CONTRA COSTA BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Psychiatrist 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)**

Brief Description Of Client

Interim History And Observations

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

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.)***

_____

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):

_____

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

OBJECTIVE DATA
AIMS Performed ☐ Ht _____ Wt _____ BMI _____ Waist _____ BP/P _____ Labs/Other Studies Reviewed ☐
Results

_____

Diagnosis

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

DSM-5 Narrative Diagnosis: _____

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

DSM-5 Narrative Diagnosis: _____

_____

Current Assessment

_____

Plan For Continued Service (Include care plan, if needed)
Labs/Other Studies ordered ☐ Referral to PCP ☐ Referral for Psychotherapy ☐ Coordination with PCP ☐

_____

Medications Ordered This Visit
☐ No Changes # Refills Authorized _____ ☐ Medication Record Updated
☐ Medication Changes and Rationale ☐ Justification of Continued Use of Benzodiazepines

_____

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 _____