



Progress Note / Service Entry 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

Telehealth consent obtained (if applicable): Yes No

Service Code (check one)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> 371 Crisis Intervention | <input type="checkbox"/> 358 IHBS | <input type="checkbox"/> 331 Assessment | <input type="checkbox"/> 355 Group Rehab |
| <input type="checkbox"/> 300 No Show | <input type="checkbox"/> 564 ICC | <input type="checkbox"/> 341 Individual Therapy | <input type="checkbox"/> 357 Group Collateral |
| <input type="checkbox"/> 400 Client Cancel | <input type="checkbox"/> 565 ICC-CFT | <input type="checkbox"/> 351 Group Therapy | <input type="checkbox"/> 541 CM Placement Services |
| <input type="checkbox"/> 700 Staff Cancel | <input type="checkbox"/> 311 Collateral | <input type="checkbox"/> 319 Family Therapy-Client present | <input type="checkbox"/> 561 CM Linkage |
| <input type="checkbox"/> 540 Non-Bill | <input type="checkbox"/> 313 Evaluation | <input type="checkbox"/> 320 Family Therapy Without Client present | <input type="checkbox"/> 571 CM Plan Dev |
| <input type="checkbox"/> 580 IMD/JAIL/JUV SVC Lock-out | <input type="checkbox"/> 315 Plan Dev | <input type="checkbox"/> 317 Rehabilitation Support | |

Location of Services (Please check one)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Office | <input type="checkbox"/> Satellite | <input type="checkbox"/> Emergency Shelter | <input type="checkbox"/> Skilled nursing facility |
| <input type="checkbox"/> Field | <input type="checkbox"/> Inpatient Psychiatric | <input type="checkbox"/> Primary Care Health Clinic | <input type="checkbox"/> Mobile Service |
| <input type="checkbox"/> Phone | <input type="checkbox"/> Inpatient Health | <input type="checkbox"/> Res Tx Ctr (child) | <input type="checkbox"/> Job Site |
| <input type="checkbox"/> Home | <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Res Tx Ctr (adult) | <input type="checkbox"/> Age Specialty Center |
| <input type="checkbox"/> School | <input type="checkbox"/> Jail | <input type="checkbox"/> Hospice | <input type="checkbox"/> Faith-Based Location |
| <input type="checkbox"/> Telehealth-Clt Home | <input type="checkbox"/> Telehealth-Other than Clt Home | | |
| <input type="checkbox"/> Nontraditional Location | <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Unknown |

Language

Language service provided in other than English: Spanish Other _____

Interpreter Name of Interpreter: _____

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

Diagnosis:

DSM-5 Diagnosis: _____ ICD-10 Code: _____ (Primary)

DSM-5 Narrative Diagnosis: _____

DSM-5 Diagnosis: _____ ICD-10 Code: _____ (Secondary)

DSM-5 Narrative Diagnosis: _____

Problem/Behavioral Health Need Addressed. Describe problem/need, reason for contact, status update, clinical impression.

Client Name: _____

Client MRN/ID: _____

Focus of Activity. Describe type of service rendered, how the service addressed client's behavioral health need, how the client responded – symptoms, condition, diagnosis, and/or risk factors.

Plan. Describe next steps – action steps by provider or client, collaboration with the client or other providers.

Targeted Case Management Care Plan (if applicable).

(1) Describe goals, including client's participation in development goals. (2) List actions/interventions (3) Describe transition plan for when client has achieved goals.

Is this late documentation? Yes No

The Problem List/Care Plan has been updated as needed

Signature/License/Designation

Printed Name

Date

Co-Signature/license (if applicable)

Printed Name

Date

Data Entry Clerk Initials _____