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 person'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:

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

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

Intervention(s) / Methods provided:

Psychopharmacology: ☐ Medication Prescribed ☐ Injection(s) Given – If Yes, Injection Site:

Medication Tolerated ☐ No ☐ Yes – If No, describe:

Counseling Provided with Client/Family/Caregiver:

☐ Diagnostic results/impressions and or recommended studies
☐ Instruction for management/treatment and/or follow-up
☐ Risk factor reduction
☐ Client/Family/Caregiver Education
☐ Risks and benefits of treatment options
☐ Importance of adherence with chosen treatment
☐ Prognosis

Coordination of Care Provided (Must be <u>with person present</u> and involves coordination of care with staff <u>outside</u> of our Agency)
Check off as appropriate and describe below-include name, phone # of person with whom coordinating care.)
Coordination with: ☐ Medical Staff ☐ Residential Staff ☐ School staff ☐ Probation ☐ Family ☐ Caregiver ☐ Other:

Other Intervention(s) / Methods provided:

Response to Intervention(s) and Progress toward goals and objectives:

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

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.***

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**
E & M Only	☐ **Greater than 50% of face to face time spent providing counseling and/or coordination of care.**

Date of Service	Staff Identifier	Loc. Code	Service Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Duration in Minutes