



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

Post-Traumatic Stress Disorder Assessment Tool			
Consumer Name:	DOB:	Record ID:	
Agency Name:	Service(s) Reviewed:		
Reviewer:	Review Date:		
Questions:			
1. Is there a complete MH assessment including medical & psychiatric co-morbidity, psychosocial status, medications, inpatient history, past or current military service, suicide risk assessment, and substance abuse involvement?	Yes	No	N/A
2. Does this assessment identify trauma exposure or other major stress related incidents?			
a. Are details regarding the nature of the trauma, as well as its effects included? Ex: flashbacks, nightmares, avoidance of reminders of event, physical ailments, etc.			
b. Is there evidence that symptoms impact daily functioning, and/or cause significant distress?			
3. 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?			
4. Is there evidence in the assessment, plan or notes that alternative and/or additional services were discussed with the member and/or guardian?			
5. If the client is a minor, is there evidence in service notes that the child member and guardian were engaged in treatment planning, and expressed understanding of the plan?			
6. Does frequency of visits change based on symptoms?			
7. If client is 65 years or older, are they taking 4 or more medications total? (For medical and/or mental health reasons)			
8. If client is a child (1-17), are they on two or more antipsychotics?			
9. Does documentation include level of client compliance with therapy & medication?			
10. Is assessment for risk of harm to self or others done each visit?			
11. 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. Did follow-up occur within 30 days? (Circle One) Y N			
12. Is there evidence of coordination of care with other services/providers?			

qmcappd 08/25/2020

P.O. Box 9, West End, NC 27376
24-Hour Access to Care Line: 1-800-256-2452
TTY: 1-866-518-6778 or 711

Serving Anson, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery,
Moore, Randolph, Richmond and Rockingham counties



13. Is there documentation of an evidence-based trauma therapy/intervention model utilized?			
a. Psycho-education for patient and any involved family members?			
a. Documentation of on-going assessment for:			
a. Clinical Status?			
i. Changes in Medical & Psych Co-morbidity			
ii. Observable, or client reported, side effects of meds			
iii. Changes in Psycho-social Status (housing, changes in family circumstances, employment)?			

Post-Traumatic Stress Disorder Assessment Tool			
Consumer Name:	DOB:	Record ID:	
Agency Name:	Service(s) Reviewed:		
Reviewer:	Review Date:		
*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? Initial evaluation?			
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?			
b. Sleep Disturbances?			
c. Pain Management?			
d. Acute Symptom Management?			
4. If client is a child, and is on two or more antipsychotics, is there evidence of metabolic testing? (Look for catchphrases like "CMP and resting metabolic rate, weight loss/gain")			
5. Is there evidence that patient was informed of possible medication side-effects?			

HEDIS measures utilized: Metabolic Monitoring of Children; Adolescents on Antipsychotics; Use of Multiple Concurrent Antipsychotics in Children and Adolescents; Diabetes screening for people with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications

Clinical Practice Guidelines utilized: NGC-10707, VA/DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder

	<i>Date Below</i>
<i>(Printed Name of Clinical Reviewer above, if applicable)</i>	
<i>(Signature of Clinical Reviewer above, if applicable)</i>	