

County of San Bernardino  
Department of Behavioral Health



ALCOHOL AND DRUG SERVICES  
QUALITY ASSURANCE REVIEW

Continued Stay Review     6-Month Stay Review     Discharge Review

Today's Date \_\_\_\_\_ Medi-Cal(Y/N) \_\_\_\_\_  
Client Name \_\_\_\_\_ Primary Counselor \_\_\_\_\_  
ID# \_\_\_\_\_ Simon# \_\_\_\_\_ Current DSM Diagnosis \_\_\_\_\_  
Admission Date \_\_\_\_\_ Prior Review Date \_\_\_\_\_  
Service Modality:  Social Model Detox     Residential     Intensive Outpatient     Outpatient

**1. Treatment Plan Information:**

Date Previous Quarterly Treatment Plan \_\_\_\_\_  
Date Current Quarterly Treatment Plan due \_\_\_\_\_ Date Completed \_\_\_\_\_  
Date M.D. Or Supervisor Signed \_\_\_\_\_  
Current plan contents: Type of counseling & frequency  Problem list   
Long/short term goals  Measurable action plan/steps  Target dates   
30 Day Treatment Plan Review   
Summarize client's work to date \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How do progress notes reflect the previous treatment plan? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. Continued Stay Justification:**

What indicates further treatment is required? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was the appropriate justification form completed?  Continued Stay     6-month Stay Review  
Next Quarterly Treatment Plan Due \_\_\_\_\_ Next Review By \_\_\_\_\_

**3. Discharge Documentation:**

Discharge Summary Date \_\_\_\_\_ Date of last face-to-face contact \_\_\_\_\_  
Was the discharge planned?  Yes  No    Discharge Criteria and 2<sup>nd</sup> ASI completed?  Yes  No

**4. Determination:**

Approve funding for modality proposed  Approve for different modality   
Conditional approval  Follow-up action required \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional Comments \_\_\_\_\_  
\_\_\_\_\_

Reviewer's Signature \_\_\_\_\_

ADS Signature \_\_\_\_\_

Date \_\_\_\_\_