Audit Form -- Best Practices Course
Evidence-based Management of SAD: Focus on Light Therapy

Pull the charts of the last 10 patients whom you have seen in the past 12 months for whom you have made the diagnosis of depressive disorder or seasonal affective disorder.

*Note: **Bold items** refer to follow-up care; all other items refer to initial assessment.*

Behaviour	Yes	No	For Optimal Management:
Diagnosis			
1. Checked for atypical features?			
2. Checked for recurrent seasonal episodes?			
3. Checked for summer remissions?			
4. Checked for regular seasonal psychosocial stressors?			
5. Checked for eating disorders?			
6. Checked for summer hypomania/mania?			
7. Checked for winter worsening of depression?			
8. Checked relevant laboratory tests, e.g., TSH?			
Total:			**All 8 items should be checked YES**
Management – Light Therapy			
1. Discussed light therapy?			
2. Warned against suntan studio use?			
3. Checked for retinal and systemic risk factors?			
4. Advised light therapy with 10,000 lux light box?			
5. Checked specifications of light box used?			
6. Discussed reimbursement issues re: light boxes?			
7. Advised light therapy for at least 30 minutes per day?			
8. Advised light therapy in early morning?			
9. Advised light therapy daily for at least 2 weeks?			
10. Checked for side effects to light therapy?			
11. Checked response to light therapy?			
12. Used a rating scale to check response?			
13. Advised when to stop light therapy in the spring?			
14. Advised when to restart light therapy next season?			
Total:			**At least 10 items should be checked YES:**
Management – Antidepressants (if applicable)			
1. Checked whether antidepressant medication needed?			
2. Used an SSRI (fluoxetine, sertraline) as first-line medication?			
3. Checked side effects/response to antidepressant?			
4. Advised when to stop antidepressant?			
Total:			**All 4 items should be checked YES**
Management – Combined Light Therapy/Antidepressant (if applicable)			
1. Used monotherapy before using combination therapy?			
2. Used combined light therapy/antidepressant?			
3. Checked side effects/response to light therapy/antidepressant?			
Total:			**At least 2 items should be checked YES**