Organization Name:		**Program Name:**	
Individual's Name (First / MI / Last):		**Record #:**	**DOB**:

List Name(s) of Individual(s) at Session:	☐ Individual Present / Contact Type: ☐ Onsite ☐ Offsite ☐ Phone Conversation ☐ Others Present (please identify name(s) and relationship(s) to individual): ☐ No Show ☐ Individual Canceled ☐ Provider Canceled Explanation:	☐ Admission Note (Check only once per episode of care as needed)

Prescriber's Evaluation

Interim Update (include the report on status, the effectiveness of medications, progress related to symptoms, substance use, any significant new issues and overall functioning since last contact): ☐ No Changes Reported/Observed

Provide Mental Status Update Narrative or complete Update section below:

Mental Status Update

Individual's Condition	**No Significant Changes Reported or Observed**	**Notable**	**If Notable, List the Changes in Individual's Condition**
Appearance and Behavior	☐	☐	
Mood and Affect	☐	☐	
Speech	☐	☐	
Thought Process	☐	☐	
Thought Content	☐	☐	
Cognition - If impaired do Folstein Mini-Mental Status Exam	☐	☐	
Insight and Judgment	☐	☐	

Risk Assessment
Danger To: ☐ None Reported or Observed **OR:**

☐ **Self**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt
☐ **Others**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt
Comments:

Takes meds as prescribed: ☐ **No** ☐ **Yes** ☐ **n/a - Comments:**

Organization Name:		Program Name:	
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Side effects reported: ☐ No ☐ Yes – If Yes, Please comment:

Changes in Medical Status: ☐ No ☐ Yes – If yes, please comment on plan:

Goal(s)/Objective(s) Addressed As Per Psychopharmacology/Individualized Action Plan or ☐ Based on Initial Plan for Services:

Goal ___	Goal ___	Goal ___	Goal ___
Objective ___ Objective ___ Objective ___ Objective ___	Objective ___ Objective ___ Objective ___ Objective ___	Objective ___ Objective ___ Objective ___ Objective ___	Objective ___ Objective ___ Objective ___ Objective ___

Stage of Treatment: ☐ Pre-Contemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance ☐ Relapse

Therapeutic Interventions Delivered in Session

Describe All / Other Interventions: (Check all that apply)

Motivational: ☐ Promote Hope and positive expectations ☐ Connect information and skills with Individual goals ☐ Explore the pros and cons of change ☐ Reframed experiences in a positive light

Educational: ☐ Medication Counseling ☐ Medication Education ☐ Reducing Relapses ☐ Coping with Symptoms and problems

Supportive: ☐ Medication Monitoring ☐ Prescribing Medication

Other: ☐ Symptom/Illness Management ☐ Injections ☐ Coordination of Services/Referrals ☐ Psychotherapy ☐ Other:

Comment on All Interventions Selected:

Response to Intervention(s) and Progress Toward Goals and Objectives:

Does the client display insight into behavior/illness/symptoms: ☐ No ☐ Yes
Level of Insight: ☐ Good ☐ Fair ☐ Poor
Judgment as it relates to behaviors: ☐ Good ☐ Fair ☐ Poor
Comments:

Lab Tests Ordered ☐ No ☐ Yes - Labs Reviewed ☐ No ☐ Yes, Results:
If Labs not received, describe action to be taken:

Weight / Height / Waist Measurement / BMI (if applicable)**:**   **Blood Pressure/VS's** (if applicable)**:**
If Appropriate Contact PCP - Comments:

Diagnosis since last visit: ☐ **No change** ☐ **Yes, CA Update Required**

Organization Name:		**Program Name:**	
Individual's Name (First / MI / Last):		**Record #:**	**DOB**:

Medication Renewal / Changes
Are their changes or renewals for Medication, herbal remedies, vitamins, nutraceuticals, or over-the-counter drugs? ☐ No ☐ Yes - *If yes, please document on the Medication List.*
Were meds delivered today? ☐ NA ☐ No ☐ Yes – **If yes, for what duration:** ☐ Weekly ☐ Monthly ☐ Other:
Prescription Written ☐ **No** ☐ **Yes - Called into the Pharmacy?:** ☐ **No** ☐ **Yes**
Instructions/Comments/Plan:
Next Appointment:

Prescriber - Print Name/Credentials		**Prescriber Signature & Credentials:**	**Date:**
Supervisor - Print Name/Credentials (if applicable):		**Supervisor - Signature** (if applicable):	**Date:**

☐	Medicare "Incident to" Services Only	**Name and Credentials of Medicare Supervising Professional on Site**								
Date of Service	**Staff Identifier**	**Loc. Code**	**Service Code**	**Mod 1**	**Mod 2**	**Mod 3**	**Mod 4**	**Start Time**	**Stop Time**	**Duration in Minutes**