NEVADA COUNTY – HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH DEPARTMENT
Diagnostic Review Form

Client Name:	**Client Number:**
Effective Date: Actual last review	

DISORDERS AND CONDITIONS

Summarize symptoms, precipitating factors, onset, duration and intensity that support diagnosis(es):

Summarize the client's personality characteristics that reach a level of clinical significance and support diagnosis(es). List supporting evidence for a mental retardation diagnosis, including general intellectual functioning and adaptive function:

Disorders and Conditions:

ICD-10 Code	Description	Priority	Begin Date	End Date

Summarize relevant medical issues as they pertain to the presenting problem:

***(26)General Medical Condition Summary Code:**	1.	2.	3.

IMPORTANT PSYCHOSOCIAL AND CONTEXTUAL FACTORS

Summarize the client's psychosocial and environmental problems that may affect the diagnosis treatment and prognosis:

Important Psychosocial and Contextual Factors

ICD-10 Code	Description	Priority	Begin Date	End Date

Current Programmatic Involvement: O MH O SA O Both

Client Experienced Trauma: O Yes O No O Unknown/Not Reported

Diagnostic impressions/conclusions:

Signature of Staff Completing Form:

				O Yes	O No	O N/A
Staff ID	Staff Name	Date	Time			

Signature of LPHA/MD Approving Diagnosis:

				O Yes	O No	O N/A
Staff ID	Staff Name	Date	Time			

Signature of Staff Entering Information (if different from above):

				O Yes	O No	O N/A
Staff ID	Staff Name	Date	Time			

Client Name: _____ Client #: _____