

**QA/QI QUARTERLY CASE FILE REVIEW WORKSHEETS**  
3793:2-1-04(D)(5)

**Date of Review:** \_\_\_\_\_ **Client ID #:** \_\_\_\_\_

<b>Reviewer:</b>	<b>STAFF</b>	<b>Y</b>	<b>N</b>	<b>COMMENTS/DEFICIENCIES</b>	<b>FOLLOW UP</b>
1. Was assessment thorough and complete? (food/ medicine allergies, OTC, mental status, degree of severity)					
2. Was assessment completed timely manner? (within 7 days of intake) Date of Assessment: _____					
	<b>STAFF</b>	<b>Y</b>	<b>N</b>	<b>COMMENTS/DEFICIENCIES</b>	<b>FOLLOW UP</b>
3. Was Treatment plan problems, goals, and objectives related to the assessment?					
4. Were services provided related to the treatment plan goals and objectives?					
5. Did documentation accurately reflect the services that were provided?					

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3. Was Treatment plan problems, goals, and objectives related to the assessment?					
4. Were services provided related to the treatment plan goals and objectives?					
5. Did documentation accurately reflect the services that were provided?					

**Note:** Client records reviewed should include records from each month of the quarter.      *Outpatient*