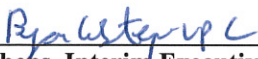
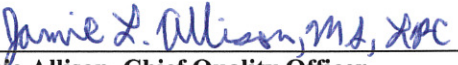




**COBB COUNTY COMMUNITY SERVICES BOARD  
DOUGLAS COUNTY COMMUNITY SERVICES BOARD**

<b>Policy # 5045</b>	<b>Record Content</b>
<b>Origination Date: February 1998</b>	
<b>Revision Date: December 2003; March 27, 2006; June 13, 2007; June 11, 2008; June 11, 2009, August 3, 2012, July 15, 2015, December 23, 2015</b>	
<b>Reviewed Date: July 2004; March 2005; May 18, 2010, October 19, 2011, October 1, 2013, October 13, 2016</b>	
<b>Approved:</b>	
 <b>Bryan G. Stephens</b> Interim Executive Director	 <b>Jamie Allison, Chief Quality Officer</b>

**POLICY:**

It is the policy of the Cobb County Community Services Board and the Douglas County Community Services Board (CSB) to maintain a clinical record on each client that contains information appropriate to the care, treatment, and services provided. As we progress from a paper record to an electronic record, information on a client may be found in both paper and electronic form.

**PROCEDURE:**

At a minimum the record will contain:

1. Signed Consent for Services
2. Signed Notice of Privacy Practices
3. Signed Client Rights and Responsibilities
4. Demographic information
5. Allergies
6. Documentation of legal guardianship
7. Other Assessments (based on the client's level of service) that may include:
  - a. Psychiatric/Diagnostic Assessment
  - b. Behavioral Health Assessment
  - c. Nursing Assessment
  - d. Physical Examination
  - e. Substance Abuse Evaluation
  - f. Vocational Profile
  - g. Inventory for Client and Agency Planning
8. Plan of Care and Reviews/Updates
9. Diagnostic and Therapeutic Orders
10. Laboratory findings (if lab (s) ordered)
11. Medication(s) administered
12. Progress Notes (group therapy, individual, family therapy, case management, etc.) which will include
  - a. Behavior of client
  - b. Interventions used with the client, including type
  - c. Client's response to interventions
  - d. Client's progress in relation to Treatment Plan/ISP/Plan of Care
  - e. Plan for client in future sessions/activities

13. Client reaction to any adverse events
14. Transition Summary if client moved to a different level of care, a service was added, a service was closed, but client will remain open in the agency, or if client transferred to a different location or site.
15. Discharge Summary upon completion of treatment within the agency
16. Continuing Care Plan when applicable
17. Other information that will aid in the provision of services to the individual client