

Nursing Progress Note/Service Entry

NAME / MRN _____

Facility Name: _____ ID: _____ Program Name: _____ ID: _____

Provider: _____ ID: _____ Service Date: _____

Service Category:

CPT/HCPC Service Provided Lockout - CPT/HCPC Service Provided

Other Service Provided:

Money Management Providing transportation Leaving voicemails

Coordination of logistics Clerical work Other _____

Direct Service
Time (Min): _____

Documentation
Time (Min): _____

Travel
Time (Min): _____

Number in Group: _____

CPT/HCPC Code: _____

Quantity: _____

Location of Service (Please check one)

- | | | |
|--------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------|
| <input type="checkbox"/> Age-Specific Community Center | <input type="checkbox"/> Homeless/Emergency Shelter | <input type="checkbox"/> Phone-provided other than in client's home |
| <input type="checkbox"/> Client's Job Site | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Residential Care - Adults |
| <input type="checkbox"/> Correctional Facility | <input type="checkbox"/> Mobile Service | <input type="checkbox"/> Residential Care - Children |
| <input type="checkbox"/> Faith-Based | <input type="checkbox"/> Non-Traditional service location | <input type="checkbox"/> School |
| <input type="checkbox"/> Field | <input type="checkbox"/> Office | <input type="checkbox"/> Telehealth/Video-provided in client's home |
| <input type="checkbox"/> Health Care/Primary Care | <input type="checkbox"/> Other Community Location | <input type="checkbox"/> Telehealth/Video-provided other than in Client's home |
| <input type="checkbox"/> Home | <input type="checkbox"/> Phone-provided in client's home | <input type="checkbox"/> Unknown/Not Reported |
| <input type="checkbox"/> Nontraditional Location | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Unknown |

Did this service involve interactive complexity? Yes No

Was an Interpreter used? Yes No

Name of Interpreter: _____

Language

Language service provided

in other than English: Spanish Other _____

Is the client pregnant? Yes No (If yes, please document how service was pregnancy-related)

EBP/Service Strategies:

- | | | |
|--------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Assertive Community Treatment | <input type="checkbox"/> Therapeutic Foster Care | <input type="checkbox"/> In Partnership w/ Health Care |
| <input type="checkbox"/> Supportive Employment | <input type="checkbox"/> Multisystemic Therapy | <input type="checkbox"/> In Partnership w/ Social Services |
| <input type="checkbox"/> Supportive Housing | <input type="checkbox"/> Functional Family Therapy | <input type="checkbox"/> In Partnership w/ SA Services |
| <input type="checkbox"/> Family Psychoeducation | <input type="checkbox"/> Peer/Family Delivered Services | <input type="checkbox"/> Integrated Services for MH/Aging |
| <input type="checkbox"/> Integrated Dual Diagnosis Treatment | <input type="checkbox"/> Psychoeducation | <input type="checkbox"/> Integrated Services for MH/DD |
| <input type="checkbox"/> Illness Management and Recovery | <input type="checkbox"/> Family Support | <input type="checkbox"/> Ethnic-Specific Service Strategy |
| <input type="checkbox"/> Medication Management | <input type="checkbox"/> Supportive Education | <input type="checkbox"/> Age-Specific Service Strategy |
| <input type="checkbox"/> New Generation Medications | <input type="checkbox"/> In Partnership w/ Law Enforcement | <input type="checkbox"/> Unknown Service Strategy |

(COUNTY STAFF ONLY) Evidence-based practice/tracking program? Yes No Program _____

This service was provided via telehealth with the consent of the client or authorized representative.

Interim History And Observations

Mental Status Exam

CURRENT MEDICATIONS: *Please list all Psychiatric and non-Psychiatric medications at each visit.*

Medication Consents are current

Adherence / Side Effects / Adverse Effects Discussed

Medication or non-medication allergies/serious reactions? No Yes (if so, please describe):

OBJECTIVE DATA

AIMS Performed Ht _____ Wt _____ BMI _____ Waist _____ BP/P _____

Labs/Other Studies Reviewed

Results:

Diagnosis

Primary
ICD-10 Code: _____ DSM-5 Narrative: _____

Secondary
ICD-10 Code: _____ DSM-5 Narrative: _____

NAME / MRN _____

Patient-Stated Goals and Concerns

Nursing Intervention

Plan For Continued Service (Include care plan, if needed)

Medications Administered This Visit

Future Appointments

with MD/DO: _____ With RN: _____ With Case Manager/Other: _____

Is this late documentation? Yes No

The problem list/Care Plan has been updated as needed: Yes No

Signature: _____

DATE: _____

Printed Name and Licensure: _____

Data Entry Clerk Initials _____