

QA Review Corrections

Clinician: _____
 Reviewer: _____
 Client: _____
 Correction Due Date: _____

Review Month: _____
 Date: _____
 ID: _____

Please make the needed corrections within two weeks, initial that you have made the corrections, and forward this form to the QA Coordinator—Shawna Watts. If a correction cannot be made to the chart, explain why and describe what you will do to prevent this condition from reoccurring. If you do not understand why this condition was noted as an error, please contact the reviewer identified above.

(Reminder: Reviewer please note who is responsible for each correction)

Corrected (Initial)	Can not be corrected (explain below)	Records Review Issue of Concern
		ISP: <input type="checkbox"/> Not Updated in the appropriate time frame <input type="checkbox"/> A service that is being provided is not listed: _____ <input type="checkbox"/> No Axis II Diagnosis <input type="checkbox"/> ISP Suspension needed <input type="checkbox"/> Other
		Client/Clinicians signature needed on: <input type="checkbox"/> POA <input type="checkbox"/> ISP <input type="checkbox"/> Client Rights Statement <input type="checkbox"/> Privacy Statement <input type="checkbox"/> Supervisory Statement <input type="checkbox"/> Other
		MACSIS Form Needs: <input type="checkbox"/> completed <input type="checkbox"/> turned in <input type="checkbox"/> is missing
		Needed form missing: <input type="checkbox"/> Referral For CSP <input type="checkbox"/> Referral For Medication Management <input type="checkbox"/> Referral For AOD <input type="checkbox"/> Medical Card Not Updated Monthly <input type="checkbox"/> Case Closure Needed <input type="checkbox"/> Other

Corrected	Can not be corrected (explain below)	Records Review-cont. Issue of Concern
		<input type="checkbox"/> Blanks on Psychosocial need to be filled in
		Physical Health Assessment needs <input type="checkbox"/> completed <input type="checkbox"/> signed <input type="checkbox"/> reviewed by nurse
		Missing case notes (See attached Case Note-Billing Incongruence Form): <input type="checkbox"/> CSP <input type="checkbox"/> Clinician
		<input type="checkbox"/> Billing Errors (Billing Clerk): See attached Case Note-Billing Incongruence Form
		<input type="checkbox"/> Other:

Peer Review Issue of Concern
<input type="checkbox"/> Multiple/Incompatible diagnosis <input type="checkbox"/> R/O diagnosis carrying for many months <input type="checkbox"/> Diagnosis and treatment plan do not match <input type="checkbox"/> CSP not listed in goals <input type="checkbox"/> CSP goals not appropriate <input type="checkbox"/> Comments do not clearly reflect period's progress
<input type="checkbox"/> Other:

Comments:

Date Corrected: _____

Clinician's Signature confirming that corrections were made: _____