CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Substance Use Disorders Progress Note and Service Entry Form

Confidential Patient Information under HIPAA & 42 CFR Part 2

NAME / MRN _____

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

Begin Date: _____ Begin Time: _____ End Time: _____

LEVEL OF CARE (Choose One)

☐ 1.0 Outpatient	☐ 3.2 Residential Withdrawal Management (WM)	☐ 4.0 Medically Managed Intensive Inpatient
☐ 2.1 Intensive Outpatient	☐ 3.3 Population-Specific High-Intensity Residential	☐ Care Coordination
☐ 2.5 Partial Hospitalization	☐ 3.5 High-Intensity Residential	☐ Recovery Services
☐ 3.1 Low-Intensity Residential	☐ 3.7 Medically Monitored Inpatient	

SERVICE INFORMATION

Elapsed Time (hrs/min):	Total Time (hrs/min):	Travel Time (hrs/min):

Confirmed Pregnancy	Interpreter	Name of Interpreter (If applicable):	Language service provided in other than English (if applicable):
☐ Yes ☐ No	☐ Yes ☐ No		

RENDERING PROVIDER (Choose All That Apply)

☐ Psychiatrist	☐ Physician Assistant	☐ Nurse Practitioner
☐ Registered Nurse	☐ Licensed Vocational Nurse	☐ Pharmacist
☐ Licensed Psychiatric Technician	☐ Medical Doctor	☐ Psychologist/Pre-licensed Psychologist
☐ Alcohol and Drug Counselor – Registered	☐ Alcohol and Drug Counselor – Certified	☐ Mental Health Rehab Specialist
☐ LPHA (MFT, LCSW, LPCC)/ Intern or Waivered LPHA (MFT, LCSW, LPCC)		☐ Peer Recovery Specialist
☐ Other Medi-Cal Billing, Qualified Providers/Designated MH staff		☐ Occupational Therapist

DOCUMENTATION TIME (Levels 1.0, 2.1, Care Coordination And Recovery Svcs Only)

Documentation Start Time:	Documentation End Time:	Total Documentation Time (in minutes):

PLACE(S) OF SERVICE (CHOOSE ALL THAT APPLY)

☐ Licensed Care Facility (Adult)	☐ Satellite	☐ Primary Care Health Clinic	☐ Telehealth other than Pt Home
☐ Office	☐ Inpatient Psychiatric	☐ Residential Tx Center (Child)	☐ Telehealth in Patient Home
☐ Field	☐ Inpatient Health	☐ Residential Tx Center (Adult)	☐ Age Specialty Center
☐ Phone	☐ Emergency Room	☐ Hospice	☐ Faith-Based Location
☐ Home	☐ Jail	☐ Skilled Nursing Facility	☐ Non-Traditional Location
☐ School	☐ Homeless / Shelter	☐ Job Site	☐ Other Location

SERVICE(S) RENDERED

☐ Assessment ☐ Counseling: Individual ☐ Counseling: Group ▪ # Beneficiaries in Group(s):_____ ▪ Duration of Session(s) (in minutes):_____ ☐ Family Therapy ☐ Medication Services ☐ Patient Education ☐ SUD Crisis Intervention	☐ Clinician Consultation ☐ MAT for Opioid Use Disorder in non-MAT Facility ☐ MAT for Non-Opioid Disorder in non-MAT Facility ☐ Recovery Services: Recovery Monitoring ☐ Recovery Services: Relapse Prevention ☐ Withdrawal Management: Observation ☐ Care Coordination: Medical/MH Care ☐ Care Coordination: Discharge Planning ☐ Care Coordination: Ancillary Services ☐ MAT: Prescribing & Monitoring for MAT for OUD ☐ MAT: Withdrawal Management Services	☐ Peer Support: Educational Skill Building ☐ Peer Support: Engagement ☐ Peer Support: Therapeutic Activity ☐ SAMHWorks: Life-Skills Group ☐ SAMHWorks: Parent-Child Counseling ☐ SAMHWorks: Treatment Planning ☐ SAMHWorks: Support Group ☐ SAMHWorks: Mental Health Service

Client Name: _____ **Client MRN/ID:** _____

PROGRESS NOTE

(IF MORE THAN ONE RENDERING PROVIDER WAS SELECTED, INDICATE THE AMOUNT OF TIME EACH PROVIDER RENDERED EACH SERVICE)

Service Provider Printed Name:	Service Provider Signature (with credentials):	Date Service Provider Printed & Signed:

Client Name: _____ **Client MRN/ID:** _____

LPHA PROGRESS NOTE

(INDICATE "N/A" IN SECTION BELOW IF DOES NOT APPLY FOR ASSOCIATED SERVICE)

LPHA Printed Name:	LPHA Signature (with credentials):	Date LPHA Printed & Signed: