



Session Progress Note Revision Date: 11-1-12 Page 1 of 1

Organization Name:							Program Name:						
Individual's Name (First / MI / Last):							Record #:				OB:		
Modality	Modality Individual Family Couple Phone Admission Note (Check only once per episode of care)												
				Present / Contact Type: Onsite Offsite Phone Conversation esent (please identify name(s) and relationship(s) to individual):									
Individua	Is Present	☐ No Show Explanation	_	☐ Person Canceled ☐ Provider Canceled									
Individual's Condition				No Significant Changes Reported or Observed			е	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													
Risk Assessment													
Danger To: □ None Reported or Observed OR: □ Self: □ Ideation □ Plan □ Intent □ Attempt □ Others: □ Ideation □ Plan □ Intent □ Attempt													
Comments:													
New Issues / Stressors / Extraordinary Events Presented Today: ☐ New Issue Resolved, No Update Required													
□ New Issue, CA/IAP Update Required □ None Reported Explanation:													
Goal(s)/Objective(s) Addressed As Per Individualized Action Plan or ☐ Based on Initial Plan for Services													
Goal Objective Objective Objective Objective				Goal Objective Objective _ Objective				<i>,</i> — <i>,</i> — .		,	Goal Objective Objective Objective Objective		
Intervention(s) / Methods provided:													
Response	e to Intervent	ion(s) and Pi	ogress	toward goals a	ınd obj	ectives:							
Plan / Additional information (OASAS-any recommendations or determinations for continued or revised treatment / ACT: also identify gaps in													
services)	:												
Completed By - Print Staff Name/Credentials: Staff Sign							nature:		Date:				
Supervisor - Print Name/Credentials (if applicable): Sup						Supervis	upervisor Signature:					Date:	
Individual's Signature (Optional):								Date:					
Guardian's Signature (Optional):										Date:			
Medicare "Incident to" Services Only Name and Credentials of Medicare Supervising Professional on Site													
Date of	Staff	Loo	Code	Service	Mod	Mod	Mod	Mod	Start	Stop			
Service	Identifie	r Loc.	Code	Code	1	2	3	4	Time	Time		Duration in Minutes	