alameda county behavioral health

MENTAL HEALTH & SUBSTANCE USE SERVICES

Clinical Quality Review Team (CQRT) Tracking Tool for Outpatient Programs

Fiscal Year: _____

Month	Number of Initial and Annual Charts Eligible for Review	Number of Charts Reviewed	Chart Status (Indicate number in each category)			Identified Trends and Follow Up
			Approved	Approved with Coaching	Not Approved	
Example	*100*	*5*	*3*	*1*	*1*	*Sent 1 chart back for correction. Provided coaching to one clinician on Progress Note elements.*
July						
August						
September						
October						
November						
December						
January						
February						
March						
April						
May						
June						

By writing your name below and dating the document, you attest that the information on this document accurately reflects the CQRT activities completed by registered, waivered and/or licensed staff at your agency.

CQRT Chair or Reviewer Name: _____ Date: _____