MH 501
Revised 10/1/15

DIAGNOSIS INFORMATION

Type of Diagnosis Information:

☐ Admission Diagnosis ☐ Clerical Revision to Admission Diagnosis ☐ Clerical Revision to Current Diagnosis
☐ Clinical Update to Current Diagnosis ☐ Other (please specify): _____

New/Updated Diagnosis: (include full *Current* ICD Diagnosis)

Note: The medication monitoring computer program will compare both the Primary and Secondary Diagnosis with any prescribed medication. A diagnosis consistent with the usual use of a given medication MUST appear as either the Primary or Secondary Diagnosis in the current/discharge diagnosis fields of the IS. If a diagnosis is inconsistent for the usual use of a medication, the medication MUST be specifically authorized through review and approval procedures.

Current Diagnosis (check one Primary and one Secondary)

☐ Primary ☐ Sec Code _____ Nomenclature _____
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Justification:

☐ See Initial Medication Support Service dated _____ ☐ See Assessment Addendum dated _____
☐ Justification from current Diagnostic Manual:

_____ _____ _____ _____
Signature & Discipline Date Co-signature & Discipline (when required) Date

☐ Diagnosis has been entered in the IS by _____ (initials) on _____ (date).

Name: **DMH ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

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Purpose: To facilitate greater diagnostic consistency between the clinical record and the Integrated System (IS), the Department's claiming system, by providing a unique place where a new or revised diagnosis can be recorded in the clinical record and subsequently the IS.

Who can complete this form: This form may be completed by a MD/DO/NP, licensed or registered and waivered Psychologists, licensed or registered Social Workers and Marriage and Family Therapists.

Recording Procedure: A client's diagnosis should only appear on two documents within the clinical record:

- Initial Clinical Assessment
- Diagnosis Information Form (this form)

To ensure the correct diagnosis is available in the Clinical Record and IS, follow these instructions regarding completing the Diagnosis Information Form:

Type of Diagnosis Information:

There are two types of diagnosis visible in the IS:

A. Admission Diagnosis – the diagnosis established at admission and appearing on the Initial Assessment except for approved situations when the Initial Medication visit has been completed prior to the Initial Assessment visit. There is never more than one admission diagnosis in the IS and it can be changed in two circumstances by marking one of the appropriate boxes on the form:
   1. **"Admission Diagnosis" box:** 1) When an Initial assessment has not been completed but an Initial Medication Support Service form has been completed use this form to open the episode documenting the admission diagnosis or 2) When an Initial Assessment has been completed and based on subsequent review of information available at admission, it is determined that a different diagnosis would have been more appropriate.
   2. **"Clerical Revision to Admission Diagnosis" box:** When a clerical mistake was made during data entry when the admission diagnosis was entered (the diagnosis was incorrectly entered into the IS) the admission diagnosis should be changed rather than a new diagnosis added.

B. Current/Discharge Diagnosis – this is the diagnosis that can be assigned anytime during the course of a client's treatment by the Department and finally at discharge. The IS will keep a sequential history of diagnosis assigned to a client throughout his/her treatment episode. The current diagnosis can be updated in two circumstances by marking the appropriate box indicated below:
   1. **"Clinical Update to Current Diagnosis" box:** When it is decided that the current diagnosis is not accurate based on new or more complete information, a new current diagnosis can be added to the IS.
   2. **"Clerical Revision to Current Diagnosis" box:** When the current diagnosis was incorrectly entered into the IS (a clerical mistake was made during data entry when the current diagnosis was entered), the current diagnosis should be changed rather than a new diagnosis added.

New/Updated Diagnosis:

Enter the complete ICD diagnosis. This represents the current ICD diagnosis for the client and the diagnosis as it should be in the IS.

Justification:

When the "Admission Diagnosis" or "Clinical Update to Current Diagnosis" box is marked for change in diagnosis, the rational must be validated in the "Justification" section of this form and/or on the Initial Medication Support Service form or Assessment Addendum. Justification should be made based on the current Diagnostic Manual.

Entering in the IS:

The completed form should be submitted to data entry staff. If a data entry error occurred when either the admission or current diagnosis was entered, the pencil icon is clicked to make the change and the date associated with the diagnosis is not changed. If there is a clinical update to a diagnosis, the blue plus sign icon is clicked and the revised diagnosis with a new date is entered. When the diagnostic information has been entered into the IS, data entry staff should initial and date the form.

Filing Procedure for Directly Operated: This form should be filed sequentially by date (most recent on top) in the Assessment/Plan section of the clinical record after data entry staff have entered the diagnostic information in the IS.