact when there are problems):

Name: _____

Address: _____

Telephone No.: _____

Dates the arrangements have been completed for the following services:

_____ Living Arrangements	_____ Economic	_____ Family-Other Supp.
_____ Physical Health	_____ Vocational Training	_____ Self Care
_____ Mental Health Mental Retardation Alcoholism	_____ Education	_____ Transportation
	_____ Social	

I. STATEMENTS OF PARTICIPATION IN PLANNING PROCESS

A. Statement by Patient or other person on behalf of the Patient:

I have participated in the development of this plan. I am aware of the plan and it meets with my approval.

Patient/Participant Signature: _____ Date: _____

B. Statement by Staff:

We, the undersigned, have participated in the development of this written individual Service Plan and approve same.

Signature	For	Name and Address of Agency	Telephone	Date
_____	OMH	_____	_____	_____
_____	DSS	_____	_____	_____
_____	County Services Board	_____	_____	_____
_____		_____	_____	_____
_____	Other Agencies	_____	_____	_____
_____		_____	_____	_____

Comments:

Appendix B 5b: (OMH 6)

INDIVIDUAL SERVICE PLAN	Patient's Name (Last, First, M.I.)

II. PATIENT'S CURRENT NEEDS AND GOALS

A. LIVING ARRANGEMENTS

Please specify needs and goals: _____

CHECK ONLY ONE

WILL RESIDE ALONE

Own Home | S.R.O. in Hotel or Motel | Boarding House | Other, describe: _____

WILL RESIDE WITH OTHERS

With Parents | With Spouse | With Relatives | With Non-Relatives

WILL RESIDE IN DOMICILIARY SETTING

Community Residence | Halfway House | Hostel | Proprietary Home

Foster Care | Family Care | Other, describe _____

WILL RESIDE IN FACILITY

Mental Hospital | General Hospital Psychiatric Unit | General Hospital-Other Unit | V. A. Hospital

Skilled Nursing Facility | Intermediate Care Facility including H.R.F. | Facility for the Retarded including I.C.F.M.R. | Narcotic Residential Facility

Prison or Other Correctional Facility | Alcoholism Facility | Other, describe: _____

Patient's Address _____ (Street) (Apt. No.) (City) (State) (Zip) (Telephone No.)

Service Arranged by: Name: _____

Service Provided by: _____ (Agency) (Address) (Telephone No.)

Follow-up Provided by: _____ Frequency of Follow-up: _____

B. PHYSICAL HEALTH

Please specify needs and goals: _____

Treatment of Physical Problem | Special Diet | Physical Rehabilitation Services | Dental

Medication: Type, Dosage, Frequency: _____

Medication Administration: Self Administered | Self Administered when Reminded or Supervised | Must be Administered

Special Therapies, Describe: _____

Other, Describe: _____

Service Arranged by: Name: _____

Service Provided by _____ (Agency) (Address) (Telephone No.)

Follow-up Provided by: _____ Frequency of Follow-up: _____

Physician: _____ (Name) (Address) (Telephone No.)

Appendix B 5c: (OMH 6)

INDIVIDUAL SERVICE PLAN	Patient's Name (Last, First, M.I.)

C. MENTAL HEALTH/MENTAL RETARDATION/ALCOHOLISM

Please specify needs and goals: _____

_____

_____

Day Activities Family Group Session Group Session Individual Session Alcoholics Anonymous*

Medication: Type, Dosage, Frequency: _____

Medication Administration: Self Administered Self Administered when Reminded or Supervised Must be Administered

Other, Describe: _____

Service Arranged by: Name: _____

Service Provided by: _____ (Agency) _____ (Address) _____ (Telephone No.)

Follow-up Provided by: _____ Frequency of Follow-up: _____

* AA, because of its structure, cannot take part in the discharge planning process, but can be utilized as a treatment resource.

D. ECONOMIC

Please specify needs and goals: _____

_____

_____

Patient's own Resources or Income (Including Retirement Benefits and Earned Disability Benefits)

Family of the Patient

SSI Benefits

Public Assistance

Medicaid

Medicare

(Social Security Benefits Unearned by the Patient)

Other Disability Benefits

Vocational Rehabilitation Benefits

Other Benefits, Describe: _____

Conservator

Service Arranged by: Name: _____

Service Provided by: _____ (Agency) _____ (Address) _____ (Telephone No.)

Follow-up by: _____ Frequency of Follow-up: _____

E. VOCATIONAL TRAINING

Please specify needs and goals: _____

_____

_____

_____

Employment Part Time Full Time

Vocational Skills/Trade Training

Work Adjustment Training

Household

Unemployed

Other, describe: _____ (e.g. retired, not applicable)

Vocational Counseling

Sheltered Workshop

Volunteer

Service Arranged by: Name: _____

Service Provided by: _____ (Agency) _____ (Address) _____ (Telephone No.)

Follow-up Provided by: _____ Frequency of Follow-up: _____

Appendix B 5d: (OMH 6)

INDIVIDUAL SERVICE PLAN	Patient's Name (Last, First, M.I.)

F. EDUCATION

Please specify needs and goals: _____

_____

_____

☐ Education Counseling ☐ Special Education ☐ College

☐ Academic Education ☐ High School Equivalency

☐ Other, describe: _____

Service Arranged by: Name: _____

Service Provided by: _____ (Agency) _____ (Address) _____ (Telephone No.)

Follow-up Provided by: _____ Frequency of Follow-up: _____

G. SOCIAL

Please specify needs and goals: _____

_____

_____

☐ Community Socio-recreational Program ☐ Socialization (Interpersonal)

☐ Leisure Time Activities ☐ Other, Describe: _____

Service Arranged by: Name: _____

Service Provided by: _____ (Agency) _____ (Address) _____ (Telephone No.)

Follow-up Provided by: _____ Frequency of Follow-up: _____

H. FAMILY – OTHER SUPPORT

Please specify needs and goals: _____

_____

_____

☐ Family ☐ Peers ☐ Other concerned Individuals

Service Arranged by: Name: _____

Service Provided by: _____ (Agency) _____ (Address) _____ (Telephone No.)

Follow-up Provided by: _____ Frequency of Follow-up: _____

I. SELF CARE

Please specify needs and goals: _____

_____

_____

☐ Personal Skills ☐ Community Skills

Service Arranged by: Name: _____

Service Provided by: _____ (Agency) _____ (Address) _____ (Telephone No.)

Follow-up Provided by: _____ Frequency of Follow-up: _____

J. TRANSPORTATION

	Service Arranged by (Agency)	(Telephone No.)	Service Provided by (Agency)	(Telephone No.)
☐ Physical Health				
☐ Mental Health Mental Retardation Alcoholism				
☐ Economic				
☐ Vocational Training				
☐ Education				
☐ Social				
☐ Family-other support				
☐ Self Care				
☐ Other (specify)				

Appendix B 6a: (AHR 116)

Form ADM 116 (MH) (5-90) — Office of Mental Health

DISPOSITION REPORT

1. PATIENT NAME *(Last, First, M.I.)*

2. "C" NUMBER

3a. FACILITY NAME

3b. FACILITY CODE

4. WARD/UNIT CODE

5. DISPOSITION DATE (Mo. / Day / Year)

6. WAS DISCHARGE IN CONFORMANCE WITH STAFF ADVICE? ☐ YES ☐ NO

A. TYPE OF DISPOSITION *("X" Only One (1) Item Below)*

1 ☐ **Termination, No Further Service** *(Complete Sections B thru E Below)*

2 ☐ **Permanent Transfer**

3 ☐ **Temporary Transfer Out of Facility**

4 ☐ **Return To Original Facility After Temporary Transfer**

Facility Name: _____ Facility Code:

5 ☐ **Service Changed From** (Outpatient to Inpatient) or (Non-Residential to Residential) — (Inpatient) (Residential) Ward Code:

6 ☐ **Service Changed From** (Inpatient to Outpatient) or (Residential to Non-Residential) *(Complete Sections B thru E)* — (Outpatient) (Non-Residential) Unit Code:

7 ☐ **Family Care Placement** *(Complete Sections B thru E.)* *(Enter Family Care Provider as "Provider Agency 1")* Family Care Unit Code:

Legal Status Continues Yes ☐ No ☐; Outpatient Services with unit _____

8 ☐ **Convalescent Care Placement** *(Complete Sections B thru E.)* (Outpatient) (Non-Residential) Unit Code:

9 ☐ **Death** - Time: : Place: _____ Place Code:

Cause. 1: _____ 2: _____

0 ☐ **Service Changed From One** (Outpatient) or (Non-Residential) Unit to Another Unit at This Facility — "New" (Outpatient) (Non-Residential) Unit Code:

B. SERVICE PLAN STATUS *("X" Only One (1) Item)*

1 ☐ Service Plan Completed — Date Completed (Mo. / Day / Year)

Reason Service Plan Not Completed

2 ☐ Service Plan Being Prepared 3 ☐ Patient Not Located 4 ☐ Patient Refused to Participate 5 ☐ Other *(Explain)* _____

C. RELEASE DATA *(See "Instructions", Reverse Side)*

1. HOUSEHOLD COMPOSITION

2. RESIDENCE CODE

3a. COUNTY OF PLACEMENT

3b. CODE

4. REFERRED TO: COUNTY DSS YES ☐ NO ☐ SSA YES ☐ NO ☐

5a. ADDRESS OF NEW RESIDENCE

5b. CITY/TOWN/VILLAGE

5c. STATE

5d. ZIP CODE

6. SOURCE OF FINANCIAL SUPPORT AFTER RELEASE OR TERMINATION

1 ☐ Full Support by Self (91-100%) 2 ☐ Full Support by Others (91-100%) 3 ☐ Major Support by Self (51-90%) 4 ☐ Major Support by Others (51-90%) 5 ☐ Source of Support Unknown

D. REFERRAL STATUS *("X" Only One (1) Item)* 1 ☐ Patient Referred *(Complete Section E Below)*

Reason Referral Not Made:

2 ☐ Unable to Locate 3 ☐ Declined Referral 4 ☐ Left Facility Without Authorization 5 ☐ No Further Care Required 6 ☐ Other *(Explain)* _____

E. PROVIDER INFORMATION *(See "Instructions", Reverse Side)*

PROVIDER AGENCY 1

1a. NAME — 1b. CODE

1c. ADDRESS

1d. CITY/TOWN/VILLAGE — 1e. STATE — 1f. ZIP CODE

PROVIDER AGENCY 2

2a. NAME — 2b. CODE

2c. ADDRESS

2d. CITY/TOWN/VILLAGE — 2e. STATE — 2f. ZIP CODE

PROVIDER AGENCY 3

3a. NAME — 3b. CODE

3c. ADDRESS

3d. CITY/TOWN/VILLAGE — 3e. STATE — 3f. ZIP CODE

PROVIDER AGENCY 4

4a. NAME — 4b. CODE

4c. ADDRESS

4d. CITY/TOWN/VILLAGE — 4e. STATE — 4f. ZIP CODE

Signature of Person Completing Form | Print Name Signed | Date

Patient's Case Record Copy

Appendix B 6b: (AHR 116)

INSTRUCTIONS FOR COMPLETING DISPOSITION REPORT (FORM ADM 116)

Completion: The ward/unit which is responsible for the patient prior to this movement/transaction is to complete this form. For inpatient transactions, the form should be completed at the same time that the patient movement is reported in the Census Turn Around Document.

Areas shaded gray are for Medical Records/Coding Unit use only.

Distribution: Copies are sent to the Medical Record Office/data entry staff and to Patient Resource Office. The original is filed in the patient's case record after the coded data has been added.

Was Discharge in Conformance with Staff Advice? — If the treatment staff are in agreement with the release or termination, check "YES"

INSTRUCTIONS FOR SECTION A

1. **Termination, no further service** — Used when the facility will not provide any additional service to the patient.
2. **Permanent Transfer Out of Facility** — Used for permanent inpatient/residential and outpatient/non-residential transfer between two State Facilities only.
3. **Temporary Transfer Out of Facility** — Used for temporary transfers for Medical Surgical, Court or Camp between two State Facilities only.
4. **Return to Original Facility After Temporary Transfer** — Used at the completion of a temporary stay, completed, by the facility who is returning the patient to which a patient was temporarily transferred using 3. above at the **completion** of that temporary stay.
5. **Service Changed Outpatient/Non-Residential to Inpatient/Residential** — Used when a patient receiving outpatient/non-residential services is admitted as an inpatient/resident at the same facility. Staff who provided the Outpatient/Non-Residential services are responsible for completion of the Disposition Report.
6. **Service Changed Inpatient/Residential to Outpatient/Non-Residential** — Used for discharges from Legal Status when the patient is scheduled to receive Outpatient/Non-Residential Services.
7. **Family Care Placement** — Used when a patient is placed on Family Care Status. The Family Care Provider data should be entered in Section E, Provider 1.
8. **Convalescent Care Placement** — Used when a patient is placed on Convalescent Care Status. Enter the code of the Unit responsible for service.
9. **Death** — Enter time of death (use 24 hour clock format); place of death, and Place Code (use Residence Code table below); and cause of death literal.
0. **Service Changed From One Outpatient/Non-Residential Unit to Another at This Facility** — Used when the Outpatient/Non-Residential Unit responsible for the patient changes. Staff from the first Unit are responsible for completing the Disposition Report.

INSTRUCTIONS FOR SECTION B

Service Plan Status — If completed, check the box and enter the date the plan was completed. If the plan was not completed, indicate the reason.

INSTRUCTIONS FOR SECTION C

Enter the Household Composition Code and Residence Code which best describe the patient's living arrangements after the release or termination.

Household Composition Code

1 Alone	3 With Siblings	5 With Children	7 With Others	9 In Residential Facility	11 Unknown
2 With Parents	4 With Spouse	6 With Other Relatives	8 In Institution	10 No Permanent Address	

Residence Code

OTHER THAN INSTITUTION / RESIDENTIAL FACILITY / PROGRAM			
12 Own Home or Apartment	13 Home of Relative or Friend	14 Boarding House	15 Hotel, Motel, Rooming House
OMH PSYCHIATRIC CENTER PROGRAMS			
18 Family Care Home	44 Community Residence—Intensive	47 Situational Crisis Residence	49 Residential Care Center for Adults
25 Inpatient Ward	45 Community Residence—Supervised	48 Acute Crisis Residence	65 Partial Hospitalization
	46 Community Residence—Supportive		
LOCAL MENTAL HEALTH RESIDENTIAL FACILITIES			
50 Family Care Home	52 Community Residence—Supervised	54 Acute Crisis Residence	56 Residential Treatment Facility for Children
51 Community Residence—Intensive	53 Community Residence—Supportive	55 Residential Care Centers for Adults	66 Partial Hospitalization
OTHER RESIDENTIAL FACILITIES / PROGRAMS			
19 Foster Care	35 Substance Abuse Facility	58 Division for Youth Facility	61 Veterans Administration Residential Program
22 Adult Home/Private Proprietary Home for Adults	36 Correctional Facility/Jail	59 Facility for Mentally Retarded/ Developmentally Disabled	62 Shelter for the Homeless
29 Alcoholism Facility	57 Skilled Nursing Facility/ Health Related Facility	60 Private School	63 Shelter for Others
MISCELLANEOUS	38 Other	39 Unknown	64 Homeless - Living on Streets

County of Placement— Enter name and code of County in which the patient will reside after release or termination.

INSTRUCTIONS FOR SECTION D

Referral Status— If contact has been made and the individual(s)/agency(s) have agreed to provide the needed services, indicate **Referred.** Otherwise, check the reason referral has not been made.

INSTRUCTIONS FOR SECTION E

Enter the name and address of the individual or agency who has agreed to accept primary responsibility for the patient as Provider Agency 1.

Provider Code

PATIENT / OTHER INDIVIDUAL	01 Self	03 Clergy	06 Other Physician
	02 Family or Friend	07 Private Psychiatrist	55 Other Private Mental Health Practitioner
OMH PSYCHIATRIC CENTER PROGRAMS			
56 Inpatient Ward	57 Crisis Residence	60 Geriatric Respite Care	63 Day Treatment, Continuing Treatment, Clinic and Other Outpatient Programs
33 Family Care Home	58 Intensive Rehabilitative Treatment	61 Mobile Mental Health Team	
36 Community Residence	59 Residential Care Center for Adults	62 Intensive Case Management	97 Partial Hospitalization
GENERAL HOSPITAL (ARTICLE 28)			
64 County/Municipal Hospital, Inpatient Psychiatric Unit	66 County/Municipal Hospital, Inpatient Medical Unit	68 County/Municipal Hospital Emergency Room,	70 For-Profit-Hospital
65 Voluntary Hospital, Inpatient Psychiatric Unit	67 Voluntary Hospital Inpatient Medical Unit	69 Voluntary Hospital, Emergency Room	
OTHER HOSPITALS	34 Private Psychiatric Hospital	71 Veterans Administration Hospital (Inpatient Ward)	72 Out-of-State Hospital
LOCAL MENTAL HEALTH PROGRAMS			
21 Emergency Services, Other Than Hospital Emergency Room	74 Crisis Residence	77 Intensive Case Management	98 Intensive Rehabilitative Treatment
37 Community Residence	75 Residential Care Center for Adults	78 Day Treatment, Continuing Treatment, Clinic and Other Outpatient Programs	99 Partial Hospitalization
73 Family Care Home	76 Residential Treatment Facility for Children		
EDUCATION RELATED	04 Public/Private School	79 Committee for Special Education	
COURT / CORRECTION / DETENTION AGENCIES			
05 Police	80 Family Court	82 Corrections Agency — State	84 NYS Division for Youth
49 Parole	81 Criminal Court	83 Corrections Agency — Local	85 NYC Dept. of Juvenile Justice
OTHER FACILITIES / PROGRAMS / AGENCIES			
12 Skilled Nursing/ Health Related Facility	87 Adult Home/Private Proprietary Home for Adults (PPHA)	90 Other Alcoholism Residential/Non-Residential Treatment Facility/Program	93 Facility/Program for the Mentally Retarded/ Developmentally Disabled
23 Outpatient Medical Clinic	88 Veterans' Administration Outpatient or Residential Program	91 Alcoholism Intervention Program/Services	94 Foster Care
31 Other			95 NYS Dept. of Social Services (OSS) Special Services for Children
32 Unknown		92 Substance Abuse Treatment Facility/Program	
86 Shelter for the Homeless/Others	89 DAAA Alcoholism Treatment Center		96 DSS-Other

Appendix B 7a: (TPC 612)

(Rev. 9/89)

DISCHARGE INSTRUCTION FORM

(To be completed by Primary Therapist)

NAME: _____

ADDRESS: _____

You have been discharged today from [redacted] The information below is intended for your use to help you in your return to the community.

1. Date of Discharge: _____
2. Your first appointment is: _____ _____
   Date Time

   Name of Clinic/Program: _____

   Phone: _____

3. Your Clinic Contact/Caseworker/Therapist is:

   Name: _____ Phone: _____

   Address: _____

4. These appointments have also been arranged: (i.e., medical follow-up, SSI, welfare)

   A. Agency: _____

   Address: _____

   Phone: _____ Date: _____ Time: _____

   B. Agency: _____

   Address: _____

   Phone: _____ Date: _____ Time: _____

5. MEDICATION(S)

A.

Name	Dosage	Time to be Taken	Special Instructions
1.			
2.			
3.			
4.			
B.			
1.			
2.			
3.			

Appendix B 7b: (TPC 612)

6. General Recommendations (e.g., other healthcare follow-up, or arrangements that you should make on your own):

_____

_____

_____

_____

7. If you have any questions about information contained on this sheet, please contact:

Name: _____

Address: _____

Phone: _____

8. WORKERS NAMES: _____
Social Worker/Primary Therapist

_____
Doctor

_____
Discharge Coordinator

_____
Patient's Signature

Date Received: _____

cc: Clinic
Caseworker
Discharge Team
Medical Records

Appendix B 8a: (AHR 725)

Form ADM 725 (MH) (7-90)

New York State
OFFICE OF MENTAL HEALTH

ADMISSION/SCREENING FORM

PURPOSE: ☐ ADMISSION ☐ READMISSION ☐ SCREENING ☐ CORRECTION ☐ UPDATE

1. "C" NUMBER	2. FACILITY NAME	3. FAC. CODE	4. SOCIAL SECURITY NUMBER	5. PATIENT'S PHONE #
			- -	

6a. PATIENT NAME (Last) (First) (M.I.)	6b. MAIDEN NAME OR AKA	7. SCHOOL DISTRICT

8. USUAL ADDRESS
Street No Street
City State Zip Code

9. LOCAL CATCHMENT AREA OR CENSUS TRACT

10. COUNTY OF RESIDENCE

U.S. CITIZEN ☐ Yes ☐ No
Date Naturalized:

11. SCREENING/EVALUATION UNIT

12. UNIT CODE

13. INTERVIEW DATE TIME
MO DAY YEAR ____A.M ____P.M

14. DATE OF BIRTH AGE
MO DAY YEAR

15. SEX ☐ Male ☐ Female

COUNTRY OF BIRTH

16. ETHNICITY/RACE
1 ☐ White (Non-Hispanic) 4 ☐ Asian or Pacific Islander
2 ☐ Black (Non-Hispanic) 5 ☐ American Indian or Alaskan Native
3 ☐ Hispanic

17. PRIMARY LANGUAGE
1 ☐ English 3 ☐ Other(Specify)
2 ☐ Spanish

18. CURRENT MARITAL STATUS
1 ☐ Never married 4 ☐ Married
2 ☐ Separated 5 ☐ Divorced
3 ☐ Widowed 6 ☐ Unknown

19. EDUCATION *(Check Highest Grade Completed)*
Preschool, Kindergarten, Elementary, Secondary
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12
Voc.,Bus. & Tech. ☐ 13 College 1st ☐ 14 2nd ☐ 15 3rd ☐ 16 4th ☐ 17
Graduate School ☐ 18 Ungraded ☐ 19 None ☐ 20 Unknown ☐ 21

20. RELIGION
1 ☐ Protestant 4 ☐ Unknown
2 ☐ Catholic 5 ☐ Other *(Specify)*
3 ☐ Jewish

21. PRESENT EMPLOYMENT STATUS
a. Not in labor force
1 ☐ Illness 5 ☐ Unemployable
2 ☐ Homemaker 6 ☐ Institutionalized
3 ☐ Student 7 ☐ Other
4 ☐ Retired
b. Armed forces
8 ☐
c. Employed
9 ☐ Full-time 10 ☐ Part-time
d. Unemployed
11 ☐ On lay-off 13 ☐ Other
12 ☐ Looking for Work

22. SIGNIFICANT PROBLEMS *(Check all which apply)*
1 ☐ Mental Illness
2 ☐ Alcohol
3 ☐ Mental Retardation/Developmental Disabilities
4 ☐ Substance Abuse
5 ☐ Significant Physical Impairment
6 ☐ Other. *(Specify)* _____

23. CURRENT LIVING ARRANGEMENTS *(See instructions)*
a. Household Composition
b. Type of Residence

24. SOURCE OF REFERRAL *(See instructions)*

25. OTHER SERVICES FOR DISABILITIES *(Check all which apply)*
a. Inpatient/Residential
☐ This Facility ☐ Other State Facility ☐ Other
b. Outpatient
☐ This Facility ☐ Other State Facility ☐ Other
c. ☐ None
d. ☐ Unknown
e. Time Since Last Service—Less Than:
1 ☐ 7 Days 3 ☐ 3 Months 5 ☐ 1 Year
2 ☐ 30 Days 4 ☐ 6 Months 6 ☐ Over 1 Year
Duration of Last Service—Less Than:
1 ☐ 1 Week 3 ☐ 1 Year 5 ☐ Over 2 Years
2 ☐ 1 Month 4 ☐ 2 Years
f. Prior State Facility Name
FACILITY CODE PRIOR "C" NO

26. ADMITTING DIAGNOSES *(Indicate PRINCIPAL DIAGNOSIS by an "X" in the appropriate "○")*

Axis I - Clinical Syndromes and V Codes

Axis II - Developmental Disorders and Personality Disorders

Axis III - Physical Disorders and Conditions (ICD-9-CM)

29. INCOME
a. Public Assistance 1 ☐ Yes 2 ☐ No
b. Annual Family Income
1. $_____ 2. Number of Persons dependent on ____

30. MEDICAID CLAIM NO.

31. MEDICARE CLAIM NO.

32. OTHER HEALTH INSURANCE
1 ☐ Yes 2 ☐ No

33. VETERAN 2 ☐ No
1 Yes *(Check 3, 4, or 5)*
3 ☐ Vietnam Era-1/1/63-5/7/75
4 ☐ Other Era (Not Vietnam)
5 ☐ Dates of Service Unknown

34. RESPONSIBLE PARTY
Last Name First M.I.
ADDRESS: Street No Street
City State Zip Code
PHONE RELATIONSHIP

Axis IV - Severity of Psychosocial Stressors
Stressor (s): _____
Severity: *(Check only one)*
1 ☐ None 3 ☐ Moderate 5 ☐ Extreme 0 ☐ Inadequate information/
2 ☐ Mild 4 ☐ Severe 6 ☐ Catastrophic No change in condition
Duration *(Check one)*: Predominately: ☐ Acute Event ☐ Enduring Circumstances

Axis V - Global Assessment of Functioning *(Enter two digit scores from 1-90)*
1 ____ Current GAF Score 2 ____ Highest GAF score for past year

27. Accepted for further services *(Check all which apply in a & b or c, d, e)*
a. No *(Check only one)*
☐ No services indicated ☐ Services unavailable ☐ Services refused ☐ Other
b. ☐ Referred to other facility — Facility Name — FAC. CODE — Type *(See instructions)*
c. ☐ Yes — ACCEPTED MO DAY YEAR — UNIT NAME — WARD/UNIT CODE
d. Admission Type:
1 ☐ Inpatient
2 ☐ Outpatient
3 ☐ Other Residential
e. Legal Status Code: — Legal Status Effective MO DAY YEAR — Legal Status Expiration MO DAY YEAR

35. SIGNATURE OF PERSON COMPLETING FORM — Title — Date Completed

Patient's Case Record Copy

Appendix B 8b: (AHR 725)

INSTRUCTIONS FOR COMPLETION OF ADMISSION/SCREENING FORM (ADM-725)

All items omitted from the instructions are considered self-explanatory

A. General

1. This form is to be used to record data for all screenings, admissions, and readmissions to OMH inpatient, outpatient, and Community Residential Programs
2. Update or Correction of Admission/Screening data may be made using this form or using the computer generated 'Client Profile
3. Areas shaded gray, are for Medical Records/Coding Unit use only
4. Upon completion of the form: copies are distributed to the Medical Record Office/data entry staff and to the Patient Resource Office. The original is filed in the patient's case record after the coded data has been added.

