alameda county behavioral health

MENTAL HEALTH & SUBSTANCE USE SERVICES

Clinical Quality Review Team (CQRT) Comment Sheet

This form can be used if more space is needed to document comments related to a chart that was reviewed during the CQRT process.

Client Name:	**Review Period: / / / to / / /**
Client ID#/PSP:	**Episode Opening Date:**
Provider Name:	
Chart Status	☐ **Approved**- *No major changes or coaching needed* ☐ **Approved with Coaching**- *No major changes needed but coaching was provided* ☐ **Not Approved**- *Changes must be made and the chart needs to be reviewed again during the next CQRT*

Item #	Comments

CQRT Reviewer Name and Title:
CQRT Chair/Other Name and Title:
Date: / /