External Communication Documentation Procedure

Program: Behavioral Health Day Treatment / Partial Hospitalization Program

Effective Date: February 15, 2026

Review Date: February 15, 2027

Responsible Party: Clinical Director / Director of Medical & Clinical Services

Purpose

To establish a standardized procedure for documenting communication with external providers, agencies, and community partners. This ensures continuity of care, accurate record keeping, and compliance with clinical documentation standards.

Policy

All clinically relevant communication with external providers, agencies, or community partners must be documented in the clinical record. External communication that occurs outside of scheduled services will be documented using the Unscheduled Encounter template within the electronic health record.

Scope

External communication may include contact with:

- Primary care providers
- Psychiatric providers
- Hospitals or emergency departments
- Community agencies
- Schools or vocational programs
- Probation or court personnel
- Case managers or social service agencies
- Other treatment providers involved in the individual's care

Procedure

1. Staff member engages in communication with an external provider, agency, or authorized collateral contact regarding the individual served.

2. Staff verify that a valid Release of Information (ROI) is on file when required prior to sharing protected information.

3. Following the communication, the staff member documents the interaction using the Unscheduled Encounter template.

4. Documentation must be completed as soon as possible after the communication occurs.

5. The documentation must clearly describe the purpose of the contact and any clinically relevant information exchanged.

Required Documentation Elements

The Unscheduled Encounter documentation must include:

• Date and time of communication

• Name of external provider or agency

• Name and role of the contact person

• Method of communication (phone, email, fax, or in-person)

• Reason for the communication

• Summary of information shared or received

• Any clinical decisions or follow-up actions required

• Name and credentials of the staff member completing the documentation

Use of Communication Tracking Log

Programs may also maintain an External Communication Documentation Spreadsheet to assist with tracking communication activities and follow-up needs. The spreadsheet serves as an internal tracking tool; however, the official clinical documentation must be entered into the Unscheduled Encounter template within the clinical record.

Confidentiality

All communication must comply with HIPAA, 42 CFR Part 2 (when applicable), and organizational confidentiality policies. Only the minimum necessary information should be disclosed.

Quality Monitoring

External communication documentation may be reviewed through chart audits, clinical supervision, and quality improvement activities to ensure appropriate documentation and coordination of care.