B. Specific

1. **"C" NUMBER** — If the patient previously received services at this facility, use the existing case number; do not assign a new number
4. **SOCIAL SECURITY NUMBER** — Effort should be made to obtain this data, but the individual has a right to refuse to furnish this number
7. **SCHOOL DISTRICT** — For all patients under 21 years of age, enter name of the local school district in which the applicant resides
13. **INTERVIEW** — This is the date and time of the current meeting being conducted with the patient
14. **DATE OF BIRTH — AGE** — Enter numbers for month, day, year and age. If unknown, estimate age and enter date of birth using the year of estimated birth and zeroes (0) for the month and day
23. **LIVING ARRANGEMENTS** — Enter a code from A and a code from B which best describe the individual's usual living arrangements

a. Household Composition - Patient Lives:

1 Alone	4 With Spouse	7 With Others	10 No Permanent Address
2 With Parents	5 With Children	8 In Institution	11 Unknown
3 With Siblings	6 With Other Relatives	9 In Residential Facility	

b. Type of Residence:

OTHER THAN INSTITUTION / RESIDENTIAL FACILITY / PROGRAM

12 Own Home or Apartment	13 Home of Relative or Friend	14 Boarding House	15 Hotel, Motel, Rooming House

OMH PSYCHIATRIC CENTER PROGRAMS

18 Family Care Home	44 Community Residence—Intensive	47 Situational Crisis Residence	49 Residential Care Center for Adults
25 Inpatient Ward	45 Community Residence—Supervised	48 Acute Crisis Residence	65 Partial Hospitalization
	46 Community Residence—Supportive		

LOCAL MENTAL HEALTH RESIDENTIAL FACILITIES

50 Family Care Home	52 Community Residence—Supervised	54 Acute Crisis Residence	56 Residential Treatment Facility for Children
51 Community Residence—Intensive	53 Community Residence—Supportive	55 Residential Care Centers for Adults	66 Partial Hospitalization

OTHER RESIDENTIAL FACILITIES / PROGRAMS

19 Foster Care	35 Substance Abuse Facility	58 Division for Youth Facility	61 Veterans Administration Residential Program
22 Adult Home/Private Proprietary Home for Adults	36 Correctional Facility/Jail	59 Facility for Mentally Retarded/ Developmentally Disabled	62 Shelter for the Homeless
29 Alcoholism Facility	57 Skilled Nursing Facility/ Health Related Facility	60 Private School	63 Shelter for Others

MISCELLANEOUS

38 Other	39 Unknown	64 Homeless - Living on Streets	

24. **SOURCE OF REFERRAL**

PATIENT / OTHER INDIVIDUAL

01 Self	03 Clergy	06 Other Physician	55 Other Private Mental Health Practitioner
02 Family or Friend	07 Private Psychiatrist		

OMH PSYCHIATRIC CENTER PROGRAMS

56 Inpatient Ward	57 Crisis Residence	60 Geriatric Respite Care	63 Day Treatment, Continuing Treatment, Clinic and Other Outpatient Programs
33 Family Care Home	58 Intensive Rehabilitative Treatment	61 Mobile Mental Health Team	
36 Community Residence	59 Residential Care Center for Adults	62 Intensive Case Management	97 Partial Hospitalization

GENERAL HOSPITAL (ARTICLE 28)

64 County/Municipal Hospital Inpatient Psychiatric Unit	66 County/Municipal Hospital, Inpatient Medical Unit	68 County/Municipal Hospital Emergency Room,	70 For-Profit-Hospital
65 Voluntary Hospital, Inpatient Psychiatric Unit	67 Voluntary Hospital Inpatient Medical Unit	69 Voluntary Hospital, Emergency Room	

OTHER HOSPITALS

34 Private Psychiatric Hospital	71 Veterans Administration Hospital (Inpatient Ward)	72 Out-of-State Hospital	

LOCAL MENTAL HEALTH PROGRAMS

21 Emergency Services, Other Than Hospital Emergency Room	74 Crisis Residence	77 Intensive Case Management	98 Intensive Rehabilitative Treatment
37 Community Residence	75 Residential Care Center for Adults	78 Day Treatment, Continuing Treatment, Clinic and Other Outpatient Programs	99 Partial Hospitalization
73 Family Care Home	76 Residential Treatment Facility for Children		

EDUCATION RELATED

04 Public/Private School	79 Committee for Special Education		

COURT / CORRECTION / DETENTION AGENCIES

05 Police	80 Family Court	82 Corrections Agency — State	84 NYS Division for Youth
49 Parole	81 Criminal Court	83 Corrections Agency — Local	85 NYC Dept. of Juvenile Justice

OTHER FACILITIES / PROGRAMS / AGENCIES

12 Skilled Nursing/ Health Related Facility	87 Adult Home/Private Proprietary Home for Adults (PPHA)	90 Other Alcoholism Residential/Non-Residential Treatment Facility/Program	93 Facility/Program for the Mentally Retarded/ Developmentally Disabled
23 Outpatient Medical Clinic	88 Veterans' Administration Outpatient or Residential Program	91 Alcoholism Intervention Program/Services	94 Foster Care
31 Other			95 NYS Dept. of Social Services (DSS) Special Services for Children
32 Unknown		92 Substance Abuse Treatment Facility/Program	
86 Shelter for the Homeless/Others	89 DAAA Alcoholism Treatment Center		96 DSS-Other

26. **ADMITTING DIAGNOSIS or Impression of Disability** — Enter the literal description of the diagnosis or condition; check the appropriate circle to indicate the Principal Admitting Diagnosis'
27. **ACCEPTED FOR FURTHER SERVICES** — (Check all items that apply)
    a. If **No** — Check appropriate box; complete remainder of form from item 29 (exclude #34).
    b. If Referred to Other Facility — Check box, enter facility name and code type (select code from item 24 above). *(NOTE: An individual may be both referred to another facility and accepted for outpatient services.)*
    c. If **Yes** — Check box and enter date the individual was accepted, unit name, and ward or unit code. Complete remainder of the form
29. **INCOME** — If patient receives public assistance, check **Yes**; do not complete **b.** If **No**; complete **b.**
33. **VETERAN**
    a. If **No** — Check box number 2.
    b. If **Yes** — Check appropriate box - number 3, 4 or 5.
34. **RESPONSIBLE PARTY** — This individual may be a member of the family, spouse, relative or friend having knowledge of the patient's financial affairs. Codes for the relationship are as follows:

    01 Spouse 02 Child 03 Parent 04 Relative 05 Sibling 06 Guardian 07 Friend 08 Other
35. **SIGNATURE** — The individual completing the form signs the form, indicating title and date completed.

Appendix B 9a: (15 MED)

Patient's Name (Last, First, M.I.) "C" No.

Sex ..... Date of Birth

Facility Name Unit/Ward No

DIAGNOSIS RECORD

INSTRUCTIONS:

1. Complete to transfer diagnostic data from the patient's case record into the information system. (See back for details),
2. File the original in the patient's case record, and
3. Forward a copy to the appropriate staff for DMHIS data entry.

	DATE		CODE	DIAGNOSIS/PROCEDURE NAME	Princ. Psych.	Med. Trans.	Deter.-tion
1		AXIS I					
2							
3							
4							
5		AXIS II					
6							
7							
8							
9		AXIS III					
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23		AXIS IV	Psychosocial Stressors Stressor (s): _____ Severity *(Check one)*: 1. ☐ None 2. ☐ Mild 3. ☐ Moderate 4. ☐ Severe 5. ☐ Extreme 6. ☐ Catastrophic 0. ☐ Inadequate information or no change in condition Duration *(Check one)*: ☐ Predominantly Acute Event ☐ Predominantly Enduring Circumstances				
24		AXIS V	Global Assessment of Functioning *(Enter two digit scores from 01-90)* ___ Current GAF score (the level of functioning at the time of the evaluation)				
25			___ Past Year GAF (the highest level of functioning for at least a few months during the past year. For children and adolescents, this must include at least a month during the school year)				

Signature of Individual Completing Form	Title	Date

*NOTE: While all of Axis IV and V information is being gathered on this form to ensure its presence in the patients case record, only part of the information will be retrievable through the DMHIS reports.

Patient's Case Record Copy

Appendix B 9b: (15 MED)

—INSTRUCTIONS—

A. Report diagnoses/procedures which are a concern for treatment or contribute to an understanding of the patient.

1. Within 10 days of an inpatient admission and prior to the fourth visit for an outpatient; upon transfer to another facility, discharge, termination or death of an inpatient, and upon termination or death of an outpatient or resident to report available diagnoses procedures not reported previously
2. Upon a comprehensive physical examination to report diagnoses and procedures not previously reported.
3. Immediately after an inpatient is determined to have a disease listed below:

Disease Diagnostic Categories Required for Infection Control Monitoring

1.	Salmonella infections	003 - 003.9
2.	Amebiasis	006 - 006.9
3.	Intestinal infections	008 - 008.8
	—Ill defined intestinal infections including diarrhea	009 - 009.3
4.	Tuberculosis	010 - 018.9
5.	Septicemia	038 - 038.9
6.	Acquired Immune Deficiency Syndrome (AIDS)	042 - 044.9
7.	Herpes Simplex	054 - 054.9
8.	Viral Hepatitis	070 - 070.9
9.	Syphilis and other venereal diseases	090 - 099.9
10.	Acute upper respiratory infections of multiple or unspecified sites	465 - 465.9
11.	Pneumonia and influenza	480 - 487.8
12.	Abscess of lung and mediastinum	513 - 513.1
13.	Urinary tract infection, site not specified	599.0
14.	Other congenital infections including herpes simplex and tuberculosis *(double code to indicate specific infection)*	771.2

B. Check appropriate box to indicate:

1. The principal psychiatric diagnosis from Axis I or II.
   The principal diagnosis is the condition that was chiefly responsible for occasioning the evaluation or admission to clinical care.
2. Medical Transfer Data
   The Axis III diagnosis that identifies the disease which caused the patient to be transferred to a medicare certified medical unit. Only the following facilities have certified medical units: Binghamton, Buffalo, Central Islip, Gowanda, Hudson River, Middletown, Rochester, St. Lawrence and Willard Psychiatric Center.
3. Previously reported data to be deleted.
   Data to be deleted, including date, must be entered exactly as originally reported.
   For Axis IV and V, check correct box for severity or enter correct GAF score(s) and enter date correct determination made.

C. Severity of Psychosocial Stressors

Code the overall severity of a psychosocial stressor or multiple psychosocial stressors that have occurred in the year preceding the current evaluation and that may have contributed to any of the following: development of a new mental disorder; recurrence of a prior mental disorder; or exacerbation of an already existing mental disorder. The rating of the severity of the stressor should be based on the clinician's assessment of the stress an "average" person in similar circumstances and with similar sociocultural values would experience from the particular psychosocial stressor (s).
The specific psychosocial stressor (s) should be noted and further specified as either: predominantly acute events (duration less than six months; or predominantly enduring circumstances (duration greater than six months).

D. Global Assessment of Functioning Scale (GAF)

Ratings on the GAF scale should be made for two time periods:

1. Current - the level of functioning at the time of the evaluation. Generally reflects the current need for treatment and care.
2. Past Year - the highest level of functioning for at least a few months during the past year. For children and adolescents, this should include at least a month during the school year.

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.
Note: Use intermediate codes when appropriate, e.g., 45,68,72.

Code	
90 81	**Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).
80 71	**If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling behind in school work).
70 61	**Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**
60 51	**Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with co-workers).
50 41	**Serious Symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).
40 31	**Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30 21	**Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).
20 11	**Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incoherent or mute).
10 01	**Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**

E. Distribution

1. File the original in the patient's case record.
2. Forward a copy to the appropriate staff for DMHIS data entry.

Appendix B 10: (139 MED)

SCREENING/ADMISSION NOTE

Screening/Admission Date	Time of Day	Legal Status (Inpatients)

Sex

SPECIAL PRECAUTIONS— If dangerous or potentially dangerous to self or others, specify extent and to whom. Also, identify allergies, medical needs, behavioral problems, etc., which require special precautions.

INSTRUCTIONS— Enter the following information in sufficient detail to allow determination of the patient's need for admission:

1. Source of referral:
   a. Name, relationship, and phone number of individual(s) who accompanied the patient.
   b. Name and phone number of agency which referred the patient.
2. Reasons for the referral (as stated by the patient and/or others):
   a. Complaint(s) (onset and duration).
   b. Onset of the current episode with any precipitating factors.
3. Family composition and living arrangements.
4. Psychiatric, physical/medical and other significant history (identify hospital, program or clinician, dates of admission and discharge, condition or disease, and type of treatment).
5. Current physical condition:
   a. Physical diagnosis(es).
   b. Current medication(s) and name of prescribing physician.
6. Mental status, including attitudes, behavior, intellectual functioning, memory and orientation.
7. Admission diagnosis(es) or diagnostic impression.
8. Assets/strengths in descriptive terms.
9. Disposition:
   a. **If not admitted,** give reason. If referred, give name and address of individual or agency. Also indicate any special precautions in box above, and actions taken, e.g., consultation with individual's physician or family, etc.
   b. **If admitted,** give reason for admission and notify and/or make arrangements for children/other family members.
10. Signature, title, and date.

Appendix B 11a: (140 MED)

Form 140 MED MH 2/86

STATE OF NEW YORK
OFFICE OF MENTAL HEALTH

INTERIM TREATMENT PLAN	Patient's Name (Last, First, MI) / Sex

SPECIAL PRECAUTIONS - If dangerous or potentially dangerous to self or others, specify extent and to whom. Also identify allergies, medical needs, behavioral problems, etc., which require special precautions. Describe required actions on back of form in Section F.

INSTRUCTIONS

1. Initiate on the day of admission and update as appropriate until the Comprehensive Treatment Plan is implemented.
2. Review this Plan within 72 hours and document results in the Progress Notes for inpatients and patients in a day treatment, continuing treatment, or day training program.

A PARTICIPATION IN TREATMENT PLAN

- Patient participated in preparation of this plan on _____/_____/_____
- Family or significant other(s) participated in preparation of this plan on _____/_____/_____

_____
Enter name(s) and relationship to patient

_____

- Describe reason(s) for nonparticipation and attempts to obtain participation of patient, family or significant other(s)

_____

_____

_____

B ROUTINES ORDERED

YES ☐ NO ☐ If no, enter reason

C SPECIAL ASSESSMENTS (List)	D REQUESTS TO OTHER INDIVIDUALS AGENCIES FOR INFORMATION (Describe type of information requested and individual agency from whom requested)

E RELEASE/DISCHARGE CRITERIA AND TENTATIVE RELEASE/DISCHARGE DATE

Appendix B 11b: (140 MED)

Form 140 MED (MH) 2-86

STATE OF NEW YORK
OFFICE OF MENTAL HEALTH

INTERIM TREATMENT PLAN	Patient's Name (Last, First, M.I.)

INSTRUCTIONS

1. At the time each treatment objective is established, enter an ID letter, description of objective and need(s), target date and description of treatment method(s) and related information.
2. Enter date and code when objective is actually attained (A), cancelled (C) or revised (R).
3. Enter signature, title, and date after each entry.
4. Physician signs or countersigns.

F. TREATMENT

ID LETTER	Objective(s) and Need(s)	Date Established	Target Date	Date/Code Attained (A) Cancelled (C) Revised (R)	Method(s) (Therapy/Staff Action) Indicate expected start date; duration; frequency; location, if off unit; and responsible person(s).
					PAGE

Appendix B 12a: (OMH 472)

FORM 472 DMH (1/73)
(Form Prescribed by N.Y.S. Department of Mental Hygiene)

VOLUNTARY REQUEST FOR HOSPITALIZATION

You can obtain admission to a hospital for treatment of mental illness, for yourself or for a person under 16 years of age, by completing and signing this form. The admission will be on a voluntary basis. Please read carefully the information below and on the following page before completing this form.

Use this form 472 DMH, for voluntary and minor voluntary admissions only.

Do not use this form for involuntary admissions or for informal admissions. Instead use Form 471 DMH for involuntary admissions and Form 473 for informal admissions.

REQUIREMENTS FOR VOLUNTARY OR MINOR VOLUNTARY ADMISSION

To be admitted to any mental hospital on a voluntary basis or for conversion to such status, the prospective patient - or in the case of a person under 16 years of age, the parent, guardian or next of kin of the patient - must voluntarily make written application for admission, be notified of and have the ability to understand the following:

1. that the hospital to which he is requesting admission is a hospital for the mentally ill.
2. that he is making an application for admission.
3. the nature of the voluntary status and the provisions governing release or conversion to involuntary status.

If the person is over 16 years of age and under 18 years of age, the director may, in his discretion, admit such person either as a voluntary patient on his own application or on the application of the person's parent, legal guardian or next of kin.

The admitting physician must certify that the applicant meets the above requirements and is therefore suitable for voluntary status.

GENERAL INFORMATION

1. MENTAL HEALTH INFORMATION SERVICE

A Mental Health Information Service exists in each Judicial Department of the Supreme Court of the State of New York. This service was established to inform patients and others interested in the patients' welfare concerning procedures for admission and retention, and to inform them of the the patients' right to have judicial hearing and review, to be represented by legal counsel and to seek independent medical opinion.

There is a Mental Health Information Service office in many hospitals. Where there is no office at the hospital, a representative of the Service visits periodically and frequently. The address of the Service can be obtained from a staff member of the hospital. Any patient or anyone in his behalf may see or communicate with a representative of the Service by telephoning or writing directly to the office of the Service or by requesting someone on the staff of the patient's ward to make such arrangements for him.

2. REIMBURSEMENT

The patient is legally responsible for payment for the cost of care. Additionally responsible, if of sufficient ability, are the patient's spouse and the parents of a patient under the age of 21. Also legally responsible are the committee,guardian, or trustee of a trust fund established for the support of the patient, or any fiduciary or payee of funds for the patient.

In order to assist in determining the ability of legally responsible relatives to pay for the cost of care, the applicant should be careful to provide the information requested as to names, addresses and ages of those relatives.

Appendix B 12b: (OMH 472)

FORM 472 DMH (1/73) PAGE 2

PROVISIONS OF VOLUNTARY STATUS

Section 31.13 Voluntary Admission.

(a) Section 31.13, paragraph a, of the Mental Hygiene Law provides for the admission of any person to any hospital on a voluntary basis.

(b) Admission under this section is restricted to a person who has sufficient orientation to understand the following:

(1) that the hospital to which he is requesting admission is a hospital for the mentally ill.

(2) that he is making an application for admission.

(3) the nature of the voluntary status and the provisions governing release or conversion to involuntary status.

(c) Admissions under this section are to be encouraged as providing optimum conditions for the treatment of the patient and the establishment of good relations with the family and the community.

PROVISIONS GOVERNING RELEASE OR CONVERSION TO INVOLUNTARY STATUS

Patients admitted on a voluntary status may be continued as voluntary patients, discharged, or converted to involuntary status. No voluntary patient shall remain in the voluntary status for more than twelve months from his admission to such status unless his suitability and willingness to remain as a voluntary patient have been reviewed by the Mental Health Information Service.

To leave the hospital, a voluntary patient must notify the hospital director. The director will then either promptly release the patient or, if there are reasonable grounds for believing that the patient is in need of involuntary care and treatment, retain the patient for a period not to exceed seventy-two hours from receipt of the patient's notice. During this seventy-two hour period, the director shall either release the patient or apply to a court for an order authorizing the involuntary retention of the patient.

If it is determined by the court that the patient is mentally ill and in need of involuntary care and treatment, the court shall issue an order authorizing the retention of the patient for sixty days from the date of the order.

Application for further retention of the patient for a period of six months, then one year, and successive two year periods thereafter, may be made to the courts if the patient's condition warrants further involuntary care and treatment.

In the case of a patient under eighteen years of age, notice requesting release of the patient may be made by the patient, by the person who made application for the patient's admission, by a person of equal or closer relationship to the patient, or by the Mental Health Information Service. If such notice is given by any other person, the director may in his discretion refuse to discharge the patient and, in the event of such refusal, such other person or the Mental Health Information Service may apply to a court for the release of the patient.

When any person under the age of twenty-one years is admitted to or is converted from one admission status to another in any hospital, written notice of such admission or conversion shall be given to the Mental Health Information Service within three days thereof and such notice shall specify the age of and admission procedure applicable to such person. No such person shall be transferred to any other hospital without the prior consent of such person and the prior written consent of his parent or legal guardian unless three days prior written notice of such proposed transfer is given to the Mental Health Information Service and an opportunity is afforded to the Service to see such person and to review the proposed transfer. Immediately upon release or transfer of any such person, the director of the hospital shall give the Mental Health Information Service written notice thereof.

Upon admission, voluntary patients must be given written notice of their status and rights (Form 460 DMH). A voluntary converted from involuntary status is given a special notice of rights (Form 460C DMH). All voluntary patients must be given written notice of status and rights every 120 days (Form 460B DMH).

At any time while on voluntary status, the patient and anyone interested in his welfare can seek information or assistance from the Mental Health Information Service, as explained on Page 1.

The hospital is not obliged to provide voluntary patients with special ward placement, single rooms, liberties or other special privileges. Living and sleeping arrangements and the granting of privileges will be based only on each patient's mental condition, without regard to the voluntary status.

