



SANDHILLS CENTER

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
 910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org Victoria Whitt, CEO

Major Depressive Disorder Assessment Tool			
Consumer Name:	DOB:	Record ID:	
Agency Name:	Service(s) Reviewed:		
Reviewer:	Review Date:		
Questions:	Yes	No	N/A
1. Is there a complete MH assessment including medical & psychiatric co-morbidity, psychosocial status, medications, inpatient history, suicide ideation and substance abuse involvement?			
2. Is there documentation of medication management?			
a. If YES ; is there evidence of coordination with prescribing physician?			
b. If NO ; was an evaluation recommended?			
c. Is there evidence of follow-up on recommendation status?			
3. IF Patient is on medication, are they 18 years or older ? (<i>Skip questions (a.) and (b.) if not on an antidepressant</i>). If YES ;			
a. Have they remained on medication for at least 12 weeks?			
b. Has patient remained on medication for at least 6 months?			
4. Does frequency of visits change based on symptoms?			
5. Does documentation include level of client compliance with therapy and/or medication? (Circle which applied, meds, or therapy, or both)			
6. If non-compliant, were barriers addressed?			
7. Is there a documented history of cutting behaviors?			
8. Is assessment for risk of harm to self or others done each visit?			
9. What types of therapy are being utilized?			
a. Individual Therapy?			
b. Group Therapy?			
c. Family Therapy?			
d. Psycho-education?			
10. Does the treatment plan and notes include: (<i>mark NA if not specifically mentioned, and refer chart for EBP audit</i>) *For licensed clinical treatment providers only			
a. CBT			
b. DBT			
c. Psychodynamic Therapy			
d. Interpersonal Therapy			
11. Do notes contain details of patient's response to treatment?			

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12. Is there evidence of follow-up after an acute episode of care?			
a. Did follow-up occur within 7 days? (Circle one) Y N			
b. If not, did follow-up occur within 30 days? (Circle One) Y N			
13. Is there evidence of coordination of care with other services/providers?			
14. If client is a child (1-17), are they on two or more antipsychotics?			
15. If client is 65 years or older, are they taking 4 or more medications total? (For medical and/or mental health reasons)			
Maintenance			
1. Documentation of on-going assessment for:			
a. Clinical Status?			
b. Changes in Medical & Psych Co-morbidity (new medical issues reported, etc.)?			
c. Changes in Psycho-social Status (housing, changes in family circumstances, employment)?			
d. Observable, or client reported, side effects of meds?			
*For Prescribing Physicians Only (to be used in ADDITION to previous page)			
Questions:	Yes	No	N/A
1. Is lab work being ordered to ensure therapeutic levels?			
2. Is there on-going assessment for side effects of medication?			
3. Is there on-going assessment for medication compliance?			
a. If non-compliant, were barriers addressed?			
4. If client is a child, and is on two or more antipsychotics, is there evidence of metabolic testing? (Look for catchphrases like "VO ² and resting metabolic rate, weight loss/gain")			
		<i>Date Below</i>	
(Printed Name of Clinical Reviewer above, if applicable)			
(Signature of Clinical Review above, if applicable)			

HEDIS measures utilized: Metabolic Monitoring of Children; Adolescents on Antipsychotics; Use of Multiple Concurrent Antipsychotics in Children and Adolescents
 Clinical Practice Guidelines utilized: NGC-8078, NGC-9575, NGC-9710, NGC-100452, NGC-10123, NGC-10234

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