Form-B

[*See* rule 6 (3)]

Basic Medical Records:

The mental health establishment shall maintain specific minimum records at their level for various types of patients they are dealing with. The requirement of records to be maintained for in-patients, out patients and community outreach may vary and is accordingly specified below. A graded approach in minimum records to be maintained may be followed:

Community outreach register shall consist of information from (a) to (h) of the basic medical record of outpatient specified in paragraph 1 below.

The mental health establishments shall maintain and provide on demand the following basic medical record to the person with mental illness or his nominated representative.

1. Basic Medical Record of all out-patients (at hospitals, nursing homes, private clinics, camps, mobile clinics, primary health care centers and other community outreach programmes, and the like matters):

(In hard copy format)

a) Name of the mental health establishment/doctor_____

b) Date_____

c) Hospital registration number_____

d) Advance Directive YES/NO

e) Patient's Name _____

f) Age_____Sex _____

g) Father's/Mother's name_ _____

Address_____Mobile No._____

h) Chief complaints _____

i) Provisional diagnosis_____

j) Treatment advised and follow-up recommendations_____

2. Basic Medical Record of In-Patient

a) Name of the hospital/nursing home_____

b) Date_____

c) Patient's name_____

d) Father's/Mother's name_ _____

e) Age_____Sex_____

f) Address_____

g) Patient accompanied by (Name, age and nature of relationship) _____

h) Hospital registration number_____

i) Identification marks _____

j) Nominated representative _____

k) Advanced Directive - Yes or No; If yes salient features of the content

l) Date of admission_____Date of discharge _____

m) Mode of admission (section under Mental Healthcare Act, 2017): Independent/ Supported

n) Chief complaints

o) Summary of Medical Examination Laboratory investigations

p) Provisional/differential/ final diagnosis

q) Course in the hospital (Treatment and Progress)

r) Condition at discharge or discharge at request or leave against medical advice or person with mental illness absconding or others

s) Treatment advice at discharge

t) Follow-up recommendations

3. Basic Psychological Assessment Report (facilities where persons with mental illness undergoes psychological assessment):

Clinic Record No. ----------

Name: **Age:** **Gender:**

Education: **Occupation:** **Date of testing:**

Referred by: **Language tested in:**

Reason for referral:

IQ assessment	☐	Specific learning disability assessment	☐	Neuropsychological assessment(Specify domain if the assessment is domain specific)	☐
Personality assessment	☐	Psychopathology assessment	☐		

Any other (Mention the specific domain such as interpersonal relationship)

Comments if any *(may give brief detail of the referral purpose; e.g., 'the individual has mental illness and he has been referred for current psychopathology assessment as well as to ascertain the level of disability')*

Brief background information *(e.g., the nature of the problem, when it started, any previous assessments and like details):*

Informant: Self ☐

Others ☐ Specify

Salient behavioral observations *(Comment on alertness, attention, cooperativeness, affect, comprehension and any other relevant information)*

Tests/ Scales administered *(Standardized tests/ scales)***:**

Salient scores *(if applicable such as Intelligence Quotient, scores obtained on cognitive function tests, severity rating on psychopathology scales, disability percentage and like details)*

Impression:

Recommendations:

Further assessment ☐ Specify

Therapy ☐ Specify

Any other ☐ Specify

Assessed by
Name:
Date:
Qualification:

Signature:

Verified/ supervised by (if applicable)
Name:
Date:
Qualification:

Signature:

4. Basic Minimum Standard Guidelines for Recording of Therapy Report (facilities where persons with mental illness are provided with therapy for any mental health problem)

Minimum Basic Standard Guidelines for Recording of Therapy
(Name of the Institute/Hospital/Centre with address)

Clinic record no._____

THERAPIST SESSION NOTES

Patient name: **Age:** **Gender:**
Psychiatric diagnosis:

Session number and date:	**Duration of session:**	**Session Participants:**	
Therapy method: Individual Couple/Family	**Objectives of the session:** **1.** **2.**		

Group Other_____	**3.** **4.**

Key issues/themes discussed: (Psychosocial stressors/Interpersonal problems/Intrapsychic conflicts/Crisis situations/Conduct difficulties/Behavioral difficulties/ Emotional difficulties/ Developmental difficulties/ Adjustment issues/ Addictive behaviours/Others).

Therapy techniques used:

Therapist observations and reflections:

Plan for next session: **Date for next session:**

Therapist	**Supervised by (if applicable)**
Name:	Name:
Date:	Date:
Qualification:	Qualification:
Signature:	Signature: