Telepsychiatry 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): ______________

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

Service Code (check one)

	☐ **300** No Show ☐ **400** Client Cancel ☐ **700** Staff Cancel	**Telepsychiatry/Medication Services** ☐ **302** New Patient – Office or O/P visit ☐ **305** Established Patient – Office or O/P visit
Loc	☐ Telehealth – Pt Home	☐ Telehealth – Other than Pt Home
Svc Stgy	☐ **50** Peer/Family Services ☐ **53** Supportive Education ☐ **51** Psycho-Education ☐ **54** With Law Enforcement ☐ **52** Family Support ☐ **55** With Health Care	☐ **56** With Social Services ☐ **59** With Developmentally Disabled ☐ **57** With Substance Abuse ☐ **60** Ethnic-specific Services ☐ **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)*:**

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

NAME/MRN

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 DIAGNOSIS*:*

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*** ☐

NAME/MRN

℞: ☐ 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