INSTRUCTIONS FOR COMPLETION OF FORM

1. On Page 3, check off box in Part A or Part B, whichever is appropriate, and complete and sign the corresponding paragraph.
2. Complete Part C on Page 3, and Part D on Page 4, in all cases.
3. The hospital admitting physician completes Part E on Page 4.

Appendix B 12c: (OMH 472)

FORM 472 OMH (1 73) PAGE 3

VOLUNTARY REQUEST FOR HOSPITALIZATION

Before completing, read the instructions on the preceding pages.

Check Off Appropriate Box and Complete Corresponding Paragraph.

PART A

Application for Voluntary Admission

SECTION 31.13

THIS SECTION MUST BE SIGNED BY THE PROSPECTIVE PATIENT

I, _____, hereby apply for voluntary admission to _____, a hospital for the mentally ill.

My reasons for requesting his care and treatment are stated in Part C below.

I have been notified and understand the nature of the voluntary status and the provisions governing release or conversion to involuntary status.

Date: _____ _____
Signature of Patient

PART B

Application for Minor Voluntary Admission

SECTION 31.13

THIS SECTION MUST BE SIGNED BY THE PARENT, LEGAL GUARDIAN OR NEXT-OF-KIN OF THE PROSPECTIVE PATIENT

I, _____, acting for my _____ (Relationship), _____ (Name), _____ (Age), hereby apply for his admission to _____, a hospital for the mentally ill.

My reasons for requesting his care and treatment are stared in Part C below.

I have been notified and understand the nature of the voluntary status and the provisions governing release or conversion to involuntary status.

Date: _____ _____
Signature of minor patient's parent, guardian, or next of kin

PART C - Statement of reasons for requesting hospitalization. (To be completed by patient or by parent, guardian or next of kin).

Appendix B 12d: (OMH 472)

FORM 472 OMH (1 73) PAGE 4

I. D. NO. (CENTRAL OFFICE USE)

PART D - IDENTIFYING DATA (Must be typed or printed clearly in ink.)

NAME OF PATIENT (Last Name) (First Name) (Middle Name)	Male 1 ___ Female 2 ___	"MEDICARE" CLAIM NO.

STREET ADDRESS	CITY	COUNTY	STATE	ZIP CODE

DATE OF BIRTH	PLACE OF BIRTH	U. S. CITIZEN 1 ___ YES 3 ___ NO	HOW LONG IN U. S.	HOW LONG IN N. Y. STATE

NAMES OF LIVING RELATIVES OF PATIENT If No Relatives, Nearest Known Friend	RELATION	AGE	STREET ADDRESS	CITY AND STATE	PHONE NO.

PREVIOUS PSYCHIATRIC TREATMENT

NAME OF FACILITY	TYPE	LOCATION (City & State)	DATE OF ADMISSION	LENGTH OF STAY

PREVIOUS NON-PSYCHIATRIC HOSPITALIZATIONS

NAME OF HOSPITAL	LOCATION (City & State)	DATE OF ADMISSION	LENGTH OF STAY	REASON

DO NOT WRITE IN THIS SPACE

PART E - TO BE COMPLETED BY STAFF PHYSICIAN ___ ADMISSION ___ CHANGE IN STATUS

I have examined the above named patient, and confirm the need for immediate care and treatment for mental illness. Hospital admission is medically necessary for

___ TREATMENT WHICH COULD REASONABLY BE EXPECTED TO IMPROVE THE PATIENT'S CONDITION

___ DIAGNOSTIC STUDY

I certify that the patient is suitable for the type of admission requested.

SIGNATURE OF ADMITTING PHYSICIAN

HOSPITAL	DATE OF ADMISSION OR CHANGE	SERVICE-WARD	IDENTIFICATION NO.

CONSECUTIVE NO.	SOCIAL SECURITY NO.	SOURCE OF REFERRAL	VETERAN-WAR SERVICE

ETHNIC GROUP	RELIGION	OCCUPATION	MARITAL STATUS	LEGAL STATUS 32 ___ Voluntary 33 ___ Minor Voluntary

Appendix B 13a: (OMH 471)

FORM 471 DMH (1 73)
(Form Prescribed by N.Y.S. Department of Mental Hygiene)

APPLICATION FOR ADMISSION OF PATIENT

Admission on medical certification to a hospital for treatment of mental illness requires the completion of this form and the appropriate examination certificates. Please read the instructions on page 2 carefully before completing this form. Errors or omissions may delay admission.

Do not Use This Form for Voluntary, Minor Voluntary, or Informal Admissions. Use Form 472 DMH for Voluntary and Minor Voluntary Admissions. Use Form 473 DMH for Informal Admissions.

GENERAL INFORMATION

1. WHO MAY MAKE APPLICATION

An application for admission of a patient to a hospital for the care and treatment of mental illness may be made by any person with whom the person alleged to be mentally ill resides, the father or mother, husband or wife, brother or sister, or the child of any such person or the nearest available relative, the committee of such a person, an officer of any public or well recognized charitable institution or agency or home in whose institution the person alleged to be mentally ill resides, the director of community services or social services official, as defined in the social service law, of the city or county in which any such person may be, the director of the hospital in which the patient is hospitalized, the director or person in charge of a facility providing care to certified narcotic addicts assigned or transferred thereto by the narcotic addiction control commission, or by the Director of the Division For Youth.

2. QUALIFICATIONS OF EXAMINING PHYSICIANS

a. For involuntary admission to a hospital of a person alleged to be mentally ill and in need of involuntary care and treatment, applications made by any of the persons listed above must be supported by two Certificates of Examination (Form 471A DMH) completed by two examining physicians. An "examining physician" for this purpose means a physician licensed to practice medicine in the State of New York.

b. An application for immediate inpatient care and treatment in a hospital for a mental illness which is likely to result in serious harm to the patient or to others, submitted by the Director of Community Services for the mentally disabled or by an examining physician duly designated by him, must be supported by a "Certificate of Examination by Director of Community Services or His Designee" (Form 471B DMH). For the purpose of conducting this Examination, the Director of Community Services must be a psychiatrist. If the Director of Community Services is not a psychiatrist, the Examining Physician designated and empowered to conduct such examinations on behalf of the Director of Community Services must be a qualified psychiatrist.

c. An examining physician must not be a relative of the person applying for the admission, or of the person to be admitted.

d. An examining physician must not be a manager, trustee, visitor, proprietor, officer, director, or stockholder of the hospital in which the patient is hospitalized or to which it is proposed to admit the patient, or have any financial interest in such hospital other than receipt of fees, privileges or compensation for treating or examining patients in such hospital.

e. A physician on the staff of the hospital to which admission is sought may act as an examining physician, if he is not disqualified by the provisions stated in paragraphs c and d above, except that if the hospital is a proprietary facility, neither examining physician may be on the staff of that hospital.

3. DATE OF APPLICATION AND EXAMINATION CERTIFICATES

The date of this application and of the required examinations may not be more than 10 days prior to the date of the patient's admission to the hospital. The date of each Certificate of Examination shall be the date the examination took place.

4. MENTAL HEALTH INFORMATION SERVICE

A Mental Health Information Service exists in New York State. This Service provides patients, and others interested in the patients' welfare, with assistance and information about admission, retention, and the patients' rights to have judicial hearing and review, to be represented by legal counsel, and to seek independent medical opinion.

A patient, or someone acting on the patient's behalf, may communicate directly with the Mental Health Information Service, or request that a member of the hospital staff contact the Service for him. The address of the Mental Health Information Service can be obtained from any member of the hospital staff.

5. REIMBURSEMENT

The patient is legally responsible for payment for the cost of care. Additionally responsible, if of sufficient ability, are the patient's spouse and the parents of a patient under the age of 21. Also legally responsible are the committee, guardian or trustee of a trust fund established for the support of the patient, or any fiduciary or payee of funds for the patient.

In order to assist in determining the ability of legally responsible relatives to pay for the cost of care, the applicant should be careful to provide the information requested as to names, addresses and ages of those relatives.

Appendix B 13b: (OMH 471)

FORM 471 DMH (1 73) PAGE 3

APPLICATION FOR ADMISSION OF PATIENT

Before Completing, Read the Instructions on the Preceding Pages.

PART A - APPLICATION Check Off Appropriate Box and Complete Corresponding Paragraph.

1. TWO PHYSICIANS CERTIFICATE ADMISSION (Sec. 31.27)

This section must be signed by applicant (relative, etc.) NOT by examining physician.

I hereby request that _____ be admitted to _____ This request is made due to the circumstances indicated in Part B below, and on the attached certificates.

Under the penalty of perjury, I attest that the information supplied on this application is true to the best of my knowledge and belief.

_____ SIGNATURE OF APPLICANT (APPLICANT MAY NOT BE EXAMINING PHYSICIAN)

_____ RELATIONSHIP TO PATIENT

_____ ADDRESS

_____ DATE

2. DIRECTOR OF COMMUNITY SERVICES OR HIS DESIGNEE ADMISSION (Sec. 31.37)

This section as well as Form 471B DMH must be signed by director of Community Services or his designee.

I hereby request that _____ be admitted to _____ This request is made due to the circumstances indicated in Part B below, and on the attached certificate.

Under the penalty of perjury, I attest that the information supplied on this application is true to the best of my knowledge and belief.

_____ SIGNATURE OF DIRECTOR OF COMMUNITY SERVICES OR HIS DESIGNEE (NOT TO BE SIGNED BY RELATIVE)

_____ OFFICIAL TITLE

_____ ADDRESS

_____ DATE

Applicant Must Complete This Statement

PART B - STATEMENT (Reasons for requesting hospitalization. Cite behavior, statements and changes in behavior or character that tend to show the existence of mental illness. If more space is needed, attach additional sheet).

Appendix B 13c: (OMH 471)

FORM 471 DMH (1 73) PAGE 4

I. D. NO. (CENTRAL OFFICE USE)

PART C - IDENTIFYING DATA (Must be typed or printed clearly in ink).

NAME OF PATIENT (Last Name) (First Name) (Middle Name)			Male 1 ___ Female 2 ___	"MEDICARE" CLAIM NO.	
STREET ADDRESS	CITY	COUNTY	STATE	ZIP CODE	
DATE OF BIRTH	PLACE OF BIRTH	U.S. CITIZEN 1 ___ YES 3 ___ NO	HOW LONG IN U. S.	HOW LONG IN N. Y. STATE	

NAMES OF LIVING RELATIVES OF PATIENT (If No Relatives, Nearest Known Friend)	RELATION	AGE	STREET ADDRESS	CITY AND STATE	PHONE NO.

PREVIOUS PSYCHIATRIC TREATMENT

NAME OF FACILITY	TYPE	LOCATION (City & State)	DATE OF ADMISSION	LENGTH OF STAY

PREVIOUS NON-PSYCHIATRIC HOSPITALIZATIONS

NAME OF HOSPITAL	LOCATION (City & State)	DATE OF ADMISSION	LENGTH OF STAY	REASON

DO NOT WRITE IN THIS SPACE

PART D - TO BE COMPLETED BY HOSPITAL ☐ ADMISSION ☐ CHANGE IN STATUS

I have examined the above named patient and confirm the need for immediate care and treatment in an institution or facility for the mentally ill because

1 ___ ALTERNATIVE CARE WOULD NOT BE ADEQUATE

OR

The following adequate alternative(s) (is) (are) not available

2 ___ PSYCHIATRIC DAY CARE
3 ☐ TREATMENT IN THE HOME BY VISITING THERAPIST
4 ___ NURSING HOME OR EXTENDED CARE FACILITY
5 ☐ OUTPATIENT TREATMENT
6 ___ TREATMENT IN GENERAL HOSPITAL PSYCHIATRIC UNIT
7 ___ OTHER _____

Hospital admission is medically necessary for

___ TREATMENT WHICH COULD REASONABLY BE EXPECTED TO IMPROVE THE PATIENT'S CONDITION
___ DIAGNOSTIC STUDY

SIGNATURE OF ADMITTING PHYSICIAN

HOSPITAL	DATE OF ADMISSION OR CHANGE	SERVICE-WARD	IDENTIFICATION NO.
CONSECUTIVE NO.	SOCIAL SECURITY NO.	SOURCE OF REFERRAL	VETERAN - WAR SERVICE
ETHNIC GROUP	RELIGION	OCCUPATION	MARITAL STATUS

LEGAL STATUS 20 ☐ Two Physicians
23 ☐ Director of Community Services or his designee

Appendix B 14: (OMH 471A)

CERTIFICATE OF EXAMINING PHYSICIAN

To Support an Application for Involuntary Admission

Person's Name (Last, First, M.)

Sex

Date of Birth

Address

CERTIFICATION

I. _____ hereby certify that:
(Name of Examining Physician)

1. I am a physician licensed to practice medicine in New York State.
2. I have with care and diligence personally examined the above named person on: MO DAY YEAR at _____
(place where examined)
3. I find:
   a. this person has a mental illness for which care and treatment in a mental hospital is appropriate;
   b. as a result of this mental illness, this person poses a substantial threat of harm to him/herself or others ("substantial threat of harm to him/herself" shall include the inability to safely survive in the community); and
   c. hospitalization can reasonably be expected to improve this person's condition or at least prevent his/her deterioration.
4. I have formed my opinion on the basis of facts and information I have obtained (described below and on the reverse side) and my examination of this person.
5. I have considered alternative forms of care and treatment but believe that they are inadequate to provide for the needs of this person, or are not available.
6. If this person has to my knowledge received prior treatment, I have, insofar as possible, consulted with the physician or psychologist furnishing such prior treatment.
7. To the best of my knowledge and belief, the facts stated and information contained in this certificate are true.

Signature	Print Name Signed	Title	
Address	Phone Number	Date Mo. Day Yr.	Time Hr. Min. AM PM

Appendix B 15: (OMH 471B)

CERTIFICATE OF EXAMINATION BY DIRECTOR OF COMMUNITY SERVICES OR DESIGNEE

I, _____, hereby certify that on the _____ day of _____, 19_____, I personally examined _____, at _____, and that in my opinion he has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate.

It is my opinion that his mental illness is likely to result in serious harm to himself or others. By "likelihood of serious harm" I mean:

(Check appropriate statements)

☐ a. substantial risk of serious harm to himself, as manifested by threats of or attempts at suicide or serious bodily harm, or other conduct demonstrating that he is dangerous to himself;

AND/OR

☐ b. a substantial risk of physical harm to other persons, as mainfested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

The behavior or specific act of this person on which I base my opinion is described in Part B of Form OMH 471 — Application For Admission of Patient.

(Check appropriate statements below, and complete where necessary)

I am: ☐ the Director of Community Services for the mentally disabled for (City) (County) of _____

OR

☐ an examining physician designated to conduct the examination of the above-named person on behalf of the Director of Community Services for the mentally disabled for (City) (County) of _____

I am a physician licensed in New York State ☐ Yes ☐ No

I certify that Hospital Admission is medically necessary

_____ Date

_____ Signature

_____ Address

_____ Print Name to be Signed

_____ Telephone Number

Appendix B 16: (OMH 471C)

Form OMH 471C (8-82)

State of New York
Office of Mental Health

EXAMINATION FOR 72 HOUR OR 24 HOUR CONVERSION TO INVOLUNTARY ADMISSION ON MEDICAL CERTIFICATION

Patient's Name (Last, First, M.I.)

"C" No. | Unit/Ward No.

Facility Name

Director of Community Services or Designee Admission

☐ Certificate of Examination *CONFIRM NEED FOR HOSPITALIZATION WITHIN 72 HOURS* (excluding Sundays and Holidays)

☐ Certificate of Observation *CONFIRM NEED FOR HOSPITALIZATION WITHIN 24 HOURS*

1. Pertinent and Significant Factors in Patient's Medical and Psychiatric History

2. Physical Condition (including any special test reports)

3. Mental Condition The conduct of the patient (including statements made to me by others) has been

4. The patient showed the following psychiatric signs and symptoms

5. Does the patient show a tendency to injure self? _____ to injure others? _____

Explain _____

6. Mental Diagnosis (if determined)

I, _____ (Print Name Clearly) . do certify as follows

a I have with care and diligence personally observed and examined on the date of this certificate, namely, on the ____ day of _____ 19____

_____ (Insert Name of Patient) now residing or being at _____.

in the county of _____ and as a result of such examination, find and hereby certify to the fact that the patient is mentally ill and requires care and treatment in an institution or facility for the mentally ill.

b I have formed this opinion from the history of the case and my examination of the patient as given above.

c. I hereby certify that the facts stated and information contained in this certificate are true to the best of my knowledge and belief

Signature	Address	Date of Exam
M.D.		

Appendix B 17a: (OMH 474)

Form OMH 474 (2-79)

STATE OF NEW YORK
OFFICE OF MENTAL HEALTH

RECORD OF EMERGENCY ADMISSION

Use this form ONLY for Emergency Admissions under Section 9.39 of the Mental Hygiene Law.

Use Form OMH 471 to request admission of patients on certificates of examining physicians (Section 9.27) or on the certificate of a Director of Community Services or his Designee (Section 9.37).

PROVISIONS GOVERNING EMERGENCY ADMISSIONS

Section 9.39 of the Mental Hygiene Law provides for emergency admission to a hospital, for a period of 15 days, of any person alleged to have a mental illness for which immediate observation, care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others.

"Likelihood to result in serious harm" is defined as:

(1) substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself;

OR

(2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

Only hospitals approved by the Commissioner of Mental Health and maintaining adequate staff and facilities for the observation, examination, care and treatment of persons alleged to be mentally ill may receive and retain patients pursuant to this section of the law.

PROCEDURE

A. Upon admission the admitting physician shall examine the person alleged to be in need of emergency admission to the hospital, and shall certify below his finding that such person qualifies for admission under the provisions outlined above.

B. He shall also record in the space below the name of the person or persons, if any, who brought the patient to the hospital, and the details of the circumstances leading to the hospitalization of the patient. As soon as possible after admission, further identifying data about the patient should be obtained and recorded on Form OMH 459, Identifying Data Sheet, and attached to this form.

C. Within 48 hours of the time of admission of the patient, he must be examined by another physician who must be a member of the psychiatric staff of the hospital. The findings of this psychiatric examiner shall be recorded on the reverse side of this form.

D. If the psychiatric examiner confirms the finding of the admitting physician, that the patient qualifies for admission under the provisions outlined above, the patient may then be retained for a period up to fifteen days from the date of his admission to the hospital.

E. The patient may be retained beyond 15 days only by a new admission on an application supported by two new examining physicians' certificates, unless he agrees to remain as a voluntary or informal patient. In either case, the date of admission shall be deemed to be the date when the patient was first received as an Emergency Admission.

RECORD OF ADMISSION

PATIENT NAME _____ AGE _____

ADDRESS _____

The patient was brought to this hospital at _____ (TIME) on _____ (DATE) by:

_____ (NAME) _____ (RELATION TO PATIENT)

_____ (OFFICIAL TITLE, OR BADGE NUMBER, IF ANY)

_____ (ADDRESS) _____ (PHONE)

The circumstances which lead to the hospitalization of this patient were as follows:

_____

_____

I have examined the patient named above and confirm his need for immediate observation, care and treatment for a mental illness which is likely to result in serious harm to himself or others.

_____
SIGNATURE OF ADMITTING PHYSICIAN

Appendix B 17b: (OMH 474)

Form OMH 474 (2-79) Page 2

PATIENT NAME (Last) (First) (Middle)	
NAME OF HOSPITAL	
DATE OF ADMISSION	TIME OF ADMISSION
"C" NO.	

EXAMINATION FOR 48-HOUR CONFIRMATION OF NEED FOR EMERGENCY ADMISSION

1. Pertinent and Significant Factors in Patient's Medical and Psychiatric History:

2. Physical Condition (Including any special test reports)

3. Mental Condition: The conduct of the patient (Including statements made to me by others) has been:

4. The patient showed the following psychiatric signs and symptoms:

5. Does the patient show a tendency to injure himself? _____; to injure others? _____

Explain _____

6. Mental diagnosis (if determined) _____

7. a. I, _____, M.D., am a member of the psychiatric staff of _____ Hospital.

b. I have with care and diligence personally observed and examined _____ (INSERT NAME OF PATIENT)

at _____ (TIME) .m., on _____, 19____, and as a result of such examination I find and hereby certify to the fact that he has a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others.

c. I have formed this opinion from the history of the case and my examination of the patient as given above.

d. I hereby certify that the facts stated and information contained in this certificate are true to the best of my knowledge and belief.

_____ M.D.
SIGNATURE

Appendix B 18a: (OMH 460)

Form OMH 460 (7-87)

State of New York
Office of Mental Health

NOTICE OF STATUS AND RIGHTS - VOLUNTARY OR MINOR VOLUNTARY STATUS

(to be given to a patient at the time of admission or conversion to voluntary or minor voluntary status)

TO: _____ _____, 19 ____

A copy of this Notice of Status and Rights is also being sent to the Mental Hygiene Legal Service.

State and Federal Laws prohibit discrimination based on race, color, creed, national origin, age, sex, or disability.

HOSPITAL	
ADMISSION DATE	CASE NO.
☐ VOLUNTARY ADMISSION (Sec. 9.13, M.H. Law)	☐ MINOR VOLUNTARY ADMISSION (Sec. 9.13, M H. Law)

(Check only one)

☐ YOU HAVE BEEN ADMITTED TO THIS HOSPITAL FOR THE MENTALLY ILL AS A VOLUNTARY OR MINOR VOLUNTARY PATIENT.

☐ YOU HAVE BEEN CONVERTED TO VOLUNTARY OR MINOR VOLUNTARY STATUS AT THIS HOSPITAL FOR THE MENTALLY ILL.

AT ANY TIME, YOU MAY GIVE WRITTEN NOTICE TO THE DIRECTOR IF YOU WANT TO LEAVE. HOWEVER, YOU MAY NOT LEAVE FOR THREE DAYS UNLESS THE DIRECTOR LETS YOU. IF THE DIRECTOR THINKS THAT YOU NEED TO STAY, HE MAY ASK A COURT FOR AN ORDER TO KEEP YOU HERE.

YOU, YOUR RELATIVES, AND YOUR FRIENDS SHOULD FEEL FREE TO ASK MEMBERS OF THE HOSPITAL STAFF ABOUT YOUR CONDITION, YOUR STATUS AND RIGHTS, AND THE RULES AND REGULATIONS OF THIS HOSPITAL.

MENTAL HYGIENE LEGAL SERVICE

THE MENTAL HYGIENE LEGAL SERVICE, A COURT AGENCY INDEPENDENT OF THIS FACILITY, CAN PROVIDE YOU, AND OTHERS ACTING IN YOUR BEHALF, WITH PROTECTIVE SERVICE, ASSISTANCE AND INFORMATION WITH REGARD TO YOUR HOSPITALIZATION. YOU HAVE A RIGHT TO A COURT HEARING AND A RIGHT TO BE REPRESENTED BY A LAWYER.

YOU, OR SOMEONE ACTING IN YOUR BEHALF, MAY CALL OR WRITE DIRECTLY TO THE MENTAL HYGIENE LEGAL SERVICE, OR REQUEST THAT A MEMBER OF THE HOSPITAL STAFF CONTACT THE SERVICE FOR YOU.

THE ADDRESS AND PHONE NUMBER OF THE MENTAL HYGIENE LEGAL SERVICE FOR THIS HOSPITAL IS:

I HAVE READ, OR HAD READ TO ME, AND UNDERSTAND THE CONTENTS OF THE ABOVE NOTICE.

_____ Date

_____ Patient's Signature or Mark

_____ Date

_____ Signature of Person Who Signed Application for Admission or Conversion to Minor Voluntary Status

THE ABOVE PATIENT HAS BEEN GIVEN A COPY OF THIS NOTICE

_____ Date

_____ Staff Physician

Appendix B 18b: (OMH 471)

NOTICE OF STATUS AND RIGHTS
INVOLUNTARY ADMISSION ON MEDICAL CERTIFICATION
(to be given to the patient at the time of admission to the hospital)
Section 9.27 Mental Hygiene Law

Admission Date:

TO: _____

Based upon the certificates of two examining physicians, whose findings have been confirmed by a member of the psychiatric staff of this hospital, you have been admitted as an involuntary-status patient to this hospital which provides care and treatment for persons with mental illness. You may be kept in the hospital for a period of up to 60 days from the date of your admission, unless you have had a court hearing. During this 60 day period you may be released, or converted to voluntary or informal status, if you are willing to continue receiving inpatient care and treatment and are suitable for such status.

