Outcome Measure Review Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

An outcome measure review note is the documentation entry of measurement-based care: the instrument administered, the score, the change from baseline, the clinical read, the conversation with the client, and the treatment decision that follows. The measures are standardized; the note format is not.

Instrument, date & administration context name it or it never happened
Do: instrument and version, administration date, and how it was completed: in session, portal beforehand, or waiting room.
Pitfall: "screen completed" with no instrument name supports neither the billing line nor the trend.

Score & scoring integrity a number you can reproduce
Do: total and subscales, plus who scored it; verify auto-scored portal results before they enter the chart.
Pitfall: a transcription error or half-completed form; a score you cannot reproduce is one an auditor cannot credit.

Trend against baseline & prior scores the flowsheet line
Do: today's score beside baseline and the last administrations, with dates and the change since each.
Pitfall: a score with no comparison; a single number tells nobody whether treatment is working.

Clinical interpretation beyond the number the part only a clinician can supply
Do: severity range, direction and size of change, and whether the score matches what you see in session; say so when they disagree.
Pitfall: restating the number as its label ("score 11, moderate") with no clinical read.

The conversation with the client feedback is the active ingredient
Do: record that you shared the result, how you framed it, and the client's response in their words.
Pitfall: no evidence the client ever saw the score; measurement without discussion is data collection.

Item-level flags & risk follow-up always the risk item
Do: note items that change the session plan; an elevated risk item gets a same-day conversation, documented with its outcome.
Pitfall: filing a positive risk item with no documented follow-up turns a routine note into the chart's weakest page.

The treatment decision that follows what the score changes or confirms
Do: continue, adjust, change frequency, refer, or carry the target into the next treatment plan review, with one line of rationale.
Pitfall: a trend that never touches the plan is the pattern payers read as measurement theater.

Signature, date & billing linkage make the claim match the chart
Do: sign and date; one unit per instrument administered, scored, and documented when reporting 96127; mind the per-day cap.
Pitfall: units billed for instruments the note never names, or a signature that would fail an authentication check.

Before you sign

- [ ] Instrument, score, and date all named
- [ ] Trend compared with baseline, dated
- [ ] Interpretation goes beyond the number
- [ ] Client discussion documented with response
- [ ] Risk item reviewed and follow-up noted
- [ ] Decision links score to the plan
- [ ] Billing units match instruments named

Drafting with AI

Capture the review as bullets: the scores with dates, what changed, what the client said when they saw the graph, and what you decided together.

"Draft an outcome measure review note from this flowsheet and these session bullets, PHQ-9 and GAD-7 across four administrations, link the decision to the trend: …"

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every note.

75 to 300 words	3 to 10 min by hand	Every administration	Client · team · payers
plus the score flowsheet	clinical team estimate	baseline to plan review	who reads it

Full guide and sample note:
bastiongpt.com/template/outcome-measure-note

BastionGPT drafts the note from your scores and bullets. Free 7-day trial.

Outcome Measure Review Note Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Client (initials): Date: Session number:

Clinician / credentials: Next administration due:

Instrument and administration
Name, version, date administered, and how: in session, portal, or waiting room

Score
Total and subscales; who scored it

Trend vs baseline and prior scores
Baseline, priors, today: date and score rows; change since baseline and since last

Clinical interpretation
Severity range, direction and size of change, fit with session presentation

Item-level flags and risk follow-up
Items reviewed or elevated; same-day risk follow-up and outcome if indicated

Discussion with client
Scores shared and discussed; the client's response in their words

Treatment decision
Continue, adjust intervention, frequency, referral, or goal update; rationale linking score to decision

Clinician signature / credentials: Date signed: