CRPO
College of Registered Psychotherapists of Ontario

Record-Keeping Practices – Clinical Records Checklist

Want a checkup on your clinical record-keeping practices? To do a self-review, use this checklist, where you will find a list of CRPO's clinical record-keeping requirements derived from the Professional Practice Standards on Clinical Records (section 5.1).

How to use this checklist

Locate a recent clinical record, and have it open in front of you. Working through each item in the list, review the clinical record to determine whether it is in alignment with the record-keeping requirements listed. Review at least three records in this manner to see if a pattern emerges.

If you come to a requirement that is not included in the clinical record, consider carefully whether the requirement has been met. In some cases, a requirement may not apply to the record selected for review. Use the comments section to keep track of insights or any potential learning needs.

Take care to maintain confidentiality throughout the record review process.

Record Identifier: (e.g. name, initials or reference number)	**Summary:**
Date Reviewed:	
Reviewer name or initials:	

	Clinical Records Checklist	Comments
The record contains a client profile, which includes:		
☐	The client's full name and date of birth	
☐	The client's address and contact number	
☐	The client's date of birth	
☐	A unique identifier (if applicable/necessary)	
☐	Relevant information about the client's substitute decision-maker (if applicable)	
☐	If the client was referred to the Member, the referring professional's full name, contact information and reason for the referral OR A notation that the client self-referred	
☐	If the Member referred the client to another professional or service, the name of the professional or service and the reason the Member referred the client	

Clinical Records Checklist		Comments
The record incorporates the following:		
☐	It is legible	
☐	Entries appear in chronological order	
☐	Each entry is dated and signed (or initialed)	
☐	Changes to the record are dated and signed (or initialed) by the Member	
☐	The original entry is visible or retrievable (when electronic form is used)	
☐	Notation of all client encounters (in-person, telephone, email, web-conferencing, etc.)	
☐	A list of client reports sent or received by the Member (if applicable)	
☐	References to additional records, if documentation is stored outside the clinical record	
The record documents the therapeutic process, as follows:		
☐	The informed consent process for initial services, and whether this consent was explicit or implied	
☐	The process of obtaining ongoing informed consent, and whether this consent was explicit or implied	
☐	The therapeutic assessment, including assessment methods and, as applicable, findings, observations, professional opinions	
☐	Risk assessment, initial and ongoing	
☐	The plan or direction for therapy, which may include a description of specific therapeutic approaches or methods that will be used	
☐	Changes to the plan or direction for therapy	
☐	Client's informed consent for changes to the direction or plan for therapy	
☐	Ongoing clinical impressions and observations	
☐	Professional opinion regarding client status	
☐	Therapeutic outcomes and/or results	
☐	As applicable, the conclusion or termination of the therapeutic relationship, including reasons, and an explanatory note, such as a summary of outcomes or follow-up recommendations.	