

RESIDENTIAL FACILITY
PATIENTS' RIGHTS-AUDIT FORM
PART II – MEDICAL RECORD REVIEW

FACILITY NAME: _____ DATE: _____

ADDRESS: _____ ADVOCATE: _____

CHART/CASE #: _____ ADMINISTRATOR: _____

FORMS/DESCRIPTION OF DOCUMENTATION REQUIRED	STATUTE/REGULATION	COMMENTS
1. NOTIFICATION OF PATIENTS' RIGHTS:	WIC 5325	
2. ADMISSION AGREEMENT:	CCR TITLE 22, 85068	
DATE OF ADMISSION:		
3. STATE INFORMED RESIDENT RIGHTS FORM:	CCR TITLE 22, 80072 (10b)	
4. PRE-ADMISSION MENTAL HEALTH ASSESSMENT:	CCR TITLE 22, 80069.3	
DATE COMPLETED:		
UPDATED:		
DSM IV DIAGNOSIS:		
5. HISTORY & PHYSICAL:	CCR TITLE 22, 80069	
MEDICAL DIAGNOSIS:		
DATE PERFORMED:		
COMPLETED WITHIN 30 DAYS:		
UPDATED:		
6. EMERGENCY INFORMATION:	CCR TITLE 22, 80070	
7. NEEDS & SERVICE PLAN:	CCR TITLE 22, 80068.3	
TREATMENT & REHABILITATION PLAN:		
LAST UPDATED:		

FORM/DESCRIPTION OF DOCUMENTATION REQUIRED.	STATUTE/REGULATION	COMMENTS
8. PERSONAL & INCIDENTAL FUNDS:	CCR TITLE 22, 80026 (h)	
ACCOUNTING RECORD:		
9. RESIDENT WEIGHT RECORD:	CCR TITLE 22, 85075.3	
10. ORIENTATION FOR NEW CLIENTS:		
11. HOUSE RULES:	CCR TITLE 22, 80072 (10c)	
12. RELEASE OF INFORMATION:		
13. MEDICATION CONSENTS:	CCR TITLE 22, 80075 (1)	
NAME/DOSAGE/FREQUENCY:		
NAME/DOSAGE/FREQUENCY:		
NAME/DOSAGE/FREQUENCY:		
NAME/DOSAGE/FREQUENCY:		
NAME/DOSAGE/FREQUENCY:		
14. CONSERVATORHIP LETTERS:		
A. TYPE PERSON/ESTATE:		
B. EXPIRATION:		
C. CONSERVATOR:		
D. CASE MANAGER:		
15. CONSENT FOR MEDICAL TX FORM:		

COMMENTS:
