**Clinical Record Content**

* A complete social history, assessment, and treatment plan that states the client’s problems, reason or reasons for requesting services, objectives and relevant timetable, interventions strategy, planned number and duration of contacts, methods for assessment and evaluation of progress, termination plan, and reasons for termination.
* Informed consent procedures and signed consent forms for release of information and treatment.
* Notes on all contacts made with third parties (such as family members, acquaintances, and other professionals), whether in person or by telephone, including a brief description of the contacts and any important events surrounding them.
* Notes on any consultation with other professionals, including the date the client was referred to another professional for service.
* A brief description of the social worker’s reasoning for all decisions made and interventions provided during the course of services.
* Information summarizing any critical incidents (for example, suicide attempts, threats made by the client toward third parties, child abuse, family crises) and the social worker’s response.
* Any instructions, recommendations, and advice provided to the clients, including referral to and suggestions to seek consultation from specialists (including physicians)
* A description of all contacts with clients, including the type of contact (for example, in person or via telephone or in individual, family couples, or group counseling), and dates and times of the contacts.
* Notation of failed or canceled appointments.
* Summaries of previous or current psychological, psychiatric, or medical evaluations relevant to the social worker’s intervention.
* Information about fees, charges, and payment
* Reasons for termination and final assessment
* Copies of all relevant documents, such as signed consent forms, correspondence, fee agreements, and court documents.

Reamer, Frederic G. (2001). The social work ethics audit. Washington, DC: NASW Press