You, and anyone acting on your behalf, should feel free to ask hospital staff about your condition, your status and rights under the Mental Hygiene Law, and the rules and regulations of this hospital.

If you, or those acting on your behalf, believe that you do not need involuntary care and treatment, you or they may make a written request for a court hearing. Copies of such a request will be forwarded by the hospital director to the appropriate court and the Mental Hygiene Legal Service.

MENTAL HYGIENE LEGAL SERVICE

The Mental Hygiene Legal Service, a court agency independent of this hospital, can provide you and your family with protective legal services, advice and assistance, including representation, with regard to your hospitalization. You are entitled to be informed of your rights regarding hospitalization and treatment, and have a right to a court hearing, to be represented by a lawyer, and to seek independent medical opinion.

You, or someone acting on your behalf, may see or communicate with a representative of the Mental Hygiene Legal Service by telephoning or writing directly to the office of the Service or by requesting hospital staff to make such arrangements for you.

The Mental Hygiene Legal Service representative for this hospital may be reached at:

THE ABOVE PATIENT HAS BEEN GIVEN A COPY OF THIS NOTICE.

_____ Signature of Staff Physician

_____ Date

COPIES TO:

_____ (Original Applicant)

_____

_____ (Nearest Relative)

_____

COPIES TO: Persons designated by patient to be informed of admission (If None, type in "NONE")

_____

_____

_____

_____

A copy of this Notice of Status and Rights is also being sent to the Mental Hygiene Legal Service.
State and Federal Laws prohibit discrimination based on race, color, creed, national origin, age, sex, or disability.

Appendix B 19: (OMH 470)

Form OMH 470 (2-79)

STATE OF NEW YORK
OFFICE OF MENTAL HEALTH

APPLICATION FOR COURT AUTHORIZATION TO RETAIN A PATIENT

(Pursuant to Section 9.13 or 9.33 of the Mental Hygiene Law)

FACILITY	
PATIENT (Last) (First) (M.I.)	
IDENTIFICATION NO.	"C" NUMBER
DATE OF ADMISSION	CURRENT ADMISSION STATUS
NO. PREVIOUS COURT AUTHORIZATIONS	EXPIRATION DATE OF LAST AUTHORIZATION

STATE OF NEW YORK

_____ COURT, COUNTY OF _____

In the Matter of the Retention of

_____ .

A Patient Admitted to

_____ Center

APPLICATION

Index No.

I am the Director of _____, a hospital for the mentally ill, and hereby respectfully make application to this court, pursuant to Section *(9.13) *(9.33) of the Mental Hygiene Law, to retain the above named patient for involuntary care and treatment at said hospital for a period not to exceed _____ (days) (months) (years).

Said person is now a patient at said hospital pursuant to Section _____ of the Mental Hygiene Law has been carefully observed and examined and is in need of retention.

I have explored all alternative forms of care and treatment and found none adequate to provide for said patient's needs other than the retention requested herein.

Said patient is either unsuitable or unwilling to remain in said hospital voluntarily.

WHEREFORE, the undersigned respectfully requests this Court to issue an order authorizing involuntary retention of said patient for the period specified above.

Date: _____, 19 _____ _____
(SIGNATURE)

_____
(PRINT NAME TO BE SIGNED)

* Strike out if inapplicable.

Appendix B 20a: (OMH 470A)

NOTICE OF APPLICATION FOR COURT AUTHORIZATION TO RETAIN A PATIENT

TO:

PATIENT	DATE OF ADMISSION	TYPE OF ADMISSION
HOSPITAL	"C" NUMBER	
	DATE OF NOTICE TO PATIENT	

_____ Court, County of _____

TO:

_____ (Original Applicant)

_____

_____

_____ (Mental Health Information Service)

_____

_____

_____ (Nearest Relative other than Original Applicant)

_____

_____

COPIES TO: Persons designated by patient to be given notice at time of admission (if None type in "NONE".)

_____

_____

_____

_____

_____

_____

_____

_____

_____

On the ____ day of _____, 19____, an application will be made to the above named court for an order authorizing your retention for a period not to exceed _____ (days) (months) (years).

A court hearing may be requested within 5 days, excluding Sunday and holidays, from the date this notice is served. Such request may be made to the Director of the hospital or to any member of the treatment staff. If no hearing is requested, the court will rule on the application of the hospital Director without a hearing.

MENTAL HEALTH INFORMATION SERVICE

The Mental Health Information Service, a court agency independent of this hospital, provides patients, and others acting in their behalf, with protective service, assistance and information with regard to their hospitalization. Patients have a right to a court hearing and a right to be represented by a lawyer.

You, or someone acting in your behalf, may call or write directly to the Mental Health Information Service for assistance and further information about this proceeding, or request that a member of the hospital staff contact the Mental Health Information Service for you.

The address and phone number of the Mental Health Information Service for this hospital is:

See reverse side for "Certification of Service of Notice (Mental Illness)"

Appendix B 20b: (OMH 470A)

State of New York
OFFICE OF MENTAL HEALTH

CERTIFICATION OF SERVICE OF NOTICE (MENTAL ILLNESS)

STATE OF NEW YORK - -

_____ COURT, COUNTY OF _____

In the Matter of the Retention of

_____,

A Patient Admitted to

_____ Hospital

CERTIFICATION
Index No.

I am the Director of _____, a hospital for the mentally ill, and hereby certify that I have caused copies of the "Notice of Application for Court Authorization to Retain a Patient" (see reverse side) to be served personally, on the _____ day of _____, 19 _____, on the patient named in the Application, and to be served by mail, posted on the _____ day of _____, 19 _____, on the Mental Health Information Service and all of the persons whose names appear at the foot of said notice, the foregoing being all of those entitled to receive such notice under Law.

DATE: _____, 19 ____

_____
(SIGNATURE)

_____
(PRINT NAME TO BE SIGNED)

See reverse side for "Notice of Application for Court Authorization to Retain a Patient"

Appendix B 21: (OMH 471A)

CERTIFICATE OF EXAMINING PHYSICIAN

To Support an Application for Involuntary Admission

Person's Name (Last, First, M.I.)

Sex

Date of Birth

Address

CERTIFICATION

I, _____, hereby certify that:
Name of Examining Physician

1. I am a physician licensed to practice medicine in New York State.
2. I have with care and diligence personally examined the above named person on: MO DAY YEAR at _____
place where examined
3. I find:
   a. this person has a mental illness for which care and treatment in a mental hospital is appropriate;
   b. as a result of this mental illness, this person poses a substantial threat of harm to him/herself or others ("substantial threat of harm to him/herself" shall include the inability to safely survive in the community); and
   c. hospitalization can reasonably be expected to improve this person's condition or at least prevent his/her deterioration.
4. I have formed my opinion on the basis of facts and information I have obtained (described below and on the reverse side) and my examination of this person.
5. I have considered alternative forms of care and treatment but believe that they are inadequate to provide for the needs of this person, or are not available.
6. If this person has to my knowledge received prior treatment, I have, insofar as possible, consulted with the physician or psychologist furnishing such prior treatment.
7. To the best of my knowledge and belief, the facts stated and information contained in this certificate are true.

Signature	Print Name Signed	Title	
Address	Phone Number	Date Mo / Day / Yr	Time Hr Min AM PM

Appendix B 22: (OMH 495)

Form OMH 495 (5-80)

STATE OF NEW YORK—OFFICE OF MENTAL HEALTH

APPLICATION FOR CHANGE IN STATUS/PRIVILEGES

Patient's Name (Last, First, M.I.)

PART I — Completed by Unit Chief and Team Psychiatrist

"C" No. | Unit/Ward No.

Facility

Patient's Status (check only one)

- ☐ CIVIL INPATIENT (Originally admitted Pursuant to Sec. 730 C.P.L.)
- ☐ SEC. 330.20 (C.P.L.) RETENTION, COMMITMENT or RECOMMITMENT
- ☐ FINAL ORDER OF OBSERVATION Pursuant to Sec. 730.40(2), C.P.L.
- ☐ TEMPORARY ORDER OF OBSERVATION Pursuant to Sec. 730.40(2), C.P.L.
- ☐ ORDER OF COMMITMENT Pursuant to Sec. 730.50 C.P.L.
- ☐ ORDER OF RETENTION Pursuant to Sec. 730.50 C.P.L.

Action Requested (check only one)

- ☐ CONDITIONAL RELEASE
- ☐ DISCHARGE
- ☐ CONVERT TO CIVIL STATUS
- ☐ RETURN TO CUSTODY OF COURT
- ☐ UNESCORTED FURLOUGHS — Describe nature and duration
- ☐ ESCORTED FURLOUGH — Describe nature and duration
- ☐ TRANSFER

Summary of Clinical, Social and Criminal History, Including Circumstances Surrounding the Act(s) Leading to C.P.L. Retention

Rationale For Action Requested

We, the undersigned, believe that the present condition of the patient referenced above warrants the action requested

Signature of Treatment Team Psychiatrist	Print Name Signed	Date
Signature of Unit Chief	Print Name Signed	Date

Appendix B 23: (OMH 496)

NOTICE OF MEETING RE APPLICATION FOR CHANGE IN STATUS / PRIVILEGES

			Patient s Name (Last First, M.I.)	
			"C" No.	Unit/Ward No.
			Facility Name	
FROM	Hospital Forsensic Committee	Name of Contract	Telephone	Date
TO	Name		Address	
TO	Name		Address	
TO	Name		Address	

A meeting will be held to consider whether the patient named above can be:

☐ granted unescorted furlough ☐ discharged ☐ transferred

☐ granted escorted furlough

☐ conditionally released ☐ converted to civil status ☐ returned to custody of court

The meeting will be held at:

Date	Time	Location

You have the right to appear at the meeting and present arguments for such change in status/privileges. The patient has the right to be represented at the meeting by the Mental Health Information Service or by an attorney or advocate of your choice.

A copy of this notice is also being sent to the Mental Health Information Service.

MENTAL HEALTH INFORMATION SERVICE

The Mental Health Information Service, a court agency independent of this facility, can provide you, and others acting in your behalf, with protective service, assistance and information with regard to your hospitalization. You have a right to a court hearing and a right to be represented by a lawyer.

You, or someone acting in your behalf, may call or write directly to the Mental Health Information Service or request that a member of the hospital staff contact the service for you.

The address and phone number of the Mental Health Information Service for this hospital is:

I HAVE READ, OR HAD READ TO ME, AND UNDERSTAND THE CONTENTS OF THE ABOVE NOTICE.

Patient's Signature or Mark — Date

THE ABOVE PATIENT HAS BEEN GIVEN A COPY OF THIS NOTICE.

Staff Physician — Date

Appendix B 24: (OMH 497)

Form OMH 497 (8-80) STATE OF NEW YORK—OFFICE OF MENTAL HEALTH

NOTICE OF CHANGE IN STATUS/PRIVILEGES

(CPL 730)

Patient's Name (Last, First, M.I.)

C No. | Unit/Ward No.

Facility Name

A.

Patient's Status (check only one)

☐ CIVIL INPATIENT (Originally admitted Pursuant to Sec. 730 C.P.L.)
☐ ORDER OF RETENTION Pursuant to Sec. 730.50 C.P.L.
☐ FINAL ORDER OF OBSERVATION Pursuant to Sec. 730.40(2), C.P.L.
☐ TEMPORARY ORDER OF OBSERVATION Pursuant to Sec. 730.40(2), C.P.L.
☐ ORDER OF COMMITMENT Pursuant to Sec. 730.50 C.P.L.

FROM	Deputy Director Clinical	Name	Telephone	Date
TO	District Attorney of County of Commitment	Address		
TO	Superintendent of State Police	Address	State Office Bldg. Campus Public Security Bldg. Albany, N.Y. 12226	
TO	Local Sheriff (Where facility is located)	Address		
TO	Local Police (Where facility is located)	Address		
TO	Patient's Attorney	Address		
TO	Persons Who May Be In Danger	Address		
TO	Court Designee (If Applicable)	Address		
TO	Family or Relative	Address		
TO	Other (List)	Address		
TO	Other (List)	Address		

The patient identified above will be granted one of the following starting on _____ (Date):

☐ CONDITIONAL RELEASE
☐ DISCHARGE
☐ TRANSFER
☐ CONVERT TO CIVIL STATUS
☐ UNESCORTED FURLOUGHS — Describe nature and duration
☐ ESCORTED FURLOUGH — Describe nature and duration

B. TO: DIRECTOR OF FORENSIC SERVICES 44 Holland Avenue, Albany, N.Y. 12229

The change in status/privileges indicated above was:

☐ Effected on Mo. Day Yr.
☐ Denied (Explain Below)

Comments

Date | Signature

Appendix B 25: (119 DMH)

Order of Transfer

[redacted]

(Pursuant to Section 29.11 of the Mental Hygiene Law and
Part 17 of the Regulations of the Department of Mental Hygiene)

[redacted]

93-31

A written request to this department having been made for the transfer of

[redacted]

a patient/resident at [redacted]

and the reasons for such transfer being satisfactory, and the Mental Health Information Service having been given notice of the proposed transfer, it is hereby ordered that the director of said facility discharge said patient/resident for transfer to

[redacted]

and that the director of the latter facility receive said patient/resident for treatment upon the presentation of this original order, together with the original admission paper and case record.

FOR THE COMMISSIONER

By [redacted]
(Signature)

[redacted]
(Print Name)

Executive Director
(Title)

[redacted]
(Location) (Date)

Appendix B 26: (324 (ADM)

Form 324 ADM (MH) (2-85)

State of New York
OFFICE OF MENTAL HEALTH

Record System Notification

(Clinical Record System)

Article 6-A of the Public Officers Law, entitled the Personal Privacy Protection Law, requires that you be notified of the following facts when information which will be maintained in a record system is collected from you

Section 33.13 of the Mental Hygiene Law requires that a clinical record be maintained for all patients receiving services from the Office of Mental Health. The maintenance of a clinical record system allows the Office of Mental Health to carry out the following activities:

- Deliver quality mental health care and treatment and related services;
- Manage resources necessary to operate the agency;
- Comply with laws, regulations and professional standards of all regulatory and accrediting bodies;
- Assist you in obtaining financial and medical assistance to which you may be entitled; and
- Bill for services rendered.

This information may be used for statistical and research purposes, however, identifying information will be kept confidential and will not be released except as authorized by law.

While failure to provide personal information will not jeopardize your receipt of treatment, it may interfere with the Office of Mental Health's ability to provide the most appropriate care or to conduct the other activities listed above

If you have any questions please contact the member of your treatment team listed below or any member with whom you feel comfortable.

Name: _____

Title: _____

Address: _____

Telephone: _____

A clinical record system notification form was given to the patient.

_____ _____
Staff Signature and Title Date

Record System Notification (Clinical Record System)	**Patient's Name (Last, First, M.I.)**	**"C" No.**

Appendix B 27: (401 ADM)

AN IMPORTANT MESSAGE from MEDICARE or CHAMPUS/CHAMP VA for Admissions to Non-PPS Hospitals and Hospital Units

The information in this mess[illegible] currently entitled to Medicare or Champus/ChampVA benefits o[illegible]

Receipt of this message and your [illegible] your rights as detailed in the booklet *"Rights of Inpatients,"* the "Notice [illegible] other materials presented to you at the time of admission.

ACKNOWLEDGMENT OF RECEIPT—[illegible] my receipt of this Message on _____ and does [illegible]

Signature of beneficiary or person acting on behalf of [illegible] Representative signature

YOUR RIGHTS WHILE YOU ARE A MEDICARE OR CHAMPUS/CHAMPVA HOSPITAL PATIENT

- **YOU HAVE THE RIGHT** to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to federal law, your discharge date must be determined solely by your medical needs, not by Medicare or Champus/ChampVA payments.
- **YOU HAVE THE RIGHT** to be fully informed about decisions affecting your Medicare or Champus/ChampVA coverage and payment for your hospital stay and for any post-hospital services.
- **YOU HAVE THE RIGHT** to request a review by a Peer Review Organization of any written Notice of Non-coverage that you receive from the hospital stating that Medicare or Champus/ChampVA will no longer pay for your hospital care. Peer Review Organizations (PROs) are groups of doctors who are paid by the Federal Government to review medical necessity, appropriateness and quality of hospital treatment furnished to Medicare or Champus/ChampVA patients. The phone number and address of the PRO for your area are:

ISLAND PEER REVIEW ORGANIZATION, INC. (I PRO)
1979 Marcus Avenue, First Floor
Lake Success, New York 11042
800-446-2447

TALK TO YOUR DOCTOR ABOUT YOUR STAY IN THE HOSPITAL

You and your doctor know more about your condition and health needs than anyone else. Decisions about your medical treatment should be made between you and your doctor. If you have any questions about your medical treatment, your need for continued hospital care, your discharge, or your need for possible post-hospital care, don't hesitate to ask your doctor. The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON

Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. This notice is called a "Notice of Noncoverage." You must have this Notice of Noncoverage if you wish to exercise your right to request a review by the PRO.

The notice of Noncoverage will state either that your doctor or the PRO agrees with the hospital's decision that Medicare or Champus/ChampVA will no longer pay for your hospital care.

If the hospital and your doctor agree, the PRO does not review your case before a Notice of Noncoverage is issued. But, the PRO will respond to your request for a review of your Notice of Noncoverage and seek your opinion. You cannot be made to pay for your hospital care until the PRO makes its decision, if you request the review by noon of the first work day after you receive the Notice of Noncoverage.

(Continued on back of sheet)

Appendix B 28a: (154 MED)

Form 154 MED (MH) (12-88)

OFFICE OF MENTAL HEALTH

NURSING ASSESSMENT

Patient's Name (Last, First, M.I.) "C" No.

Name, Address and Phone Number of Person to Contact in Case of Emergency

Sex Date of Birth

Facility Name Unit/Ward No.

Part I — Initial Assessment — Data Collection *(Obtain data from Patient/Family/Concerned Others and Prior Case Record)*

A. General Characteristics:

1. **Identifying Data:**
   - a. Age
   - b. Sex
   - c. Height
   - d. Weight
   - e. Hair Color
   - f. Eye Color
   - g. complexion: light ☐ medium ☐ dark ☐

2. **Overall Appearance — Grooming/Hygiene:** Good ☐ Fair ☐ Poor ☐

3. **Patient Smokes:** Yes ☐ No ☐

B. Physical Status:

1. **Vital Signs:**
   Blood Pressure: Pulse: Temperature: Respiration:

2. **Skin:**

	NO	YES	LOCATION/DESCRIPTION
a. Bruises	☐	☐	
b. Rashes	☐	☐	
c. Scars	☐	☐	
d. Other *(specify)*	☐	☐	

3. **Date of Last Menstrual Period:**

Pain or other difficulties NO ☐ YES ☐
(If YES describe)

4. **Diet (Requirements/Restrictions):**

	NO	YES	
a. Restrictions	☐	☐	
b. Assistance Needed	☐	☐	

c. Last Meal *date/time*

5. **Sleep Pattern:**
   - a. Time Patient Usually Retires
   - b. Time Patient Usually Arises
   - c. Problems *(describe)* NO ☐ YES ☐

6. **Elimination:**
   - a. Usual Frequency of Bowel Movements
   - b. Urine NO YES
     - • Incontinent ☐ ☐
     - • catheter ☐ ☐
     - • other *(describe)* ☐ ☐

7. **Assistive/Safety Devices; Does the Patient Usually Use:**

	NO	YES		NO	YES
a. Glasses/ Contact Lenses	☐	☐	e. Pacemaker	☐	☐
b. Dentures	☐	☐	f. Cane, Walker	☐	☐
c. Hearing Aid	☐	☐	g. Crutches, Wheelchair	☐	☐
d. Ostomy Device	☐	☐	h. Other	☐	☐

(specify)

Appendix B 28b: (154 MED)

State of New York
OFFICE OF MENTAL HEALTH

NURSING ASSESSMENT

Patient's Name (Last, First, M.I.)

Part I — Initial Assessment — Data Collection (Cont'd.) *(Obtain data from Patient/Family/Concerned Others and Prior Case Record)*

B. Physical Status (Cont'd.)

8. Which of the Following Best Describes the Patient's Ability to Walk:

a. Fully Independent ☐
b. Unsteady ☐
c. Uses Cane or Walker ☐
d. Walks Only with Staff Assistance ☐
e. Uses Wheelchair
—Independently ☐
—Must be Pushed ☐
f. Chairfast ☐
g. Needs Posey Support ☐
h. Bedfast ☐

9. Communication/Sensory Problems ***(If YES, describe):***

	NO	YES			NO	YES	
a. Visual/Eyesight	☐	☐	_____	c. Language	☐	☐	_____
b. Hearing	☐	☐	_____	d. Other	☐	☐	_____
				(specify) _____			

10. Allergies ***(If YES, complete all items):***

	NO	YES	ALLERGIN	HOW MANIFESTED	HOW MANAGED
a. Food	☐	☐	_____	_____	_____
b. Medication	☐	☐	_____	_____	_____
c. Other *(specify)* _____	☐	☐	_____	_____	_____

11. Other Physical Complaints/Problems:

Signature of Person Completing this Part	Title	DATE		
		Month	Day	Year

Appendix B 28c: (154 MED)

NURSING ASSESSMENT	Patient's Name (Last, First, M.I.)

Part II Registered Nurse's Assessment and Patient Summary

A. Consider Information From Part I and the Following Information From The *Screening/Admission Note*, Form 139 MED:

1. Source of Referral
2. Reasons for Referral
3. Family Composition and Living Arrangements
4. Past and Current Psychiatric, Physical/Medical, Alcohol/Substance Abuse and Other Significant History
5. Use of Medication, Drugs and Other Substances.

B. Priority Patient Needs/Problems To Be Addressed by Nurses During This Hospitalization *(Address any identified problems from Part I)*

1. Special Patient Management Considerations *(Risk of harm to self or others)* *(If YES, describe)*

	NO	YES	
a. Elopement Risk	☐	☐	_____
b. Suicide Risk	☐	☐	_____
c. Assaultive Risk	☐	☐	_____
d. Homicide Risk	☐	☐	_____

2. Psychiatric/Emotional *(Problems Related to Attitudes, Goals, Adjustments to Hospitalization, Current Life Circumstances)*

3. Physical and Functional *(Dietary, Ambulation, Medical Diagnosis with Nursing Care Implications)*: *(If YES, describe)*

	NO	YES	
a. Unusual Sleeping Pattern	☐	☐	_____
b. Unusual Eating Pattern	☐	☐	_____
c. Other	☐	☐	_____

4. Educational/Needs of Patient/Family to Achieve Highest Level of Self Care Possible:

5. Psychosocial Needs—support system; ethnic/cultural/religious issues:

6. Environmental and/or Equipment Needs:

7. Discharge Planning Needs Required for Highest Level of Patient Self Care Possible:

Appendix B 28d: (154 MED)

Form 154 MED (MH) (12-88) page 4

OFFICE OF MENTAL HEALTH

NURSING ASSESSMENT	Patient's Name (Last, First, M.I.)

Part II Registered Nurse's Assessment and Patient Summary (Cont'd.)

