Psychiatric Services Progress Note/Billing Form

NAME / MRN ____________________

Facility Name: ________________ ID: _______ Program Name: ____________________ ID: _________

Provider: ___________________ ID: _______ Number in Group: ________ Group ID: _________

Elapsed Time (Total Minutes): ______________ Travel Time (Total Minutes): ______________

Co-Staff:
Provider: ___________________ ID: _______ Number in Group: ________ Group ID: _________

Elapsed Time (Total Minutes): ______________ Travel Time (Total Minutes): ______________

Service (Begin) Date: ____________________ Begin Time: 12:00 am

Service Code (check one)

	Med Svcs		**MH Services**	**CM and Non-Billable Services**
	☐ **300** No Show	☐ **362** RN/INJ	☐ **311** Collateral	☐ **541** Case Mgmt - Placement
	☐ **400** Client Cancel	☐ **363** EDUC	☐ **341** Indiv Therapy	☐ **561** Case Mgmt - Linkage
	☐ **700** Staff Cancel	☐ **364** PLAN/DEV	☐ **351** Group Therapy	☐ **540** Non-Billable - MH Services
	☐ **361** EVAL/RX	☐ **369** MED GROUP	☐ **371** Crisis Intervention	☐ **580** Non-Billable - Lock-outs
Loc	☐ Office	☐ Home	☐ Inpatient	☐ Telehealth – Pt Home
	☐ Field	☐ School	☐ Other	☐ Telehealth – Other than Pt Home
	☐ Phone	☐ Correctional Facility		
Svc Stgy	☐ **50** Peer/Family Services	☐ **53** Supportive Education	☐ **56** With Social Services	☐ **59** With Developmentally Disabled
	☐ **51** Psycho-Education	☐ **54** With Law Enforcement	☐ **57** With Substance Abuse	☐ **60** Ethnic-specific Services
	☐ **52** Family Support	☐ **55** With Health Care	☐ **58** With Aging Providers	☐ **61** Age-specific Services

BRIEF DESCRIPTION OF CLIENT ***(Age, Gender, Current Presentation, Date of Last Visit):***

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

☐ **Interpreter** Name of Interpreter**:** ____

Language service provided in other than English: ☐ Spanish ☐ Other ______________________

INTERIM HISTORY AND OBSERVATIONS

(Progress and Improvement, Current and/or Persistent and/or Symptoms/Problems/Issues):

Client Name: ______________________________________ **Client MRN/ID:** ___________________

TARGETED MENTAL STATUS EXAM ***(Orientation, grooming, mood, affect, thought/perceptual content, insight)*:**

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

☐ ***Medication Consents are current*** ☐ ***Adherence / Side Effects / Adverse Effects Discussed***

OBJECTIVE DATA: *AIMS Performed* ☐ *Ht* _____ *Wt* ______ *BMI* _____ *Waist* ______ *BP/P* ____________

Lab or other Studies Reviewed ☐

Results:

CURRENT DIAGNOSTIC IMPRESSION*:* ICD-10 Code, DSM-5 Diagnosis and Narrative

ICD-10 Code: ________________________ DSM-5 Diagnosis: ___________________ (Primary)

DSM-5 Narrative Diagnosis: ____

ICD-10 Code: ________________________ DSM-5 Diagnosis: ___________________ (Secondary)

DSM-5 Narrative Diagnosis: ____

DESCRIPTION OF PSYCHOTHERAPEUTIC INTERVENTION, IF ANY:

PLAN FOR CONTINUED SERVICE: *(Including Lab Orders, Education, Coordination of Care).*

LABS/ Other Studies ordered: ☐ ***REFERRAL to PCP*** ☐ ***REFERRAL for Psychotherapy*** ☐ ***Coordination with PCP*** ☐

Client Name: ______________________________________ **Client MRN/ID:** ___________________

℞: ☐ **No ℞ Changes** **# Refills Authorized** ___________ ☐ **Medication Record Updated**

☐ **Medication Changes and Rationale** ☐ **Justification of Continued Use of Benzodiazepines**

SPECIFIC CHANGES:

Next Appointments:

with MD/DO: _____________ With RN: _____________ With Case Manager/Other: ___________

MD/DO/NP/RN Signature:____ DATE: _______________

MD/DO/NP/RN NAME: ____

____
Data Entry Clerk Initials