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 CRPO Professional Practice Standard 5.1: Clinical Records.

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 met in the clinical record, consider carefully whether any future changes are needed. 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	
	The client's address and contact number(s)	
	The client's date of birth	
	A unique identifier (if applicable/necessary)	
	Relevant information about the client's legally authorized representatives (if any, as described in the *Health Care Consent Act, 1996*, e.g., a substitute decision-maker)	
	If the client was referred to the registrant, the referring professional's full name, contact information and reason for the referral OR A notation that the client self-referred	

	If the registrant referred the client to another professional or service, the name of the professional or service and the reason the registrant referred the client	
The record incorporates the following:		
	It is legible, written in plain language, and up-to-date	
	Written in English or French OR Written in language of service, with the client profile, client record summary, and other important notes written in English or French	
	Entries appear in chronological order	
	Each entry includes the date and name or signature of the registrant	
	Each entry includes client name or unique identifiers (if applicable)	
	When amending records, the original entry is visible or retrievable and updated with the name of the person making the change, reason and date of amendment	
	Complete clinical record kept in one location to avoid incomplete or lost information	
	Notation of all client encounters (in-person, telephone, email, messaging, web-conferencing, etc.)	
	A list of client reports sent or received by the registrant (if applicable)	
The record documents the therapeutic process, as follows:		
	The informed consent process for initial services, and whether this consent was oral and/or written	
	The process of obtaining ongoing informed consent, and whether this consent was explicit or implied	
	The therapeutic assessment, including assessment methods used and, as applicable, results, conclusions, problem formulation, observations, or professional opinions regarding client status	

	Initial and ongoing risk assessments	
	The plan for therapy (or therapy plan), 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	
	Any details of incidents regarding the professional relationship, or any significant unexpected negative outcome	
	Maintaining a copy of all written reports made in compliance with mandatory reporting obligations OR When making a verbal report, preparing a written summary of the discussion and including it in records	
	Progress notes including notations of client statements, therapist observations, impressions, and proposed plans in response to client needs	
	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, referrals made, or follow-up	