C. Patient Capabilities and Limitations to be Considered When Addressing Patient Needs/Problems and Formulating Nursing Goals ***(Ability to understand/comprehend, degree of patient participation, history of independent functioning, etc.):***

D. Summary/Formulation of Plan of Care ***(Record Plan of Care below or in another place as indicated by Facility Policy):***

Signature of Registered Nurse	Title	DATE		
		Month	Day	Year

Appendix B 29a: (99 MED)

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

INSTRUCTIONS

1 Complete Examination Procedure (reverse side) *before making ratings*
2 Enter the following
- a Current psychotherapeutic medication and corresponding dosages
- b The rating that reflects the highest severity level observed in each area
- c Description of abnormal or extreme normal movements
- d Signature and title of rater
- e Date of examination
- f Status of patient's education and
- g Signature of treating physician and date

RATING SCALE	0 NONE 1 MINIMAL MAY BE EXTREME NORMAL 2 MILD 3 MODERATE 4 SEVERE	SEVERITY RATING (Circle Below)
FACIAL AND ORAL MOVEMENTS	1 **Muscles of Facial Expression** e g , movements of forehead, eyebrows, periorbital area, cheeks, include frowning, blinking, smiling, grimacing	0 1 2 3 4
	2 **Lips and Perioral Area** e g , puckering, pouting, smacking	0 1 2 3 4
	3 **Jaw** e g , biting, clenching, chewing, mouth opening, lateral movement	0 1 2 3 4
	4 **Tongue** Rate only increase in movement both inside and outside of mouth, NOT inability to sustain movement	0 1 2 3 4
EXTREMITY MOVEMENTS	5 **Upper (arms, wrists, hands, fingers)** Include choreic movements, (i e , rapid, objectively purposeless, irregular, spontaneous), athetoid movements (i e , slow, irregular, complex, serpentine) Do NOT include tremor (i e , repetitive, regular, rhythmic)	0 1 2 3 4
	6 **Lower (legs, knees, ankles, toes)** e g , lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot	0 1 2 3 4
TRUNK MOVEMENTS	7 **Neck, shoulders, hips** e g , rocking, twisting, squirming, pelvic gyrations	0 1 2 3 4
GLOBAL JUDGEMENT	8 **Severity** of abnormal movements	0 1 2 3 4
	9 **Incapacitation** due to abnormal movements	0 1 2 3 4
	10 **Patient's awareness** of abnormal movements *Rate only patient's report*	No awareness 0 Aware, no distress 1 Aware, mild distress 2 Aware, moderate distress 3 Aware, severe distress 4
DENTAL STATUS	11 Current problems with teeth and/or dentures?	No 0 Yes 1
	12 Does patient usually wear dentures?	No 0 Yes 1

Description of abnormal movement or other comments:

Current Psychotherapeutic Medication and Dosage:

Status of Patient Education regarding Medication/Neuroleptic Therapy: *(To be completed by Treating Physician)*

Physician Signature:

Date

Rater Signature and Title and Date of Examination:

Signature

Title

Date

AIMS EXAMINATION PROCEDURE

Either before or after completing the Examination Procedure observe the patient unobtrusively, at rest (e g , in waiting room)

The chair to be used in this examination should be a hard, firm one without arms Patients should be asked to remove shoes so that toe movements can more readily be observed

1 Ask patient whether there is anything in his/her mouth (i.e , gum, candy, etc) and if there is, to remove it

2 Ask patient about the **current** condition of his/her teeth Ask patient if he/she wears dentures Do teeth or dentures bother patient **now?**

3. Ask patient whether he/she notices any movements in mouth, face, hands, or feet If yes, ask to describe and to what extent they **currently** bother patient or interfere with his/her activities

4. Have patient sit in chair with hands on knees, legs slightly apart, and feet flat on floor (Look at entire body for movements while in this position)

5 Ask patient to sit with hands hanging unsupported over knees (Observe hands and other body areas)

6 Ask patient to open mouth (Observe tongue at rest within mouth) Do this twice

7. Ask patient to protrude tongue (Observe abnormalities of tongue movement) Do this twice

8 Ask patient to tap thumb, with each finger, as rapidly as possible for 10-15 seconds, separately with right hand, then with left hand (Observe facial and leg movements)

9 Ask patient to stand up (Observe in profile Observe all body areas again, hips included)

10 Ask patient to extend both arms outstretched in front with palms down (Observe trunk, legs, and mouth)

11 Have patient walk a few paces, turn, and walk back to chair (Observe hands and gait) Do this twice

After conducting the examination, rate abnormal involuntary movements in each of the body areas using the following scale

0 - none

1 - minimal, may be extreme normal

2 - mild

3 - moderate

4 - severe

Appendix B 30a: (TPC 512)

Form TPC [illegible] Rev 19[illegible] State [illegible]
Office of Mental [illegible]

PSYCHIATRIC ASSESSMENT

INSTRUCTIONS:

- Complete within 2 days of admission
- Update during the course of treatment to document new information which is of ongoing importance to treatment
- Enter the following.

ADMISSION DATA

Date of Admission:	Date of Birth:	Informants/Reliability:	
Legal Status:	**Religion:**	**Marital Status:**	**Ethnicity:**

Chief Complaint: *(In patient's own words)*

HISTORY DATA

History of Present Illness: *(Include details of crisis precipitating admission emphasizing behavior, attempts made to keep patient in community and why they failed, e.g. non-compliance, substance abuse, family dysfunction, etc.)*

Appendix B 30b: (TPC 512)

State of New York
Office of Mental Health

PSYCHIATRIC ASSESSMENT	Patient's Name (Last, First, M.I.)

HISTORY DATA (Continued)

Past Psychiatric History: *(Include prior diagnoses/admissions with dates, reasons, treatments, etc.)*

Family Psychiatric History:

Educational History: *(Include last grade attended, reasons for leaving)*

Substance Abuse History: *(Include prior treatments)*

Work History:

Appendix B 30c: (TPC 512)

PSYCHIATRIC ASSESSMENT	Patient's Name (Last, First, M.I.)

HISTORY DATA (Continued)

Summary of Medical History: *(Include present illnesses and treatments)*

Course of Treatment: *(For yearly renewal, update to LAST YEARLY Psychiatric Assessment)*

MENTAL STATUS

General Appearance:

Attitude: *(Cooperative/Uncooperative/Guarded/Avoidant/Seductive, etc.)*

Appendix B 30d: (TPC 512)

PSYCHIATRIC ASSESSMENT	Patient's Name (Last, First, M.I.)

MENTAL STATUS (Continued)

General Behavior: *(Describe psychomotor activity during examination, e.g. responds to internal stimuli, eye contact, etc.)*

Speech:

Rate: *(Normal/Slow/Mute/Rapid)*

Rhythm: *(Normal/Abnormal)*

Content: *(Aphasic-Receptive/Expressive/Conductive/Paraphasics/Word Salad/Clangs/Echolia, etc.)*

Sensorium (Level of Consciousness): *(Fully awake/Normally responsive to environment/Lethargic/Comatose/Fluctuating)*

Mood: (General Affective State): *(Euthymic/Elated/Euphoric/Dysthymic)*

Stability: *(Labile/Stable)*

Affect (Immediate Affective State): *(Happy/Elated/Laughing, etc.)*

Stability: *(Labile/Stable)*

Congruent to Content/Not:

Appendix B 30e: (TPC 512)

PSYCHIATRIC ASSESSMENT	Patient's Name (Last, First, M.I.)

MENTAL STATUS (Continued)

Thought Content: *(Hallucinations/Delusions/Illusions/Ideas of Reference [Describe each in terms specific to this patient])*

Thought Process-Structure: *(Logical and Organized/Circumstantial/Tangential/Disorganized [Describe each in terms specific to this patient])*

Rate: *(Paucity/Normal/Flight of Ideas):*

Orientation:

Time: *(Season/Year/Month/Day/Next Holiday)*

Place: *(Type/Exact name)*

Person: *(Who examiner and others are)*

Memory:

Attention: *(Immediate Recall)* *(Digit span/Serial 7's)*

Short Term: *(3 object/1, 3, 5, 10 minutes)*

Long Term: *(Personal/Non-Personal)*

Appendix B 30f: (TPC 512)

Form TPC 512 Rev. 4/91 Page 6 — Office of Mental Health

PSYCHIATRIC ASSESSMENT	Patient's Name (Last, First, M.I.)

MENTAL STATUS (Continued)

Intellectual/Function: *(Average/Above/Below)*
As evidenced by: (Vocabulary/Fund of Knowledge, etc.)

Insight: *(Include understanding of illness, consequences of actions)*

Judgment:

Impulse Control: *(Describe behavior supporting observation)*

Danger Profile: *(Suicidal or homicidal ideations, potentials for violence based upon behavior, etc.)*

Appendix B 30g: (TPC 512)

State of New York
Office of Mental Health

PSYCHIATRIC ASSESSMENT	Patient's Name (Last, First, M.I.)

CASE FORMULATION

PSYCHIATRIC PROBLEMS

MEDICAL PROBLEMS

Appendix B 30h: (TPC 512)

PSYCHIATRIC ASSESSMENT

Patient's Name (Last, First, M.I.)

STRENGTHS

DISABILITIES

PROGNOSIS

TREATMENT

OTHER COMMENTS

DSM III-R DIAGNOSIS ACCORDING TO AXES I-V

Indicate PRINCIPAL DIAGNOSIS by an "X" in the appropriate "O"
(CHECK EITHER AXIS I OR AXIS II — NEVER BOTH)

Axis I - Clinical Psychiatric Syndromes and Other Conditions

. . . .	O
. . . .	
. . . .	

Axis II - Personality Specific Developmental Disorders

. . . .	O
. . . .	
. . . .	

Axis III - Physical Disorders (ICD-9-CM Codes)

. . . .	
. . . .	
. . . .	

Physician's or Psychiatrist's Signature	Title	Date

Axis IV - Severity of Psychosocial Stressors

Stressor (s) _____

(Check only one)

1 ☐ None
2 ☐ Mild
3 ☐ Moderate
4 ☐ Severe
5 ☐ Extreme
6 ☐ Catastrophic
0 ☐ Inadequate information or no change in condition

Describe Stressor

_____

Duration *(Check one)*

☐ Predominantly Acute Event
☐ Predominantly Enduring Circumstances

Axis V - Global Assessment of Functioning

(Enter two digit scores from 01-90)

____ Current GAF Score

____ Highest GAF Score for Past Year

Appendix B 31: (42 MED)

State of New York
Office of Mental Health

PSYCHIATRIC ASSESSMENT SUPPLEMENT
Specific to:
Acquired Immune Deficiency Syndrome (AIDS)
and AIDS Related Complex

Patient's Name (Last, First, MI)

Sex

Facility Name

Complete assessment when indicated. Update during the course of treatment to document new information which is of ongoing importance to treatment.

INSTRUCTIONS:

Enter the following:

1. History and orientation of sexual relationships.
2. History of intravenous substance abuse.
3. History of contact with blood/body fluids from an individual with AIDS/ARCS.
4. Any AIDS specific or applicable abnormal physical or laboratory findings.
5. Any signs/symptoms of exacerbation of psychotic, personality disorder or other psychiatric disorders or conditions.
6. Patient's basic level of understanding of the illness.
7. Patient's capability and willingness to deal with the issues of counseling and testing.
8. Assessment of denial, apathy, anxiety, anger, depression, fear, etc. due to a nonspecific diagnosis, prognosis, and/or therapy.
   a. self image changes and/or disfigurement.
   b. concepts of death and dying.
   c. family and/or friends support, acceptance/nonacceptance. *Include a description of the family's support and level of acceptance.*
9. Patient's capability and willingness to comply with the recommendations of treating clinicians, (e.g. blood and body fluid precautions, sexual activity).
10. Psychiatric and physical disorders or conditions relevant to understanding or management of the patient.
11. Any special treament issues.
12. The patient's strengths and disabilities.
13. Treatment recommendations, and
14. Signature, title, and date

Appendix B 32a: (145 MED)

Form 145s MED (MH) (8-81)

OFFICE OF MENTAL HEALTH

SOCIAL ASSESSMENT

Patient's Name (Last, First, M.I.) | ID No.

INSTRUCTIONS

- Complete as soon as possible after admission
- Update during the course of treatment to document new information which is of ongoing importance to treatment
- Enter the following and, when applicable, name(s) and relationship of informant(s)

Facility Name | Unit/Ward No.

1 Patient/Family History

A Childhood History

For patients under 18, provide a developmental assessment, which includes the following and other relevant elements described in terms of chronological age: (1) Developmental history (prenatal to present), (2) Rate of progress, (3) Developmental milestones, (4) Developmental problems, and (5) Current age - appropriate developmental needs including a detailed appraisal of peer and group relationships and activities

B. Subsequent History

(1) Marital/psychosexual, (2) Military; (3) Legal (as appropriate)- include the extent to which the individual's legal situation will influence his or her progress in treatment and the urgency of the legal situation.

Form 145s MED (MH)(8-81)

Appendix B 32b: (145 MED)

OFFICE OF MENTAL HEALTH

SOCIAL ASSESSMENT	Patient's Name (Last, First, M.I.)

1 B Subsequent History (Continued)

C Current Environmental and Home Situation
(1) Constellation of the family and peer group, current living situation, and social, religious, ethnic, cultural, financial, emotional, and health factors (including the use of drugs and alcohol), and (2) Family expectations regarding the length of time and type of treatment required.

Appendix B 32c: (145 MED)

Form 145s MED (MH)(6-81)

STATE OF NEW YORK
OFFICE OF MENTAL HEALTH

SOCIAL ASSESSMENT	Patient's Name (Last, First, M.I.)

C. Current Environmental and Home Situation (Continued)

D. Family/Other History

Appendix B 32d: (145 MED)

SOCIAL ASSESSMENT	Patient's Name (Last, First, M.I.)

1. D. Family Other History (Continued)

2. Psychosocial assessment including patient's problems, strengths, and disabilities, and treatment recommendations

Signature	Title	Date

Appendix B 33: (143 MED)

143 MED (Rev. 4-81)

OFFICE OF MENTAL HEALTH

PSYCHOLOGICAL ASSESSMENT	Patient's Name (Last, First, M.I.) "C" No. Unit/Ward No. Facility Name

Complete assessment when indicated. Update during the course of treatment to document new information which is of ongoing importance to treatment.

INSTRUCTIONS

Enter the following:

1. History of psychological problems and prior psychotherapy
2. Direct observations and behavioral appraisal
3. Results of intellectual, projective, and personality tests (indicate procedures/instruments used)
4. Results of language, cognitive, self-help, and social-affective and visual-motor functioning evaluations
5. Patient's problems, strengths, and disabilities, and treatment recommendations
6. Signature, title, and date

Appendix B 34: (TPC)

PSYCHOLOGY DEPARTMENT

PSYCHOLOGICAL ASSESSMENT ☐

PSYCHODIAGNOSTIC TESTING ☐

NEUROPSYCHOLOGICAL TESTING ☐

SPANISH-SPEAKING TESTING ☐

Psychological interviews or testings can be valuable adjuncts to clarification of a patient's psychodynamics and/or differential diagnosis when these cannot otherwise be ascertained. In order to expedite your request for psychological services and to insure provision of the most efficient service to you and your patient, formulate questions specifically. Please fill out Form and return to Staff Psychologist who will forward it for approval to the Unit Supervising Psychologist.

Referring Person:_____ Name of Unit:_____

Date of Request:_____ Ward #:_____

Hospital #:_____

Patient's Name:_____ Date of Admission:_____

Date of Birth:_____

Reason for Request: (Include particular areas you wish evaluated - i.e., differential diagnosis, acting out potential, ego functioning, etc.)_____

_____

_____

_____

Has the patient been evaluated psychologically previously? Where, when? Are previous results in the chart?_____

_____

Provisional Diagnosis:_____

Does the patient speak English?_____ If not, what language(s) does he speak_____

Relevant Information: (i.e. Medication, Medical Intercurrent Diagnosis)_____

_____

☐ Approved (To be assigned to):_____ Date of Assignment:_____
(Print Name)

(To be supervised by):_____
(Print Name)

☐ Disapproved:_____

_____ Date:_____

_____
Signature of Unit Supervising Psychologist

_____
Print Name

A REPORT OF THE FINDINGS AND RECOMMENDATIONS WILL APPEAR IN THE MEDICAL CHART

(Rev. 1/13/86)

Appendix B 35a: (147x MED)

Form 147x MED (MH) (8-81)

OFFICE OF MENTAL HEALTH

ACTIVITIES ASSESSMENT

INSTRUCTIONS

- Complete as soon as possible after admission
- Update during the course of treatment to document new information which is of ongoing importance to treatment
- Enter the following

Patient's Name (Last, First, M.I.)	
"C" No.	Unit/Ward No.
Facility Name	

1 Current skills, talents, aptitudes, and cultural/recreational interests

2 Relevant life experiences including past and/or current utilization of leisure time

Appendix B 35b: (147x MED)

ACTIVITIES ASSESSMENT	Patient's Name (Last, First, M.I.)

2 Relevant life experiences (Continued)

3 Patient's problems, strengths, motivations, disabilities/limitations, and treatment recommendations

4 Signature	Title	Date

Appendix B 36: (TPC)

REHABILITATION SERVICES REFERRAL
[redacted] PSYCHIATRIC CENTER

NAME _____ HOSPITAL = _____
first last

HOSPITAL UNIT _____ CLINIC WARD _____ SOC. S. = _____

DATE OF BIRTH ___/___/___ SEX _____ DATE OF ADMISSION _____

CURRENT MEDICATION _____

SIDE EFFECTS _____

OTHER MEDICAL PROBLEMS (i.e. diabetes, epilepsy, etc.) _____

_____

WHAT BEHAVIOR DOES CLIENT EXHIBIT WHEN AND IF (S)HE BECOMES UPSET? _____

_____

_____

ARE DISCHARGE PLANS BEING MADE? IF SO, WHEN? WHERE? _____

_____

_____

WHO WILL PROVIDE FOLLOW-UP TREATMENT UPON DISCHARGE?

_____ EXTENSION _____

IF OUT-PATIENT: MEDICAID = _____

TYPE OF RESIDENCE: _____ ADDRESS _____

TELEPHONE =: _____ IN AN EMERGENCY CALL: _____

REASON FOR REHAB. REFERRAL _____

_____

HAS CLIENT BEEN INVOLVED IN AN ACTIVITY PROGRAM? _____
IF SO, SUBMIT A COMPLETED ACTIVITY THERAPY REPORT.

STAFF MEMBER MAKING REFERRAL _____ EXT. _____

PRIMARY THERAPIST _____ EXT. _____

DATE OF REFERRAL _____

N.B. THE TREATMENT PLAN MUST BE SUBMITTED AS PART OF THIS REFERRAL

6/78

Form 148x MED (MH) (8-81)

Appendix B 37a: (148x MED)

OFFICE OF MENTAL HEALTH

NUTRITIONAL ASSESSMENT

INSTRUCTIONS

- Complete acording to physician's order (A nutritional assessment is ordered for any patient on a modified diet)
- Update during the course of treatment to document new information which is of ongoing importance to treatment
- Enter the following

Patient's Name (Last, First, M.I.)

"C" No. **Unit/Ward No.**

Facility Name

1. Diet significant information as appropriate regarding
   a. medical diagnoses

   b. medications

   c. lab values

   d. vitamins food supplements

   e. patient's nutritional history

   f. patient's ability to masticate and swallow food

   g. patient's food preferences and habits

   h. patient's allergies

   i. patient's ability to purchase food

Appendix B 37b: (148x MED)

Form 148x MED (MH) 8-81)

OFFICE OF MENTAL HEALTH

NUTRITIONAL ASSESSMENT	Patient's Name (Last, First, M.I.)

1. Other relevant information from patient, family, nursing staff, and others

2. Current diet including caloric and nutrient content

Name of prescribing physician

3. Patient's problems, strengths, and disabilities, and treatment recommendations

Signature	Title	Date

Appendix B 38a: (146x MED)

Form 146x MED (MH-9-81)

STATE OF NEW YORK
OFFICE OF MENTAL HEALTH

VOCATIONAL ASSESSMENT

INSTRUCTIONS

- Complete assessment when indicated
- Update during the course of treatment to document new information which is of ongoing importance to treatment
- Enter the following

Patient's Name (Last, First, M.I.)	
"C" No.	Unit/Ward No.
Facility Name	

1 Vocational history

2 Educational history including academic and vocational training

Appendix B 38b: (146x MED)

Form "46x MED White-8"

OFFICE OF MENTAL HEALTH

VOCATIONAL ASSESSMENT	Patient's Name (Last, First, M.I.)

3 Description of the patient's past experiences with, and attitudes toward, work, present motivations or areas of interest, and possibilities for future education, training, and employment

4 Patient's problems, strengths, and disabilities, and treatment recommendations

5 Signature	Title	Date

Appendix B 39a: (157x MED)

EDUCATIONAL ASSESSMENT

INSTRUCTIONS

Complete assessment within thirty days of admission for inpatients under 21 years of age, who do not have a high school diploma/equivalency, and otherwise when indicated. Update during course of treatment to document new information which is of ongoing importance to the patient's academic status

Patient's Name (Last, First, M.I.)

"C" No. **Unit/Ward No.**

Facility Name

1 After reviewing the results of any assessments, tests, reports and other information obtained from the school/other sources, integrate and enter relevant information regarding the following to the degree necessary to describe the patient's academic history and status in relation to developmental level, chronological age, sex and special handicaps

a. School history

(1) Schools attended and related educational services provided, including dates;

(2) Placement (grade and program type), pattern of attendance, progress (instructional and functional levels) and relations with peers and teachers

b. Tests and achievement levels (as available)

(1) Testing instruments utilized and modifications, if any, in standard testing procedures required for the patient;

(2) Mastery: present level of achievement in subject areas.

(3) Intelligence and cognitive factors.

Appendix B 39b: (157x MED)

EDUCATIONAL ASSESSMENT	Patient's Name (Last, First, M.I.)

c Present motivations and attitudes toward school.

d Vocational training and previous work history (If under 21, complete as appropriate.)

(1) History.

2) Attitudes, motivations, interests and future possibilities.

2 Describe the patient's problems, strengths and disabilities (include consideration of relevant information regarding motor and perceptual functioning, verbal and written expressive and receptive functioning and ADL skills/deficits), and enter recommendations regarding the academic components of the education program, including adaptive devices and special equipment required by the patient to participate

Signature	Title	Date

Appendix B 40: (149 MED)

Form 149 MED MH 8-85

STATE OF NEW YORK
OFFICE OF MENTAL HEALTH

ASSESSMENT/ASSESSMENT CONTINUATION SHEET

Type of Assessment

Patient's Name (Last, First, M.I.)

"C" No.

Unit/Ward No.

Facility Name

Appendix B 41a: (150 MED)

COMPREHENSIVE TREATMENT PLAN
(Discharge Plan)
Part I

Patient's Name (Last, First, M.I.)		
	"C" No.	Unit/Ward No.

Date Prepared	Next Review Date	Primary Therapist	Facility Name

INSTRUCTIONS

1 Begin preparation of Part I of Comprehensive Treatment Plan as soon as information on discharge planning is available Update whenever new information obtained
2 Prepare Parts I II III of the Comprehensive Treatment Plan within 14 days of admission to an inpatient day treatment continuing treatment or day training program and within 11 visits or 90 days whichever occurs first of admission to a clinic program
3 Enter revisions/additions to Part I as appropriate Date and sign name and title for each revision addition indicate the rationale for the revision addition in the Progress Notes or Periodic Treatment Plan Review
4 The physician signs or countersigns for the entire Treatment Plan (Parts I II III) at the end of Part III (Treatment Team Conference Note)

A PARTICIPATION IN TREATMENT PLAN

- Patient participated in preparation of this plan on _____/_____/_____
- Family or significant other(s) participated in the preparation of this plan on _____/_____/_____

_____
Enter name(s) and relationship to patient.

_____

- Describe reason(s) for nonparticipation and attempts to obtain participation of patient, family or significant other(s)

_____

_____

_____

B ENTER NAMES AND TITLES OF STAFF WHO PARTICIPATED IN PREPARATION OF TREATMENT PLAN

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

C TENTATIVE RELEASE/DISCHARGE DATE (Revise as appropriate.)

