Psychopharmacology- Psychotherapy
Progress Note ACT only

This form is to be completed ONLY by an ACT Team psychiatrist, advanced practice nurse, or other medical personnel with prescribing privileges when providing a service which includes psychopharmacology.

Data Field	Identifying Information Instructions
Organization Name	Enter your organization name.
Program Name	Enter your program name
Individual's Name	Record the first name, middle initial, and last name of the Individual served. Order of name is at agency discretion.
Record #	Record your agency's established record number for the Individual served.
DOB	Record Individual's date of birth. **Example : mm/dd/yyyy**
List of Names of Individual(s) at Session	Check the box that applies for the contact type. List location if offsite. Check appropriate box: "Individual Present"- If individual is present "Others Present" – If others are present. Identify name(s) and relationship (s) to the Individual. "No Show" – If Individual did not show. Follow-up as indicated by agency policy/ procedures "Individual Canceled" – If Individual canceled. "Provider Canceled" – If provider canceled. Document explanation(s) as relevant. Manual and Agency Policy should indicate need to address missed appointments (No Show and Cancellation) in subsequent progress notes.
Data Field	**Prescriber's Evaluation**
Interim Update	Document an interval history of individual including progress made since last session, effectiveness of medications, progress related to symptoms, substance use, significant new issues, changes in family and social history and overall functioning. If there are "No Changes Reported/Observed", then check appropriate box.
Does the Individual require a full Mental Status Exam?	Check appropriate box. If Yes is checked, attach a completed Mental Status Exam form and move to Risk Assessment Section. If No is checked, complete the Mini-Mental Status.
Mini-Mental Status	Comment on current areas of mental status evaluation, including significant changes since last visit. For each condition you must check either no changes or Notable. If Notable is checked, comment on the changes reported or observed in the appropriate sections. For substance abuse "not applicable" can be checked.
Risk Assessment **Danger To**	Check appropriate box(s). Document any risk issues and, if present, document actions taken.
Takes meds as prescribed	Record whether medication was taken as prescribed since last session, *yes/no* or *n/a*. Provide additional relevant information after *Comments*.

Side effects reported	Record whether side effects are present or occurred since last session, *yes/no*. Check all boxes that apply. Provide additional relevant information after *Comments*, e.g. increased thirst, dizziness, decreased sexual function.
Allergic reactions	Record any reported or observed allergic reactions to medications, yes/no. As appropriate, provide additional relevant information after *Comments.*
Changes in Medical Status	Record whether there have been any changes in medical status since last session, *yes/no.* Provide additional relevant information after *Comments*.
Other Meds	Record any other medications the Individual is/was taking since last session, *over the counter/herbal/ none/other*. Provide additional relevant information after *Comments*.
Goal(s) Addressed as Per Psychopharmacology/ Individualized Action Plan	Identify the specific goal(s) and objectives in the Psychopharmacology Plan / IAP addressed during this session. .
Stage of Treatment	Check the appropriate box.
Data Field	**Interventions**
Describe All/Other Interventions	Check all boxes as applicable and comment on all interventions selected.
Response to Intervention/Progress Toward Goals/Objectives	This section should address **BOTH**: • *The Individual's response to the intervention* - Include evidence the Individual participated in the session and how, and information about how the Individual, family, and /or collaterals were able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • *Progress toward goals and objectives* - Include an assessment of how the session has moved the Individual closer, further away, or had no discernable impact on meeting the Individual's identified goal(s) and objective(s). **OR** • *Plan to overcome lack of progress* - If no progress is made over time, this section should also include how the prescriber intends to change his/her strategy to produce positive change in the individual. **Individual Example: John actively participated by listing triggers. Agreed to practice de-escalation and calming techniques during the next two weeks, particularly on the job; he is very anxious about this. John agrees identifying those situations in which his anger is a problem is a big step forward for him. Agrees he must continue to work on this or possibly lose his job.** **Couples Example: John served was able to say that it was quite difficult to listen without interrupting. His partner reported that he became anxious trying to do the exercise but wants to be supportive.**
Lab Tests Ordered	Indicate whether lab tests were ordered by checking appropriate box. Summarize key laboratory test results received and reviewed. Check appropriate box to indicate whether key laboratory test results were *reviewed* (with the individual). If lab results were *not received*, describe action to be taken to obtain results.

Height/Weight/BMI **Blood Pressure/VS**	Record information pertaining to Individual's height, weight, body mass index, blood pressure, and vital signs as relevant. Document if there has been communication between the prescriber and the PCP. Provide additional relevant information as appropriate.
Diagnosis	Document whether or not the Individual's psychiatric diagnosis has changed. If diagnosis has changed, check *yes* and proceed to Comprehensive Assessment Update form.

Data Field	Medication Renewal / Changes
Rationale for Changes in Medications	If no changes were made today, check the appropriate box. Otherwise, document rationale for any medication changes. This is a required section for evaluation and management and should reflect the prescriber's medical decision making.
Medication Grid	For each medication prescribed, indicate if the medication is renewed (R*enew*), Change (*Change),* newly prescribed *(New*) or Discontinued (D/*C*). Write the name of the medication, dosage, freq. (*frequency*), # of Days, QTY, (quantity), and number of Refills prescribed. For each new medication prescribed, the Individual should be given information about its risks and benefits. If the Individual does not demonstrate an understanding of the risks and benefits, then the prescriber should indicate in the Instructions /Comments Section what steps should be taken. This section is to record changes ONLY, not to relist every medication the individual is taking. This note is not a substitute for the agency's medication reconciliation form where all medications are listed.
Were meds delivered today?	Check box that applies; if yes, indicate duration.
Prescription Written	Check box that applies; if yes indicate if prescription was called into pharmacy.
Instructions/Comments/Plan as applicable:	Document any additional relevant instructions or psycho-educational information.
Next Appointment:	Indicate the date of next appointment or fill in time frame to return. **Example : mm/dd/yyyy**
Data Field	**Signature, Medicare Services and Billing Strip Instructions**
Prescriber - Print Name/ Credentials/Title:	Legibly print the prescriber's name, including credentials and title, and date. **Example : mm/dd/yyyy**
Prescriber's Signature:	Legibly record provider's signature credentials and date. **Example : mm/dd/yyyy**
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Supervisor Name - Print Name/ Credentials/Title:	If required, legibly print name of supervisor and date. **Example : mm/dd/yyyy**
Supervisor Signature:	If required, legibly record supervisor's signature credentials and date. **Example : mm/dd/yyyy**
Date	Record the date of signature, including the month, day and year. **Example : mm/dd/yyyy**

Data Field	Medicare "Incident To" Instructions
Medicare "Incident to" Services Only (if applicable)	Check the box when service is to be billed using the "incident to" billing rules.
Name and Credentials of Medicare Supervising Professional on Site (if applicable)	Enter the name of the supervising professional who provided the on-site supervision of the "incident to" service. **Note:** The presence of an appropriately licensed supervising professional is one of the key requirements for an "*incident to"* service. For nursing services this must be an MD or an NPP. In some cases, the service is billed under the number of the supervising professional. In others, the attending professional's number should be used. Providers should consult with their Medicare Carrier's Local Medical Review Policies.