Nursing 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

Telehealth consent obtained (if applicable): ☐ **Yes** ☐ **No**

Service Code (check one)

☐ **300** No Show	☐ **362** RN/Inj	☐ **311** Collateral	☐ **541** Case Mgmt - Placement
☐ **400** Client Cancel	☐ **363** Evaluation	☐ **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 – Lockouts

Location of Services (check one)

☐ Office	☐ Phone	☐ School	☐ Telehealth-Clt Home
☐ Field	☐ Home	☐ Correctional Facility	☐ Telehealth-Other than Clt Home

☐ Other ___________________________________ ☐ 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)**

Interim History And Observations

Mental Status Exam

Appearance/Grooming ***(appears stated age, good grooming/hygiene, disheveled, malodorous, etc.)***

Behavioral Relatedness ***(NAD, cooperative, playful, difficult to redirect, inappropriately laughing/smiling, etc.)***

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Motor Activity ***(normokinetic, gait, posturing, tics/tremors/EPS, psychomotor agitation or retardation, etc.)***

Speech ***(fluent, rate/rhythm/volume, spontaneous, hyperverbal, dysarthric, mute, etc.)***

Mood/Affect ***(Congruent/incongruent, full, flat, blunted, restricted, elated, dysphoric, labile, inappropriate, etc.)***

Thought Process ***(linear, goal-oriented, tangential, flight of ideas, circumstantial, thought blocking, loose associations, etc.)***

Thought Content ***(suicidal/homicidal/paranoid ideations, grandiose/persecutory delusions, etc.)***

Perceptual Content ***(Auditory/visual hallucinations, responding to internal stimuli, etc.)***

Cognition/Orientation

Attention/Concentration

Memory

Abstract Reasoning

Insight/Judgment

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

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

Diagnosis

DSM-5 Diagnosis: ____________________ ICD-10 Code: _________________________ (Primary)

DSM-5 Narrative Diagnosis: ____

DSM-5 Diagnosis: ____________________ ICD-10 Code: _________________________ (Secondary)

DSM-5 Narrative Diagnosis: ____

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 _______________

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