D RELEASE DISCHARGE CRITERIA

Goal Nos	1 Describe changes in the patient's condition, situation, or functioning which must occur in order for the patient to be released/discharged from the facility or program Indicate goals, described in Part II of this Plan, which relate to these changes

Appendix B 41b: (150 MED)

COMPREHENSIVE TREATMENT PLAN (Discharge Plan) Part I	Patient's Name (Last, First, M.I.)

2 Service Needs Describe/indicate the following
a Patient's expected needs/ on release/discharge in each of the following areas
b Tentative plans to meet needs (Enter specific arangements as they are made), and

3 Individual and/or agency who will be responsible for each need after release/discharge (Enter as they are identified)

Living Arrangements

Health (including medication and diet)

Psychiatric (including medication)

Economic

Vocational Training/Education

Social (including leisure activities)

Family-Other Support

Self-Care

Transportation

Other-Specify

PAGE

Appendix B 42a: (150A MED)

COMPREHENSIVE TREATMENT PLAN
(Goal Plan)
Part II

Prepare a separate Goal Plan for for each goal

INSTRUCTIONS

Enter the following

1. The behavior, condition, or situation requiring action: the degree to which it interferes with functioning, and circumstances under which it is observed
2. Number and description of the goal (desired change)
3. For each objective
   a. ID letter
   b. Description of objective
   c. Date established.
   d. Target date (Date objective is expected to be attained)
   e. Treatment method(s) and related information
4. Revisions/additions to the goal, objectives, and methods
5. Signature, title, and date for each entry

Current Patient Behavior/Condition/Situation Requiring Goal **(Describe degree to which it interferes with functioning; circumstances under which it is observed; and related patient strengths/assets which may be used to address it.)**

Goal

NO.

Date Code Attained (A) Cancelled (C) Revised (R)

ID LETTER	Objective(s)	Date Established	Target Date	Date/Code Attained(A) Cancelled (C) Revised (R)	Method(s) (Therapy/Staff Action) Indicate expected start date; duration; frequency; location, if off unit; and responsible person(s).

Appendix B 42b: (150A MED)

COMPREHENSIVE TREATMENT PLAN
Part II

Patient's Name (Last, First, M.I.)

ID LETTER	Objective(s) Continued	Date Established	Target Date	Date/Code Attained (A) Cancelled (C) Revised (R)	Method(s) (Therapy/Staff Action) Indicate expected start date; duration; frequency; location, if off unit; and responsible person(s).

PAGE ____

Appendix B 43: (150B MED)

Form 150B MED MH: 8-81

STATE OF NEW YORK
OFFICE OF MENTAL HEALTH

COMPREHENSIVE TREATMENT PLAN
(Treatment Team Conference Note)
Part III

Patient's Name (Last, First, M.I.)

"C" No. **Unit/Ward No.**

Facility Name

INSTRUCTIONS
1. Document the treatment team's rationale for the Treatment Plan
2. Physician signs or countersigns for the entire Treatment Plan (Parts I, II, III) at the end of this Note

Appendix B 44: (151 MED)

PERIODIC TREATMENT PLAN REVIEW

Date Prepared	Next Review Date	Primary Therapist

INSTRUCTIONS

1. Review the Comprehensive Treatment Plan as follows:
   (a) Inpatient, day treatment, continuing treatment, or day training programs:
   — Within 40 days after admission to program
   — At least every 60 days for remainder of first year; and
   — At least every 90 days after the first year
   (b) Clinic treatment program:
   — Every 3 months after formulation of the Comprehensive Treatment Plan or every 20 visits, whichever occurs first, for the first year; and
   — Every 6 months or every 20 visits, whichever occurs first after the first year
2. Enter the following:
   (a) Patient's progress and current status in meeting the goals and objectives of his/her treatment plan. (Enter the goal numbers and objective letters next to corresponding information.)
   (b) New problems, strengths, and disabilities.
   (c) Efforts made to address expected needs on release/discharge
   (d) Rationale for continuation of or revisions/additions to goals, objectives, time frames, treatment methods, and/or release/discharge plans indicated by the patient's progress, new information. (Enter revisions/additions to Part I or II of the Comprehensive Treatment Plan as indicated.)
3. Physician signs or countersigns at the end of the Review

A PARTICIPATION IN TREATMENT PLAN REVIEW

- Patient participated in review of this plan on _____/_____/_____
- Family or significant other(s) participated in review of this plan on _____/_____/_____

_____
Enter name(s) and relationship to patient

_____

- Describe reason(s) for nonparticipation and attempts to obtain participation of patient, family or significant other(s)

_____

_____

_____

B ENTER NAMES AND TITLES OF STAFF WHO PARTICIPATED IN REVIEW OF TREATMENT PLAN

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Appendix B 45a: (TPC-PCMR)

PATIENT CARE MONITORING CONSULTATION

PART I - ADMINISTRATIVE DATA

DATE: _____

UNIT/DEPARTMENT: _____

STAFF ATTENDANCE: _____

CHIEF OF SERVICE/DEPARTMENT HEAD/DESIGNEE:

_____ TITLE _____

CONSULTANT (S):

_____ TITLE _____

_____ TITLE _____

_____ TITLE _____

PATIENT: _____

CONSECUTIVE #: _____ PATIENT'S UNIT/WARD: _____

_____ TITLE

_____ TITLE

_____ TITLE

_____ TITLE

_____ TITLE

_____ TITLE

_____ TITLE

_____ TITLE

PART II - CURRENT PROBLEM AND DURATION:

PART III - RATIONALE FOR CASE REVIEW:

PART IV - BRIEF HISTORY AND COURSE IN HOSPITAL: (Include complaint on admission, subsequent problems, summary of course of past treatment provided, present condition and treatment).

Appendix B 45b: (TPC-PCMR)

PART IV - BREIF HISTORY AND COURSE IN HOSPITAL: (Continued)

PART V - CONSULTANT (S) RECOMMENDATION (S) :

PART VI - COMMENTS BY UNIT CHIEF: (Include provisions for supervision of staff and follow-up consultant (s) recommendation (s), if followed, and, if not, reason for not doing so).

CONSULTANT (S) SIGNATURE:

TITLE

TITLE

TITLE

CHIEF OF SERVICE/DEPARTMENT HEAD SIGNATURE

TITLE

Copy to:
Clinical Director
Asst. Director-Quality Assurance
Treatment Team Leader
Unit Chief/ OPD Coordinator (If appropriate)

Appendix B 46: (TPC 52)

TPC-52 (8-86) Rev.

Patient's Name (Last, First, MI)

"C"

Unit/Ward & No.

Facility Name

[redacted]

MEDICAL SUMMARY SHEET

Date of Birth: _____

Sex: _____

Comm. Hosp. & No.: _____

_____

Medicaid No: _____

Medicare No: _____

Blood and Body Fluid Precautions: Yes ☐ No ☐

Major Medical Diagnoses/Unresolved Problems:

1. 4.

2. 5.

3. 6.

Major Psychiatric Diagnoses:

1.

2.

Significant Past Medical/Surgical History:

Date of Last Tetanus Booster:

Date and Result of Last Tuberculin Test:

Allergies:

Other Significant Medical Information:

_____ _____

Signature Date

Appendix B 47a: (34 MED)

PHYSICAL EXAMINATION AND ASSESSMENT

Patient's Name (Last, First, M.I.) | C No

Purpose
Admission | Annual | Discharge | Other
Readmission | Transfer | Conditional Release | Specify

Sex | Date of Birth

Source of History: | Estimate of Reliability/Accuracy: | Exam Date (Mo. / Day / Yr)

Facility Name | Unit/Ward No

I. **Comprehensive Patient History** *(Any information not available at the time history is taken should be obtained as soon as possible. If it cannot be obtained, describe reason)*

A. Chief Complaints

B. History of Present Illness

C. Past Medical History *(Include SEXUAL HISTORY, significant physical problems, previous surgery and hospitalizations)*

D. Family Medical History

E. Immunization History

F. Diet *(Special or other)*

G. Current Prescribed Medications

H. Substance Use/Abuse *(Include history/current use of alcohol, drugs, tobacco and caffeine)*

I. Allergies

Appendix B 47b: (34 MED)

PHYSICAL EXAMINATION AND ASSESSMENT	Patient's Name (Last, First, M.I.)	"C" No.

I. Comprehensive Patient History *(Continued)*

J. Review of Systems *(For each system below, indicate past and current health problems, relevant symptomatology and other chronic complaints. For pertinent findings check "YES" box and describe in space below; if there are none, check "NO" box.)*

	YES	NO		YES	NO
1. Head, Eyes, Ears, Nose, Mouth, Throat and Neck	☐	☐	7. Musculoskeletal System and Connective Tissue	☐	☐
2. Respiratory System	☐	☐	8. Nervous System and Sense Organs	☐	☐
3. Circulatory System	☐	☐	9. Endocrine, Nutritional, Metabolic and Immune Systems	☐	☐
4. Digestive System	☐	☐	10. Blood and Blood Forming Organs (give blood type, if known)	☐	☐
5. Skin and Subcutaneous Tissue	☐	☐	11. Symptoms, Signs and Other Ill defined conditions, including speech impediments, weight loss, fatigue, swollen glands	☐	☐
6. Genito-urinary System	☐	☐			

Signature of Person Completing Form if Other than Examining Physician	Print Name Signed	Title	Date Signed (Mo / Day / Yr)
Signature of Physician	**Print Name Signed**	**Title**	**Date Signed (Mo / Day / Yr)**

Appendix B 47c: (34 MED)

PHYSICAL EXAMINATION AND ASSESSMENT	Patient's Name (Last, First, M.I.)	"C" No.

II. Physical Examination

Color of Hair	Color of Eyes	Ethnicity/Race	Height	Weight

Vital Signs: Temperature	Pulse	Respiration	Blood Pressure

A. General Description

B. Skin and Subcutaneous Tissue *(Color, Turgor, Elasticity)*

Skin: Hair:

Nails:

C. Lymph Nodes

D. Head

E. Eyes *(Control, Sclera, Conjunctiva, Pupils, Funduscopic Exam)*

Vision: without glasses / with glasses

Glaucoma Test: ☐ Ordered ☐ Done ☐ N/A Rt. 20/____ Left 20/____ Rt. 20/____ Left 20/____

F. Ears *(Configuration, Pinnae, Canals, Tympanic Membranes)*

Hearing:

• Right _____ Left _____

G. Nose

H. Mouth and Pharynx *(Teeth, Tongue, Gums, Pharynx)*

I. Neck

J. Respiratory System

Chest: Lungs:

K. Circulatory System *(Heart, Arterial Circulation, Venous Circulation)*

L. Abdomen/G.I. Tract *(Organs, Masses, Sounds, Tenderness)*

Rectal Examination: _____

Appendix B 47d: (34 MED)

PHYSICAL EXAMINATION AND ASSESSMENT

Patient's Name (Last, First, M.I.) | "C" NO.

M. Genito-urinary System *(Genito reproductive)*

Genitalia: | Breasts:

Gynecologic:

N. Musculoskeletal System and Connective Tissue

Extremities:

O. Nervous System

1. Mental Status:

2. Cranial Nerves

I. Olfactory _____

II. Optic

Fields _____

III., IV, VI

Pupils _____

Nystagmus _____

Extraocular movements _____

V. Trigeminal

Mastication _____

Facial Sensation _____

VII. Facial: _____

VIII. Acoustic

Hearing: _____

Equilibrium: _____

IX., X., Swallowing _____

Phonation _____

Gag Reflex _____

XI. Spinal Accessory

Trapezius _____

Sternocleidomastoid _____

XII Hypoglossal _____

3. Sensation

pain and temperature

vibration and position

touch

4. Reflexes (Indicate 0 to 4 (0-Absent, 1-Sluggish, 2-Active, 3-Very Active, 4-Exaggerated to Clonus))

	R	L		R	L		R	L
Biceps:			Brachioradialis:			Achilles:		
Triceps:			Patellar:			Plantar:		

5. Motor Functioning

Muscle strength | Gait and station:

Muscle tone | Coordination:

Fasciculation | Involuntary movements:

Atrophy

P. Endocrine, Nutritional, Metabolic and Immune Systems *(Stature, Development, Endocrine Abnormalities)*

Q. Other Signs and Ill-Defined Conditions, Including Speech Impediments:

Appendix B 47e: (34 MED)

PHYSICAL EXAMINATION AND ASSESSMENT	Patient's Name (Last, First, M.I.)	"C" No.

III. Summary of Findings — *Initial Recommendations and Tests Ordered. Enter all physical disorders/conditions in Problem List, Item V, page 6.*

	Speech/Hearing Examination Indicated		Comprehensive Eye Examination Indicated
	Comprehensive Gynecologic Examination Indicated		Other - *Specify*
	Other - *Specify*		Other - *Specify*

Signature of Person Completing Form if Other than Examining Physician	Print Name Signed	Title	Date Signed Mo	Day	Yr
Signature of Physician	Print Name Signed	Title	Date Signed Mo	Day	Yr

IV. Physical Assessment and Final Recommendations - *Consider reports of pertinent laboratory and other tests/consultations, including Aims evaluation; additional information from others*

Signature of Examining Physician	Print Name Signed	Title	Date Signed Mo	Day	Yr

Appendix B 47f: (34 MED)

PHYSICAL EXAMINATION AND ASSESSMENT	Patient's Name (Last, First, M.I.)	C" No.

V. Problem List

Date Identified Mo. Day Yr.	Initials	Physical Disorder/Condition	Date Resolved Mo. Day Yr.	Initials

Name and Title	Initials	Name and Title	Initials	Name and Title	Initials

Appendix B 48a: (TPC 11)

TPC 11 (9/90)

PHYSICAL EXAM & ASSESSMENT PT NAME _____
ADDENDUM

Consec #_____

INSTRUCTIONS: Circle the appropriate responses. Describe any abnormalities in the space provided.

I OLFACTORY
Patient was able to smell coffee or tobacco (circle one) with each nostril separately. yes/no

---

II OPTIC
Field of vision: normal by the "Confrontation Test" (each eye is tested) yes/no
Fundoscopy: using ophthalmoscope
a- discs are sharp and flat yes/no
b- no exudates yes/no
c- vessels are normal yes/no

III.IV.VI
Pupils: Equally round and reactive to light and accommodation. yes/no
Nystagmus: absent/present
Extraocular movements: able to follow finger in all six directions. yes/no

---

V TRIGEMINAL
Mastication: Pt. is able to make chewing movement and open mouth against resistance yes/no
Facial Sensation: intact to pinprick and touch with gauze. yes/no

---

VII FACIAL
Full range of expression (in repose, frowning, eye closing, eyebrow elevation, showing teeth) yes/no

---

VIII ACOUSTIC
Hearing: able to identify whispered words yes/no
Equilibrium: Romberg's sign absent/present
past pointing absent/present

Appendix B 48b: (TPC 11)

IX.X

Swallowing: swallows water without difficulty yes/no
laryngeal contours rise with swallowing yes/no

Phonation: hoarseness absent/present
inspiratory stridor absent/present

Gag reflex: intact by touching the back of the throat with a tongue blade yes/no

XI SPINAL ACCESSORY

Trapezius: Strength normal (shoulders raised verses resistance) yes/no

Sternocleidomastoid: Strength normal (chin brought back to midline against resistance) yes/no

XII HYPOGLOSSAL

Tongue is midline with protrusion yes/no

Fasciculation absent/present

Strength normal (tongue verses cheek with outside hand resistance) yes/no

Additional Comments:

Physician Name _____ Date _____

Appendix B 49: (36A MED)

[redacted] (Name of Facility)

GYNECOLOGICAL CHART

Name [redacted] Ward [redacted] Date of Examination: [redacted]

Age: 49 Civil Cond.: No. Children: 4

No. miscarriages: 1 Causes: dissent (Chow)

Duration of pregnancies when interrupted: 1 month

Character of labors: NL

Age at which menstruation began: 16

Unusual symptoms during early menstrual: abdom. cra

Character of Menstruation:

- Frequency: irregular sometimes
- Duration: 7 days
- Quantity: Slight: / Moderate: / Profuse
- Pain: Before Menstruation: / During Menstruation: / After Menstruation:) none
- Change since mental trouble: no

Menopause: Date of last menstruation: about end of June Age at cessation: —

OPERATIONS: Character and dates: None

History of Leucorrhoea: Chronic Vaginitis of Backache: denied

Constipation: denied of Headache: denied

According to previous medical record. pt. has + pelvic mass probably fibroid which found by. And also small fibrocystic nodule. @ breast (7).

REMARKS:

7-31-41
Stz, 1 Cyl
9/4/41

Appendix B 50a: (9 MED)

FORM 9 MED. (MH) (4-73) State of New York OFFICE OF MENTAL HEALTH **IMMUNIZATION RECORD**	Patient's Name:	Date of Birth:
	Building, Ward, Unit:	Consecutive Number:
	Facility Name:	

ROUTINE IMMUNIZATION SCHEDULE

(If immunizations not administered at facility enter history of immunizations)

AGE	2 MO.	4 MO.	6 MO.	15 MO.	18 MO.	4–5 Yrs.	14–16 Yrs.
DPT*							
Oral Polio virus							
Td							
Measles							
Rubella							
Mumps							

Td – given at age 14–16 Yrs. and every 10 Yrs. thereafter (adult type).

IMMUNIZATION SCHEDULE FOR PERSONS NOT IMMUNIZED IN INFANCY

AGES 12 MOS.–5 Yrs.	INITIAL IMMUN.	2 MO. AFTER INITIAL	4 MO. AFTER INITIAL	18 MO. AFTER INITIAL
DPT				
OPV				
Measles				
Mumps				
Rubella				

AGES 6 & OVER	INITIAL IMMUN.	2 MO. AFTER INITIAL	14 MO. AFTER INITIAL	*** EVERY 10 Yrs.	*** AS NECESSARY FOR INJURY
Td (Adult)					
OPV (Polio) **					
Measles					
Mumps					
Rubella					

* If an adverse reaction occurs after use of DPT, use an altered dose of DPT or Td for further immunization.

** Not routinely recommended for those over age 18.

*** Td continued on other side.

Additional Note: See other side.

REACTIONS

DATE	IMMUNIZATION	COMMENTS

Appendix B 50b: (9 MED)

Td	Td
q. – 10 YRS.	PRN FOR INJURY

PPD SKIN TEST	
DATE	RESULT

INFLUENZA	
DATE	TYPE

OTHER	
DATE	TYPE

NOTE:

1. A delay between scheduled doses does not interfere with final immunity regardless of interval elapsed. Simply pick up the schedule where it left off.
2. Live virus should not be used: 1) in patients with immuno deficiencies, 2) those on immunosuppressive drugs, 3) those with moderate to severe febrile illness, 4) if immune serum globulin was administered in the past six weeks, 5) any other altered immune state.
3. Persons with a clear history of natural measles, mumps or rubella need not be immunized. If history is unclear immunization may be carried out without enhanced risk.
4. Rubella vaccine should be given before puberty. It should be given selectively to adolescents and women of child bearing age; they should be tested for the presence or absence of rubella antibody and only those who are susceptible, not pregnant and able to avoid pregnancy for two months should be vaccinated.

Appendix B 51: (TPC 53)

WEIGHT CHART

NAME: _____ CONSECUTIVE NUMBER: _____

WARD: _____

HEIGHT: _____FT._____IN. WEIGHT ON ADMISSION: _____ LBS.

IDEAL WEIGHT RANGE: _____ / _____ LBS.
FROM TO
(Required for Special Diets Only)

DATE	WEIGHT	MHTA SIGNATURE (First Initial, Last Name)	R.N./LPN SIGNATURE (First Initial, Last Name)	M.D. Initials

POLICY: ALL PATIENTS ARE TO BE WEIGHED ON ADMISSION AND MONTHLY THEREAFTER UNLESS MORE FREQUENT MEASUREMENTS ARE ORDERED BY A PHYSICIAN.

Appendix B 52: (NSG 2)

DEPARTMENT OF NURSING

MONTHLY BLOOD PRESSURE

WARD:_____ PATIENT'S NAME: _____

CONSECUTIVE NUMBER: _____

DATE	BLOOD PRESSURE	MHTA SIGNATURE (First Initial, Last Name)	RN/LPN SIGNATURE (First Initial, Last Name)

NOTE: This form should be used to record routine monthly BP's only. When additional blood pressure measurements are ordered by the physician, they should be recorded on the 223 Med. Revised: 4/16/91

Appendix B 53: (26 MED)

CLINICAL CHART

FORM 26 MED. (MH) (4-78)

State of New York
OFFICE OF MENTAL HEALTH

NAME _____ WARD _____

CONS. #	DATE		DATE		DATE		DATE		DATE		DATE	
I.D.#												
BIRTHDATE	DAYS ILL	DAYS PO	DAYS ILL	DAYS PO	DAYS ILL	DAYS PO	DAYS ILL	DAYS PO	DAYS ILL	DAYS PO	DAYS ILL	DAYS PO
SEX												
PULSE / TEMPERATURE C° F°	4 8 12 4 8 12											
150												
140												
130												
120												
110												
100 — 105												
90 — 40.0 — 104												
80 — 103												
70 — 38.9 — 102												
60 — 101												
50 — 37.8 — 100												
99												
36.7 — 98												
97												
35.6 — 96												
RESPIRATION 40												
30												
20												
BLOOD PRESSURE												
WEIGHT												
DIET												
FLUID INTAKE: MOUTH												
IV												
SC												
TOTAL												
OUTPUT: EMESIS												
WNGSTN.												
DRAINAGE												
URINE												
TOTAL												
STOOL												

Appendix B 54: (TPC-126)

DIABETIC CONTROL RECORD
(File in patients history when completed)

Hospital No. _____

Name _____ Identification No. _____

Date	Hours	URINE Sugar	Acetone	Kind & Amt of Insulin Given	Employee's Signature
	7 am				
	11 am				
	4 pm				
	7 pm				
	7 am				
	11 am				
	4 pm				
	7 pm				
	7 am				
	11 am				
	4 pm				
	7 pm				
	7 am				
	11 am				
	4 pm				
	7 pm				

Date: _____

Requested By: _____

Appendix B 55: (216 MED)

FORM 216 MED (MH) (3-79)

STATE OF New York
OFFICE OF MENTAL HEALTH

SEIZURE CHART

G – Generalized (Grand Mal)
A – Absence (Petit Mal)
P – (Psychic, Jacksonian, etc.)

Name .....

Identification No. .....

Year .....

	Number of Seizures																															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
JAN. D																																
JAN. N																																
FEB. D																																
FEB. N																																
MAR. D																																
MAR. N																																
APR. D																																
APR. N																																
MAY D																																
MAY N																																
JUNE D																																
JUNE N																																
JULY D																																
JULY N																																
AUG. D																																
AUG. N																																
SEPT. D																																
SEPT. N																																
OCT. D																																
OCT. N																																
NOV. D																																
NOV. N																																
DEC. D																																
DEC. N																																

Grand Total .....

Appendix B 56: (82 MED)

Form 82 Med. (MH) Laboratory Reports (8-78)
State of New York
OFFICE OF MENTAL HEALTH

Laboratories of

Family Name | First Name

Case No. | Ward

NUMBER OF TUBES NEEDED AND COLOR OF TUBE TOP
EXPL.: R2, red top 2 tubes; L - lavender; B - blue; GR - Gray top tubes

ADMISSION MULTICHEM 12 R2

Calcium
8.6 - 10.6 mg. %

Phosphorous
3.0 - 4.5 mg. %

Glucose
70 - 110 mg. %

BUN
10 - 20 mg. %

Uric Acid
2.5 - 7 mg. % (M)
2.5 - 5.5 mg. % (F)

LIVER R2

Bilirubin, Total
0.3 - 1 mg. %

Bilirubin, Direct
0.1 - 0.4 mg. %

Cholesterol
150 - 250 mg. %

Protein
6.5 - 7 gm. %

Globulin
2.3 - 3.5 gm. %

Albumin
4.2 - 5.4 gm. %

SGOT
9 - 36 U./ml

LDH
varies according to methodology

Alk. Phos.
9 - 35 I.U. 100 ml

SGPT
0 - 35 U./ml

CARDIAC, ART SC., CVA R2

Glucose
70 - 110 mg. %

BUN
10 - 20 mg./%

Cholesterol
150 - 250 mg. %

SGOT
9 - 36 U./100 ml

LDH
200 - 500 U./ml*

CPK
4 - 17 I.U./100 ml

Triglycerides
30 - 200 mg./%

HYPERTENSION, KIDNEY, R2

Creatinine
0.7 - 1.3 mg./%

Uric Acid
3.5 - 7.0 mg. % (M)
2.5 - 5.5 mg. % (F)

BUN
10 - 20 mg./%

Protein, Total
6.5 - 7 mg./%

Albumin
4.2 - 5.4 gm./%

Potassium
3.5 - 5 meq./L

(Paste 3rd report here and succeeding ones on above lines)

(Paste 2nd report on this line)

(Paste 1st report on this line)

ATTACH ALL REPORTS ON THIS PAGE. THE FIRST REPORT IS ATTACHED AT THE BOTTOM LINE OF THIS SHEET AND OTHERS ABOVE THIS. LOOSE REPORTS ARE OFTEN LOST.

Sodium
134 - 143 meq. L

Potassium
3.5 - 5 meq. L

Chloride
96 - 105 meq. L

CO_2
23 - 30 meq. L

Lithium
0 - 1.5 meq. L

Acid Phos.
0 - 2.9 I.U. 100 ml

Amylase
60 - 160 U. 100 ml

Hemoglobin
13.5 - 18 gm % M
12.0 - 16 gm % F

HCT.
40 - 54% M
38 - 47% F

WBC.
5,000 - 10,000 cu mm

RBC.
4.5 - 5 mill. cu mm

Sed. Rate
2 - 10 M mm / hour
5 - 20 F mm / hour

Reticulocytes
0.5 - 1.5%

CBC & Indices

MCV
80 - 90cu

MCH
20 - 27 uugm

MCHC
33 - 38%

Serum Fe.
45 - 135 ug %

SER I.B.C.
280 - 390 ug %

B-12 (serum)
.330 - 1.025 ng ml

Folic Acid
5 - 20 ng ml

APTT
35 - 45 sec.

Prothrombin
11 - 14 sec.

Bleeding Time
1 - 6 min.

T_3 Uptake
25 - 35%

T_4 Uptake
4.5 - 12.5 mc. 100 ml

Protein
15 - 45 mg %

Chloride
118 - 132 meq. L

Glucose
45 - 75 mg %

Cells
3 - 8 cumm.

ALL VALUES MAY VARY ACCORDING TO METHODOLOGY AND LABORATORY STANDARDS.

Appendix B 57: (82.13 MED)

State of New York
Office of Mental Health

RADIOLOGY REQUEST

RADIOLOGY SERVICE	Medicare # / Medicaid # / Other	FOR X-RAY REQUESTS: • ☐ STRETCHER ☐ AMBULATORY ☐ CHAIR • MAY DRESSING BE REMOVED? ☐ Yes ☐ No • PREVIOUS X-RAY ☐ Yes ☐ No ☐ Unknown

DIAGNOSIS	AGE	SEX

EXAMINATION REQUESTED OR REASON FOR REFERRAL:

PERTINENT CLINICAL HISTORY. Clinical Findings, Operations, Site of Injury/Lesion, Duration of Symptoms, etc.

PHYSICIAN'S SIGNATURE	Request Date	☐ Adm ☐ STAT ☐ Routine	Requested Response Date

REPORT	Film No.	Date of X-Ray

RADIOLOGIST'S NAME, TITLE, AND SIGNATURE	DATE OF REPORT

RADIOLOGY REQUEST	Patient's Name (Last, First, M.I.)	"C" No.

Appendix B 58: (36 MED)

CONSULTATION REQUEST

Patient's Name Last First M | C No

Sex | Date of Birth

Facility Name | Unit Ward No

Consulting Service	Diagnosis(es)	Medicare #
		Medicaid #
		Other

PERTINENT CLINICAL HISTORY AND REASON FOR REFERRAL | Age | Sex

Physician's Signature | Request Date | Adm / Stat / Other | Date Response Requested

REPORT (Findings, Diagnosis, Recommendations)

USE BACK OF FORM IF NECESSARY

Consultant's Signature and Title | Date of Report

CONSULTATION REQUEST | Patient's Last Name | "C" No.

Appendix B 59: (122 MED)

State of New York
OFFICE OF MENTAL HEALTH

DENTAL CHART

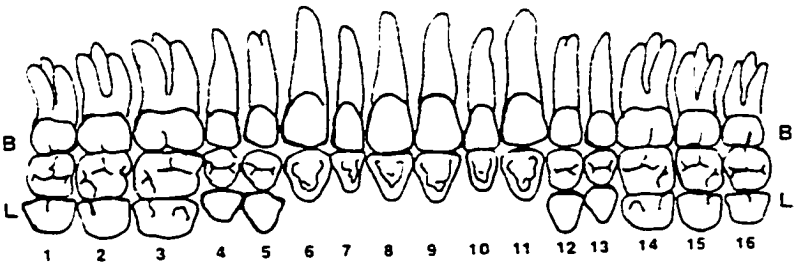
[redacted]

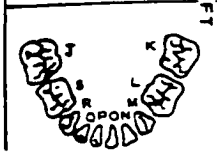
"C" No. [redacted] Unit Ward No. [redacted]

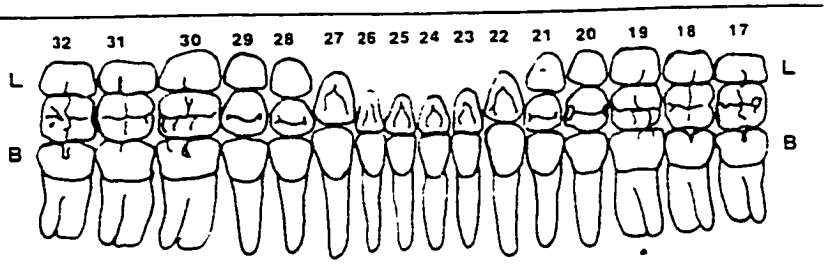
Facility Name [redacted]

DECIDUOUS

PERMANENT







KEY

CARIES

FILLING

TOOTH TO BE EXTRACTED

EXTRACTION DONE

CROWN

FIXED BRIDGE

TOOTH MISSING

Periodontitis
Mild Moderate
Severe

Prosthetic Status
Dentures

HB_sAg - -

Medical Diagnosis (if any) [redacted]

Medication Patient is Receiving:

Behavior or Physical Status Relevant to Dental Treatment:

Oral Hygiene
Poor Good Excellent

Gingiva Healthy
Drianin hyperplasia

Gingivitis
Mild Moderate Severe

Calculus
Light Moderate Heavy

Orthodontic Status
Class Class II Class

Openbite Overbite
Crossbite Overjet

Allergies, Drug Sensitivities:

Premedication or Anesthesia Required:

Findings:
3/16/79 Brief consult Patient refused treatment

Treatment Plan:

[redacted]
Signature

Appendix B 60: (152 MED)

PROGRESS NOTES	Patient's Name (Last, First, M.I.)	"C" No.
	Sex	Date of Birth
	Facility Name	Unit/Ward No.

INSTRUCTIONS

* Enter individual progress notes or team notes as follows or more frequently as appropriate

a Inpatient - Physician, nurse, social worker and other significantly involved staff enter notes weekly for the first two months and monthly thereafter

b Outpatient - Staff enter individual notes or a team note in
Clinic program - for every visit.
Day treatment program - weekly, and
Continuing treatment and day training programs - every two weeks

2. Enter notes to document the following
   a Implementation of the treatment plan
   b All treatment provided.
   c Response of the patient to treatment, including changes in patient's behaviors, conditions, and situations
   d. Chronology of the patient's clinical course including outcome of treatment and progess in relation to goal(s) and objective(s). (Enter goal number(s) and objective letter(s) for progress notes which refer to the Treatment Plan, and describe progress in measurable/observable terms.)
   e Other information which significantly relates to the patient's behaviors, conditions, and situations.
   f New information about the patient/family including the response of significant other(s) to important events
   g Administrative actions and actions related to the patient's legal status
3. Enter signature, title, and date after each progress note. (For team note, include the input, names, and titles of all participants.)

Date	Goal No. and Obj. Letter	

Appendix B 61: (89 MED)

PHYSICIAN'S ORDERS

3147 | Weight | Diet

Allergies

| | None Known

NO.	DATE WRITTEN	PHYSICIAN TO INDICATE DRUG NAME DOSAGE FREQUENCY & ROUTE AND TO SIGN NAME AND TO INDICATE IF ADDITIONAL CONTROLLED SUBSTANCE)	START DATE	STOP DATE	NURSING PERSONNEL SIGNATURE
01					
02					
03					
04					
05					
06					
07					
08					
09					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					

Appendix B 62: (TPC 1)

RESTRAINT OR SECLUSION ORDER SHEET

PATIENT'S NAME (last, first, MI) | "C" NUMBER | UNIT/WARD NO

SEX | DATE OF BIRTH

ORDER TYPE
(Seclusion or Restraint)
If Restraint Specify Type

ORDER START/STOP TIMES *(Indicate A.M. or P.M.)*

SECLUSION OR RESTRAINT RATIONALE: *(Including failure of less restrictive means)*

CONTRAINDICATIONS: *(If NONE, write NONE)*

PRN MEDICATION(S) ALREADY GIVEN:
YES ☐ NONE ☐

IF YES: WHAT MEDICATION(S)
Name/Dose

Time Given:

RESULTS OF PERSONAL EXAMINATION BY PHYSICIAN

(Include patient's behavior, thought content, actual or potential dangerousness, level of consciousness, overall physical condition, hydration, color, ambulation, etc.)

INITIAL VITAL SIGNS:			*(If unable to obtain, document reason)*	FREQUENCY OF VITAL SIGNS:
BP	PULSE	RESPIRATION		

RELEASE CRITERIA: *(Relate release criteria to initial reason for restraint or seclusion)*

SPECIFY MEDICATION(S) TO BE GIVEN WHILE INSECLUSION OR RESTRAINT: *(Including regular medications) If NONE, indicate NONE*

PHYSICIAN SIGNATURE	DATE	TIME	NURSING PERSONNEL SIGNATURE	DATE	TIME

White Copy Patient Chart Yellow Copy Medical Records Department

Appendix B 63a: (223 MED)

Form 223A MED (MH) (2-85)

MEDICATION/TREATMENT RECORD (MEDEX)

Medications and Treatments Administered for Period: / / to / /

A. Allergies/Special Considerations

Allergies:

None determined (check): ______

Special Considerations:

None determined (check): ______

Patient's Name (Last, First, M.I.) C. No

Sex Date of Birth

Facility Name Unit Ward No

INSTRUCTIONS:

1. **Transcribe prescriber's orders as soon as written:**
   a) Identify allergies/special considerations in Section A and on back of form. Update as indicated.
   b) Enter all medications/treatments, including IVs and dietary supplements, to be administered by nursing personnel.
   c) Include instructions to record blood pressure/vital signs when related to administration of a specific medication, and
   d) Use as many medication/treatment blocks as necessary.
2. **Document administration of medications/treatments immediately:**
   a) For **STAT** or single dose medications/treatments, enter time administered and initials in Section C.
   b) For scheduled medications/treatments, enter initials in appropriate box in Section D.
   c) For **PRN** medications/treatments, enter initials and time in appropriate box in Section D, and
   d) For all injected medications, enter code below initials to indicate location.
3. **Document nonadministration of medications/treatments immediately by entering reason code with initials in Sections C or D.**
4. **Refer to facility manuals regarding other forms related to unit dose.**

B. Name and Title	INIT	Name and Title	INIT

DATE	C. STAT or Single Dose Medication/Treatment (Name and Dose)	RT	TIME	INIT	DATE	STAT or Single Dose Medication/Treatment (Name and Dose)	RT	TIME	INIT

CODES:

Reason for Nonadministration:

1	Drug holiday	5	On leave/LWOC
2	Drug not in formulary	6	Patient unavailable
3	Hold	7	Self administered
4	Medication/treatment refused	8	Other (Explain in notes.)

Location of Injection (Indicate Right (R) or Left (L)):

A	Abdomen	C	Iliac Crest	T	Thigh
B	Buttock	D	Deltoid	U	Upper Arm

D. Scheduled and PRN Medications/Treatments (Enter dates in top row of boxes across the page.)

START	STOP	SCHEDULED MEDICATION/ TREATMENT	TIME																															
		NAME																																
		DOSE RT FREQ																																
		NAME																																
		DOSE RT FREQ																																
		NAME																																
		DOSE RT FREQ																																

Appendix B 63b: (223 MED)

MEDICATION/TREATMENT RECORD (MEDEX)

Medications and Treatments Administered for Period / / to / /

D Scheduled and PRN Medications and Treatments (Enter dates in top row of boxes across the page.)

PRN MEDICATION TREATMENT (Specify name dose route and frequency)

SCHEDULED MEDICATION TREATMENT	TIME
NAME	
DOSE · RT · FREQ	
NAME	
DOSE · RT · FREQ	
NAME	
DOSE · RT · FREQ	
NAME	
DOSE · RT · FREQ	

Patient's Name (Last, First, M.I.)

Allergies/Special Considerations

Appendix B 64a: ((TPC 7)

RESTRAINT OR SECLUSION MONITORING FORM

Patient's Name (Last, First, M.I.) | C No

Sex | Date of Birth

Facility Name | Unit/Ward No.

INSTRUCTIONS:

1. Except for an emergency (see #6) restraint or seclusion may be applied only when authorized by the written order of a Physician. The facts justifying the restraint must be immediately recorded in the progress notes.
2. There is a four hour time limit on orders of restraint or seclusion except an order written after 9 P.M. may extend to 9A.M. of the next day. However, if the patient is awake for four continuous hours during this period, the order shall expire.
3. An assessment as to the need for continued restraint or seclusion, the general comfort, and well being of the patient (including vital signs and medication, per physician's orders; and meals, bathing, and use of toilet as appropriate) must be made every 15 minutes. The assessments must be made even when the patient is asleep. The assessments are to be recorded on this form.
4. The patient must be released after 2 hours except when asleep.
5. Whenever released, if the actions of the patient do not threaten serious harm to self or others, the restraint or seclusion must not be reimposed and a physician must be notified immediately. Then, restraint or seclusion can only be reimposed if the physician examines the patient and determines that for the good of the patient the restraint or seclusion is still necessary as ordered.
6. If restraint or seclusion is applied in an emergency, a physician must be summoned immediately. Until the physician writes the order, the patient must be kept under constant supervision and any assessments made must be recorded on this form. Part I of this form must be completed.

PART I – Emergency Use of Restraint or Seclusion

A To be completed by Senior Staff Member present

DATE	TYPE OF RESTRAINT/SECLUSION	PHYSICIAN CALLED: NAME	TIME CALLED	SIGNATURE OF SENIOR STAFF MEMBER

If Physician does not arrive within 30 minutes of being called, record the delay in Part III (assessment) of this form and indicate:
- actions of patient which requires maintaining the restraint/seclusion until the arrival of the physician;
- why a less restrictive form of restraint was not used;
- steps taken to ensure that the patient's needs, comfort and safety were properly cared for.

B To be completed by Physician

TIME ARRIVED	If time of arrival is more than 30 minutes after being called, explain reason for delay.
	PHYSICIAN'S SIGNATURE

PART II – Information on Order

☐ RESTRAINT ☐ SECLUSION	TYPE OF RESTRAINT	LENGTH OF TIME AUTHORIZED: FROM / TO	DATE	NAME OF PHYSICIAN

TIME RESTRAINT APPLIED OR PATIENT PLACED IN SECLUSION	EMERGENCY APPLICATION OF RESTRAINT? ☐ YES ☐ NO	NAMES AND TITLES OF STAFF RESPONSIBLE FOR ASSESSING PATIENT'S CONDITION:
NAME AND TITLE OF PERSON COMPLETING PART I:		

PART III – To Be Completed by Direct Care Staff Assigned to Monitor Patient

Action Code: [A] CONTINUED RESTRAINT OR SECLUSION [B] RELEASE AND IMMEDIATE RETURN TO RESTRAIN OR SECLUSION [C] RELEASE FROM RESTRAINT OR SECLUSION

Date	Actual Time Monitored	Action Code	Assessment	Signature & Title

Appendix B 64b: (TPC 7)

RESTRAINT OR SECLUSION MONITORING FORM

PATIENT'S NAME (LAST, FIRST, M.I.)

PART III – (Continued) – To Be Completed by Direct Care Staff Assigned to Monitor Patient

Action Code: [A] CONTINUED RESTRAINT OR SECLUSION [B] RELEASE AND IMMEDIATE RETURN TO RESTRAIN OR SECLUSION [C] RELEASE FROM RESTRAINT OR SECLUSION

Date	Action Time Monitored	Action Code	Assessment	Signature & Title

Appendix B 65: (152 MED)

Form 152 MED (M-H 4-85)

STATE OF NEW YORK
OFFICE OF MENTAL HEALTH

PROGRESS NOTES

INSTRUCTIONS

1 Enter individual progress notes or team notes as follows or more frequently as appropriate

a Inpatient - Physician, nurse, social worker and other significantly involved staff enter notes weekly for the first two months and monthly thereafter

b Outpatient - Staff enter individual notes or a team note in
Clinic program - for every visit
Day treatment program - weekly and
Continuing treatment and day training programs - every two weeks

2 Enter notes to document the following
a Implementation of the treatment plan
b All treatment provided
c Response of the patient to treatment, including changes in patient's behaviors, conditions, and situations.
d Chronology of the patient's clinical course including outcome of treatment and progess in relation to goals and objectives; (Enter goal number(s) and objective letter s. for progress notes which refer to the Treatment Plan and describe progress in measurable/observable terms.)
e. Other information which significantly relates to the patient's behaviors, conditions, and situations
f New information about the patient/family including the response of significant other(s) to important events
g Administrative actions and actions related to the patient's legal status

3 Enter signature, title, and date after each progress note. (For team note, include the input, names, and titles of all participants.)

Date	Goal No. and Obj. Letter	

Appendix B 66: (BPR 1453)

BPR 1453 Medicare Payment Request (9-89)

NEW YORK STATE
OFFICE OF MENTAL HEALTH

PATIENT:
"C" NO.:
FACILITY:
MEDICARE CLAIM #:

MEDICARE PAYMENT REQUEST AND AUTHORIZATION TO RELEASE INFORMATION

I authorize The Office of Mental Health to release to Medicare and its intermediaries (or carriers) any information needed for this or a related Medicare claim.

I request that payment of authorized benefits be made on my behalf for any services related to this admission.

Admission Date	Signature of Patient or Authorized Representative	Date Signed
	☐ Check here if patient unable to sign Show representative's relationship to patient _____ Give brief explanation why patient is unable to sign _____ _____ _____ _____	

Appendix B 67a: (OMH 11)

Form OMH 11 (5-87)

State of New York
OFFICE OF MENTAL HEALTH

CONSENT FOR RELEASE OF INFORMATION

See Reverse Side for Instructions

Part I — Consent To Release Information

Extent or Nature of Information to be Disclosed

Purpose or Need for Information

From: Name, Address and Title of Person/Organization/Facility/Program Disclosing Information	**To:** Name, Address and Title of Person/Organization/Facility/Program to Which Disclosure Is To Be Made

A. I Hereby Authorize the One-time Release of the Above Information to the Person/Organization/Facility/Program Identified Above. I Understand that the Information to be Released is Confidential and Protected from Disclosure. I also Understand that I Have the Right to Cancel My Permission to Release Information at any Time.

My Consent to Release Information Will Expire When Acted Upon, or 90 Days From this Date, Whichever Occurs First.

Signature of Patient/Person Acting For Patient	Relationship	Date Signed	Signature of Witness	Title	Date Signed

B. I Hereby Authorize the Periodic Release of the Above Information to the Person/Organization/Facility/Program Identified Above as Often as Necessary to Plan For/Provide Care and Treatment. I Understand that the Information to be Released is Confidential and Protected from Disclosure. I also Understand that I Have the Right to Cancel My Permission to Release Information At Any Time.

My Consent to Release Information to the Person/Organization/Facility/Program Identified Above, Will Expire When I am no longer Receiving Services from such Person/Organization/Facility/Program, or One Year from this Date, Whichever Occurs First.

Signature of Patient/Person Acting for Patient	Relationship	Date Signed	Signature of Witness	Title	Date Signed

Record of Information Released

Signature of Staff Person Releasing Information	Title	Date Released

Appendix B 67b: (OMH 11)

Part II — Cancellation/Refusal To Release Information

I Hereby Cancel My permission to Release Information Indicated in Part I to the Person/Organization/Facility/Program whose Name and Address is:	☐ I Hereby Refuse to Authorize the Release of Information Indicated in Part I, to the Person/Organization/Facility/Program whose Name and Address is:

Signature of Patient/Person Acting for Patient	Relationship	Date Signed	Signature of Witness	Title	Date Signed

(Use this space if additional room is needed to complete any of the items on the reverse side)

- INSTRUCTIONS -

1. Patient Signs A. if the Release of Information is for a Single Event.
2. Patient Signs B., if Information is to be Released Periodically during an episode of treatment.
3. If the patient is under 18 years of age, only the responsible parent, relative or guardian must sign
   Exception: If patient is a Voluntary Admission on own application, at least 16 years of age but under 18 years of age, only the patient must sign.

Appendix B 68a: (OMH 144)

Form OMH 144 (10-81)

State of New York
OFFICE OF MENTAL HEALTH

CONSENT FOR RELEASE OF INFORMATION TO A COMMUNITY SUPPORT SYSTEM (CSS) AGENCY See Reverse Side For Instructions	Patient's Name (Last, First, M.I.)	"C" Number
	Patient's Address	Date of Birth
Agency Name	Agency Address	

Part I - Consent To Release Information

☐ I authorize _____ (Agency to Release Information) to release the dates and locations of all my inpatient psychiatric admissions to the director of _____ (Agency to Receive Information)

I understand that this information is to be used only to arrange services for me; is confidential; and is protected from disclosure.

☐ I authorize _____ (Agency to Release Information) to release clinical information from my psychiatric/medical record to the director of _____ (Agency to Receive Information). I understand that this information is to be used only to arrange services for me; is confidential; and is protected from disclosure.
The extent or nature of information to be released is restricted to the following:

I also authorize the director of _____ (Agency to Receive Information) to share it with the agency(s) listed below when I am referred to the agency(s) for service. I understand that the agency(s) will maintain the confidentiality of this information and will not release it to any other agency or individual without my signed consent:

1. 4.
2. 5.
3. 6.

I understand that I have the right to cancel my permission to release information any time before it is released. I also understand that this consent to release information will expire when acted upon or 180 days from this date, whichever occurs first.

Signature of Patient/Person Acting for Patient	Print Name Signed	Relationship	Date Signed
Signature of Witness	Print Name Signed	Title	Date Signed
Signature of Person Completing Form	Print Name Signed	Title	Date Signed

Part II - Record of Information Released

Signature of Staff Person Releasing Information	Print Name Signed	Title	Date Released

Use Part III. on reverse side. to Record Cancellation of Existing Consent to Release Information or Refusal to Allow Release of Information

Appendix B 68b: (OMH 144)

Part III - Cancellation/Refusal To Release Information	
☐ I hereby cancel my permission to release information to the following agency(s):	☐ I hereby refuse to authorize the release of information to the following agency(s):

Signature of Patient/Person Acting for Patient	Print Name Signed	Relationship	Date Signed
Signature of Witness	Print Name Signed	Title	Date Signed
Signature of Person Completing Form (If Applicable)	Print Name Signed	Title	Date Signed

INSTRUCTIONS:

When Requesting Information from An Agency

1 Complete Part I of form in triplicate

2 Check appropriate box to indicate information requested

3 Enter name of agency to release information and name of agency to receive information in appropriate space

4 Enter name and address of each agency to which patient may be referred

5 Obtain signatures of patient (or person authorized to act on behalf of patient) and witness

6 Forward original to agency from which information is requested, give copy to patient (or person who acted for patient), file copy in patient's case record

When Sending Information to An Agency

1 Complete Part II of form

2 File in patient's case record

Note:

"Signature of Person Completing Form" is the person soliciting patient's consent (i.e., agency staff person or other individual responsible for explaining this form to the patient). This person is different from the "Witness"

Appendix B 69: (3 ADM)

Form 3-Adm. (April 1959)

New York State
Department of Mental Hygiene

RECORD OF VISITS

Patient's Name: ..... (Last) (First) (Middle)

Admission Date	Ident. No.	Hospital No.

VISITORS

Name	Address	Telephone No.	Relationship
1.			
2.			
3.			
4.			
5.			
6.			

DATES OF VISIT

1	2	3	4	5	6

Appendix B 70: (TPC)

[redacted]

CONSENT AND RELEASE--ADULT

[redacted]

Series: [redacted]
Program: [redacted]
Date: [redacted]

I hereby agree to participate in the above public television program produced by [redacted] and authorize [redacted] to record, re-record, and photograph my likeness, performance, and voice. [redacted] may edit and adapt my participation as it deems appropriate.

I further agree that the program and all of its elements, including all still photographs taken in connection with it, belong entirely and exclusively to [redacted] so that [redacted] and its licensees and assigns may duplicate, distribute, broadcast, exhibit, or otherwise use or exploit the program, any portion of it, or related still photographs, without limitation or restriction throughout the world in perpetuity. If my participation includes music owned, composed or arranged by me, [redacted] will have synchronization and performing rights so that the music can be used in the program. If my participation includes still photographs, footage, artwork or other materials owned by me, [redacted] will have the right to use such materials in the program. I release [redacted] and its licensees and assigns from any liability arising from my participation in the program, and authorize use of my name, likeness, voice, performance, and biography for project purposes, including but not limited to program and institutional publicity, supplementary literary material, and other purposes.

I represent that I am 18 years of age or older.

sig. ave for patient interview

[redacted]
Signature

[redacted]
Name (please print)

[redacted]
Address

[redacted]

Appendix B 71: (67 BUS)

STATE OF NEW YORK
OFFICE OF MENTAL HEALTH
RECORD OF CLIENT'S PROPERTY FORWARDED TO BUSINESS OFFICE

- To be signed by 2 employees on the living unit.
- All four copies are forwarded to Business Office.
- Property Clerk or Cashier signs form verifying receipt of indicated property.
- Original is filed alphabetically in Business Office.
- Copy is returned to living unit for filing in client's folder.
- Copy is filed by press number in Business Office.
- Copy is forwarded to Patient Resource Agent.

107370

Date

Client's Name	Consecutive Number	Admission Date

Removed by:	Approved and Checked by:
Print Name	Print Name
Print Title	Print Title
Signature	Signature

CASH:

PROPERTY:

Received the above property on _____ Date _____ Signature of Property Clerk/Cashier

_____ Print Name Signed

Property withdrawn on _____ Date Received by _____ Signature of Client or Representative

Appendix B 72: (72 ADM)

FORM 72 ADM. (MH) (6.78)

State of New York
OFFICE OF MENTAL HEALTH

PATIENT'S PERSONAL CLOTHING RECORD

PATIENT NAME

CASE NO. | ADMISSION DATE

QUANTITY	ARTICLE DESCRIPTION	DATE	DISPOSITION	DATE	WITNESS

Appendix B 73: (72A ADM)

Form 72A ADM (MH) (10-78)

State of New York
OFFICE OF MENTAL HEALTH

Inventory of Patient's Personal Property Maintained on Living Unit

Patient's Name	
Consecutive No.	Admission Date

Description of Property	Date	Cost	Disposition	Date	Signature

Appendix B 74: (55 MED)

BRONX PSYCHIATRIC CENTER

PERMISSION TO LEAVE GROUNDS

WARD_____

PATIENT:_____ DOCTOR_____

This obligation is to be signed by every relative or friend of the patient who is permitted by the ward physician to take the patient out on the Hospital grounds or off the grounds during the hours that permission is granted.

By signature, the friend or relative agree to assume full responsibility for the conduct of the patient while under his jurisdiction and agree to return the patient at the designated time.

FROM	AM	PM	OUT	SIGNATURE AND RELATIONSHIP	TO	AM	PM

Appendix B 75: (528 MED)

Form 528 MED (MH) (5-90)

State of New York
Office of Mental Health

INDEPENDENT TEAM MEDICAID CERTIFICATION FORM **(For Patients Under Age 21)**	Patient's Name (Last, First, M.I.) C No Sex Date of Birth
Referral Source:	Facility Name Unit/Ward No

INSTRUCTIONS: This certification must be completed by a team prior to admission for other than emergency admissions for all patients under 21 years of age who are Medicaid recipients, and who are referred or transferred for admission for inpatient care and treatment.

The certification team must have knowledge of the individual's situation and have competence in the diagnosis and treatment of mental illness, preferably in child psychiatry. The team must consist of a physician and at least one other individual.

CERTIFICATION

I certify for the above patient that:

1. Ambulatory care resources available in the community do not meet the patient's treatment needs;
2. Proper treatment of the patient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the patient's condition or prevent further regression so that services will no longer be required.

_____
Physician

_____ _____
Team Member *Professional Qualification*

_____ _____
Team Member (Optional) *Professional Qualification*

DATE. _____

Appendix B 76: (529 MED)

TREATMENT TEAM MEDICAID CERTIFICATION FORM
(For Patients Under Age 21)

Patient's Name (Last, First, M.I.) | C No.

Sex | Date of Birth

Facility Name | Unit/Ward No

INSTRUCTIONS: This certification must be completed for all patients under the age of 21 within 14 days after an admission on an emergency basis or for a patient at the time an application for Medicaid benefits is made. At a minimum, the team certifying the patient's need for inpatient services must include either:

1) a Board-eligible or Board-certified psychiatrist; or
2) a clinical psychologist who has a doctoral degree, and a physician licensed to practice medicine or osteopathy; or
3) a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State Psychological Association.

In addition the team must include one or more of the following:

1) a psychiatric social worker;
2) a registered nurse with specialized training or one year of experience in treating mentally ill individuals;
3) an occupational therapist who is licensed by the State, and who has specialized training or one year of experience in treating mentally ill individuals; or
4) a psychologist who has a master's degree in clinical psychology, or who has been certified by the State or by the State Psychological Association.

CERTIFICATION

I certify for the above patient that:

1. Ambulatory care resources available in the community do not meet the patient's treatment needs;
2. Proper treatment of the patient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the patient's condition or prevent further regression so that services will no longer be required.

_____ _____
Team Member *Professional Qualification*

_____ _____
Team Member *Professional Qualification*

_____ _____
Team Member *Professional Qualification*

DATE: _____

Appendix B 77: (70 MED)

MEDICARE CERTIFICATIONS FOR PSYCHIATRIC INPATIENT TREATMENT

Patient's Name (Last, First, M.I.) C... No.

Sex ..... Date of Birth

Facility Name Unit/Ward No.

INSTRUCTIONS:

Physician completes certifications during a Medicare covered stay as follows:

- Initial certification:
  - When a patient is Medicare covered upon admission or becomes Medicare covered after admission due to age or disability.
  - When a Medicare covered patient is transferred in from another facility.
- Recertifications:
  - On this form for all Medicare patients on the 12th, 18th, 48th, 78th, 108th, 138th, and 168th day.

INITIAL CERTIFICATION UPON ADMISSION OR WHEN PATIENT BECOMES MEDICARE COVERED / / MO DAY YR	I CERTIFY THAT INPATIENT HOSPITAL SERVICES ARE REQUIRED FOR TREATMENT WHICH CAN REASONABLY BE EXPECTED TO IMPROVE THE PATIENT'S CONDITION OR FOR DIAGNOSTIC STUDY.	
	Physician's Signature	Date / /
FIRST RECERTIFICATION DUE 12th DAY / / MO. DAY YR.	I CERTIFY THAT INPATIENT HOSPITAL SERVICES ARE REQUIRED FOR TREATMENT WHICH CAN REASONABLY BE EXPECTED TO IMPROVE THE PATIENT'S CONDITION OR FOR DIAGNOSTIC STUDY AND THAT THE HOSPITAL SERVICES FURNISHED WERE EITHER INTENSIVE TREATMENT SERVICES, ADMISSION AND RELATED SERVICES NECESSARY FOR DIAGNOSTIC STUDY OR EQUIVALENT SERVICES.	
	Physician's Signature	Date / /
SECOND RECERTIFICATION DUE 18th DAY / / MO. DAY YR.	I CERTIFY THAT INPATIENT HOSPITAL SERVICES ARE REQUIRED FOR TREATMENT WHICH CAN REASONABLY BE EXPECTED TO IMPROVE THE PATIENT'S CONDITION OR FOR DIAGNOSTIC STUDY AND THAT THE HOSPITAL SERVICES FURNISHED WERE EITHER INTENSIVE TREATMENT SERVICES, ADMISSION AND RELATED SERVICES NECESSARY FOR DIAGNOSTIC STUDY OR EQUIVALENT SERVICES.	
	Physician's Signature	Date / /
THIRD RECERTIFICATION DUE 48th DAY / / MO. DAY YR.	I CERTIFY THAT INPATIENT HOSPITAL SERVICES ARE REQUIRED FOR TREATMENT WHICH CAN REASONABLY BE EXPECTED TO IMPROVE THE PATIENT'S CONDITION OR FOR DIAGNOSTIC STUDY AND THAT THE HOSPITAL SERVICES FURNISHED WERE EITHER INTENSIVE TREATMENT SERVICES, ADMISSION AND RELATED SERVICES NECESSARY FOR DIAGNOSTIC STUDY OR EQUIVALENT SERVICES.	
	Physician's Signature	Date / /

Appendix B 78a: (75 MED)

MEDICAID CERTIFICATIONS

Patient's Name: Last, First, MI

Sex

Facility Name

INSTRUCTIONS:

Physician completes certifications as follows.

- On admission and every 60 days thereafter for a patient who is 65 or over in a psychiatric unit.
- On admission of all patients to a medical unit and every 60 days thereafter.

CERTIFICATION

I certify that inpatient hospital services are/were needed by the above patient.

1. Due Date ___/___/___ (Mo. Day Year) — Physician's Signature — Date

2. Due Date ___/___/___ (Mo. Day Year) — Physician's Signature — Date

3. Due Date ___/___/___ (Mo. Day Year) — Physician's Signature — Date

4. Due Date ___/___/___ (Mo. Day Year) — Physician's Signature — Date

5. Due Date ___/___/___ (Mo. Day Year) — Physician's Signature — Date

6. Due Date ___/___/___ (Mo. Day Year) — Physician's Signature — Date

7. Due Date ___/___/___ (Mo. Day Year) — Physician's Signature — Date

8. Due Date ___/___/___ (Mo. Day Year) — Physician's Signature — Date

9. Due Date ___/___/___ (Mo. Day Year) — Physician's Signature — Date

(OVER)

Appendix B 78b: (75 MED)

MEDICAID CERTIFICATIONS	Patient's Name (Last, First, M.I.)

I certify that inpatient hospital services are/were needed by the above patient.

10. Due Date Mo.. / Day / Year	Physician's Signature	Date
11. Due Date Mo.. / Day / Year	Physician's Signature	Date
12. Due Date Mo.. / Day / Year	Physician's Signature	Date
13. Due Date Mo.. / Day / Year	Physician's Signature	Date
14. Due Date Mo.. / Day / Year	Physician's Signature	Date
15. Due Date Mo.. / Day / Year	Physician's Signature	Date
16. Due Date Mo.. / Day / Year	Physician's Signature	Date
17. Due Date Mo.. / Day / Year	Physician's Signature	Date
18. Due Date Mo.. / Day / Year	Physician's Signature	Date
19. Due Date Mo.. / Day / Year	Physician's Signature	Date
20. Due Date Mo.. / Day / Year	Physician's Signature	Date

Appendix B 79: (UR-3)

PATIENT RECORD NOTATION UTILIZATION REVIEW DOCUMENTATION	**Patient's Name (Last, First, M.I.)**
	"C" No. / **Unit/Ward No.**
	Facility Name

Medicaid No.:	**Medicaid Authorization Date:**
Medicare No.:	**Medicare Authorization Date:**

	Check One In Each Step				
	1st Step		2nd Step		
	Approved	Not Approved	Approved	Not Approved	Reviewer's Initials
AR Completed[1]					
ICSR Completed[2]					
SCSR Completed[3]					
SCSR Completed					
SCSR Completed					
SCSR Completed					
SCSR Completed					
SCSR Completed					
SCSR Completed					
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SCSR Completed					
SCSR Completed					
SCSR Completed					
SCSR Completed					
SCSR Completed					

PATIENT RECORD NOTATION UTILIZATION REVIEW DOCUMENTATION	**Patient's Name (Last, First, M.I.)**	**"C" No.**

1 Admission Review
2 Initial Continued Stay Review
3 Subsequent Continued Stay Review

NOTE: Date of next review should be recorded in the first column, to be considered completed when determination is checked and last column is initialed. Federal regulations require date of next review to be entered in the patient's file.

Approved: Approved for Admission or Continued Stay

Not Approved: Not Approved for Admission or Continued Stay

Appendix B 80: (OMH 5)

NOTIFICATION OF REFERRAL FOR SERVICES

PART A – COMPLETED BY OMH

1. County of Proposed Placement (Name & Address of Liaison)

2. Agency(s) to Which Patient is Referred for Mental Health Services.
   a.
   b.

3. DSS County of Origin – If applicable (Name & Address of Liaison)

4. Community Services Board (Name & Address of Liaison)

5. Patient's Name (Last) (First) (M.I.)

6. Consecutive Number

7. Date of Birth (Month, Day, Year)

8. Date of Admission (Month, Day, Year)

9. Social Security Number

10. Address of Client at Time of Admission (No.) (Street) City) (State) (Zip)

11. County of Origin

12. Recipient of Public Assistance at the Time of Admission
☐ Yes ☐ No ☐ Unknown

13. County of Proposed Placement

14. Date of Probable/Actual Release/Discharge
Probable Date Actual Date

15. a. ☐ Discharge
b. Conditional Release (1) ☐ Convalescent Care (2) ☐ Family Care

16. NYS ID No.

17. Eligible Under Chapter 620
☐ Yes ☐ No

18. Eligible Under Chapter 621
☐ Yes ☐ No

19. Meets Community Support System (CSS) Eligibility Criteria
☐ Yes ☐ No

20. Please Contact the Following OMH Liaison in This Facility as Soon as Possible to Develop a Written Service Plan.
OMH Liaison Unit Telephone

21. Completed By
Name & Title _____ Date _____
Facility Name & Address _____

PART B – COMPLETED BY DSS INDICATED IN ITEM 3 ABOVE.

1. ☐ _____ (DSS County of Origin) will contact the OMH Facility and plan for the Patient's Release/Discharge.

2. ☐ I hereby request and authorize _____ (DSS County of Proposed Placement) to act on behalf of _____ (DSS County of Origin) to complete applications for Medical Assistance, Income Maintenance and/or Services and to participate in the required planning for _____ (Patient's Name)

2a. ☐ Please forward a copy of the completed Individual Service Plan.

3. Name _____
Title _____ Date _____
Signature _____

PART C – COMPLETED AFTER ADMISSION BY AGENCY PROVIDING MENTAL HEALTH SERVICES INDICATED IN ITEM 2 ABOVE.

1. _____ (Name of Agency) is providing _____ (Types of Service) services to _____ (Patient's Name)

2. Name _____
Title _____ Date _____
Signature _____

Appendix B 81: (527 DMH)

8/7/90 **ADMISSION REVIEW OF MEDICAID CERTIFICATION FORMS FOR PATIENTS UNDER AGE 21**
REVIEW OF INDEPENDENT TEAM MEDICAID CERTIFICATION FORM (528 MED)

Patient Name _____ Facility Name _____

Patient 'C' Number _____ _____
Signature of Reviewer

Date _____

CHECK HERE IF:

1. ☐ REFERRAL SOURCE CERTIFICATION
2. ☐ FOURTH PARTY CERTIFICATION

I. UR PROCEDURE - **The following procedures are required to document compliance with federa medicaid certification of need for care requirements only. The findings o: this review are not related to the decision to admit or not admit the patient. The criteria for admission on Form UR-9A must still be met.**

During admission reviews for all patients meeting the conditions stated below, the UR Coordinator must determine that the independent team medicaid certification for patients under age 21 (Form 528 MED) is:

A.	present in the patient's record	YES _____	NO _____
B.	dated prior to admission	YES _____	NO _____
C.	signed by a physician and at least one other individual	YES _____	NO _____

The 528 MED For must be attached and filed with the UR-9A, Psychiatric Utilization Review Screening Report (for admission reviews)

II. NOTE: **The Independent Team Certification (Form 528 MED)** must be completed by an Independent Team prior to admission for other than emergency admissions for all patients under 21 years of age who are medicaid recipients, and who are referred or transferred for admission for inpatient care and treatment.

The certification team must have knowledge of the individual's situation and have competence in the diagnosis and treatment of mental illness, preferably in child psychiatry. The team must consist of a physician and at least one other individual.

Appendix B 82: (72 MED)

ADVERSE REACTION REPORT

Instructions complete in triplicate for
1) Allergic reaction 3) Side Effect
2) Toxicity 4) Idiosyncratic Reaction

Copy I - to Pharmacy
Copy II - to Pharmacy for P & T Committee
Copy III - to Ward Physician

PATIENT'S NAME			
Date of Birth	Sex	Case No	
Diet	Allergies	☐ None known	
Date	Location (wd. clinic)		

Name of Medication	Dose Adm	Form	Route	Freq. Prescribed
Total Daily Dose	Duration of Therapy	Diagnosis		

Other Medications	Dose	Route	Freq.	Duration

Description of Reaction

Treatment and Results

Reported by Name _____ Title _____ Date _____

Pharmacy Use Only:
Product Manufacturer:

Reviewed by Pharmacy and Therapeutics Committee: Date: _____

Disposition: ☐ no further action necessary
☐ *refer* to U.S.P. Drug Problem Reporting

Recommendation and comments:

Signature of Chairperson _____ Date _____

Appendix B 83: (20 MED)

Form 20 Med. (MH) (4/78)

STATE OF NEW YORK - OFFICE OF MENTAL HEALTH

. . . . . .
Date

PERMISSION FOR AUTOPSY

In re:—

I hereby authorize the Director of . . . . . ., a State Psychiatric Children's Psychiatric Center, and such other person or persons as he may designate, to perform an autopsy on the body of my

. . . . . (Relationship)

. . . . . (Name of Patient)

The autopsy here authorized may be either a complete autopsy or a partial autopsy and such parts of the body may be removed for study subsequent to the autopsy as in the judgment of the physician by whom it is performed may be found necessary to accomplish its purpose.

. . . . . (Signature)

. . . . . (Print Name Signed)

. . . . . (Witness)

. . . . . (Print Name Signed)

Appendix B 84: (103 MED)

Form 103 MED (MH) (11-82)

State of New York

OFFICE OF MENTAL HEALTH

(Name of Institution)

Autopsy No. .....

Case No. .....

Ident. No. .....

AUTOPSY RECORD

NAME ..... Sex ..... Ward .....

Date and hour of death .....

Date and hour of autopsy ..... hrs. after death

Authority .....

Autopsy performed by Dr. ..... Restoration by .....

Present, Drs. .....

.....

Mental diagnosis .....

Anatomical diagnosis { Primary: ..... / Contributory: .....

.....

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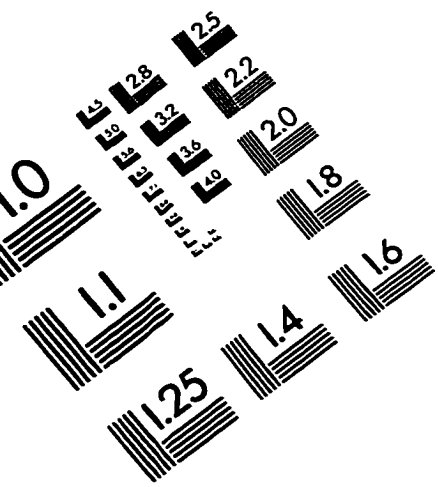
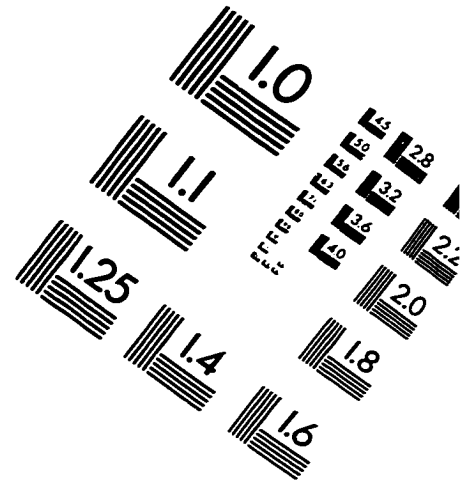
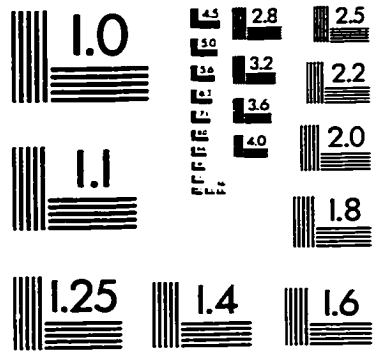
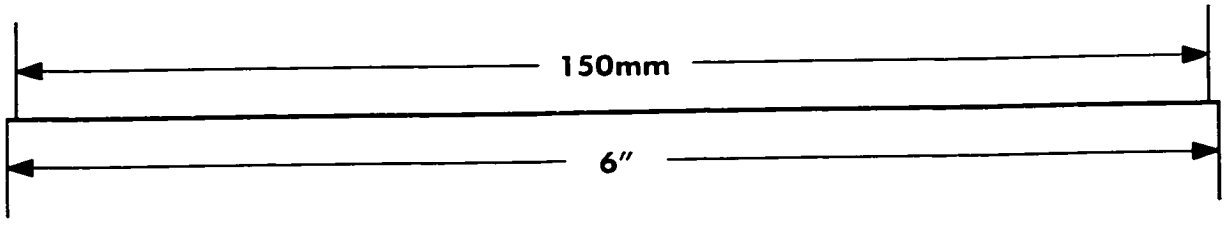
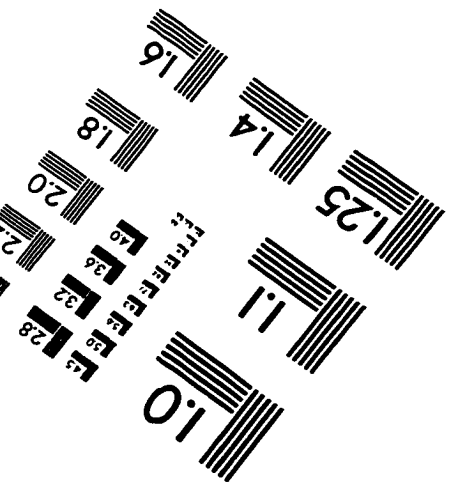
IMAGE EVALUATION
TEST TARGET (QA-3)

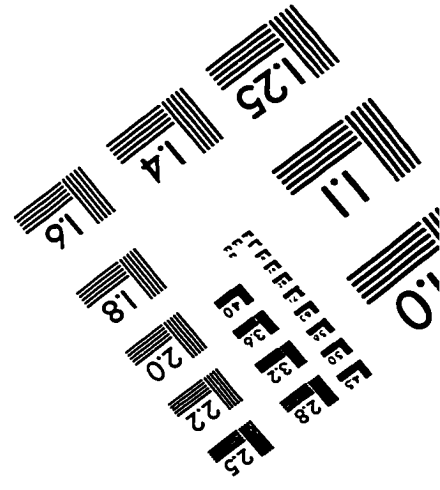












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