Section

4

Using the NYSCRI Progress Note Documentation Processes/Forms

This section provides a sample of each Progress Note form type, guidelines for the use of each form, and instructions for completion of the forms, including definitions for each data field.

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Note: Forms utilized in Section Four have been modified in both height and width to accommodate the format of the Training Manual. Please utilize electronic versions of actual forms for reproduction and use within Provider Agency.

Pre-Admission Note
Revision Date: 11-25-10

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

Narrative (Indicate the type of services, activities, interventions delivered during the preadmission meeting):

Print Staff Name/Credentials/Title :	**Staff Signature:**	Date:
Print Supervisor Name/Credentials/Title (if applicable)**:**	**Supervisor Signature:**	Date:
Individual's Signature (Optional)**:**		Date:

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

Pre-Admission Progress Note

Required for OMH Mental Health Clinics, OASAS Outpatient, OASAS Adolescent Outpatient, Methadone programs, Partial Hospitalization Programs, CDT, and PROS.

Data Field	Identifying Information Instruction
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 the individual's date of birth. **Example : mm/dd/yyyy**
Narrative	Please indicate type of services, activities, interventions, delivered during pre-admission meeting.
Data Field	**Signature Instruction**
Print Staff Name/ Credentials/Title	Print staff name, credentials (degree/license), and title.
Staff Signature	Legible signature
Date	Record the date of signature, including the month, day and year. **Example : mm/dd/yyyy**
Supervisor Name/Credentials/Title (if needed)	Print the supervisor's name, credential (degree/license) and title of supervisor, if needed.
Supervisor Signature	Legible signature
Date	Record the date of signature, including the month, day and year. **Example : mm/dd/yyyy**
Individual's signature (optional)	Legible signature. This is encouraged, especially if the note was written collaboratively.
Date	Record the date of signature, including the month, day and year. **Example : mm/dd/yyyy**



Screening /Admission Note
Revision Date: ***11-25-10***

Organization Name:	**Program Name:**	
Individual's Name (First / MI / Last):	**Record #:**	**DOB**:
Admission Date:	**Service Plan Due:**	

Below 18 years if age? Yes ☐ No ☐ - If Yes, identify collateral by name and relationship:

Referral source:

Reason for referral:

Diagnosis: ☐ DSM Codes (or successor) ☐ ICD Codes (or successor)

Check Primary	Axis	Code	Narrative Description
☐	Axis I		
☐			
☐			
☐	Axis II		
☐			
	Axis III		
	Axis IV		
	Current GAF:		Highest GAF in Past Year (if known):

Narrative:

Results of the Psychiatric Rehabilitation Readiness Determination: (**For IPRT only**): Please indicate the score as a result of completing the readiness determination. Include any referrals and pertinent information:



Individual's Name (First / MI / Last):	**DOB**:
Admission indicated: ☐ **Yes** ☐ **No – (Please note the reason for admission or reason for non-admission, disposition, and any referrals given below):**	
Strengths (Describe Individual's strengths):	
Clinical, Immediate and Other Services Related Needs: (Based on referral information and/or evaluation, describe the individual's needs or issues):	
Rehabilitation aspirations: (For IPRT / Optional for others): Describe what the individual wants to achieve from the rehabilitation experience? What is the individual's desired outcome?	



Individual's Name (First / MI / Last):	**DOB**:

Initial Services - Indicate the service(s) staff will provide to meet the individual's identified needs. Specify the activities that will make up the services:

Indicate collaterals interviewed if applicable: (For OMH Mental Health Clinics, and Children's Day Treatment programs only)

Print Staff Name/Credentials/Title:	**Staff Signature:**	Date:
Print Supervisor Name/Credentials/Title (if applicable)**:**	**Supervisor Signature:**	Date:
Individual's Signature (Optional)**:**		Date:

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

Screening/Admission Progress Note

Required for OMH Programs only: IPRT, Mental Health Clinics, Partial Hospitalization Programs, ACT Teams, CDT, and PROS.

Data Field	Identifying Information Instruction
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 the Individual's date of birth. **Example : mm/dd/yyyy**
Admission Date	Record the admission date using the month, day, and year. **Example: mm/dd/yyyy**.
Service Plan Due	Record the date the service plan is due. **Example : mm/dd/yyyy**
Referral source	Identify referral source, agency affiliation, name, address, title of contact and phone number.
Reason for referral	Describe reason for referral.
Diagnosis	Complete all diagnosis codes as applicable.
Narrative	Provide additional information if necessary.
Results of Psychiatric Rehabilitation Readiness Determination (IPRT Only)	Indicate the score as a result of completing the readiness determination. Include any referrals and pertinent information.
Admission indicated	Check box that applies. Indicate the reason for admission or reason for non-admission, disposition, and any referrals given.
Strengths	Describe the Individual's strengths.
Clinical, Immediate, and other services related to needs	Based on referral information and/or evaluation, describe the Individual's needs or issues to be addressed.
Rehabilitation aspirations (For IPRT only)	Describe what the Individual served wants to achieve from the rehabilitation experience? What is the person's desired outcome?
Initial services	List the services that will be delivered to meet the assessed needs. Specify the activities that staff will use to implement the services. Engagement, assessments, relapse prevention, crisis intervention etc.
Indicate collaterals interviewed if applicable	Indicate collaterals that were interviewed if applicable. (For OMH Mental Health Clinics, and Children's Day Treatment programs only)
Data Field	**Signature Instruction**
Print Staff Name/ Credentials/Title	Print staff name, credentials (degree/license) and title.
Staff Signature	Legible signature

Date	Record the date of signature, including the month, day and year. **Example : mm/dd/yyyy**
Supervisor Name/Credentials/Title (if needed)	Print the supervisor's name, credential (degree/license) and title of supervisor, if needed.
Supervisor Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Individual's signature (optional)	Legible signature. This is encouraged, especially if the note was written collaboratively.
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Medicare "Incident to" Services Only (if applicable)	Check the box when service is to be billed using the "incident to" billing rules.

Admission Note – Residential Only
Revision Date: *11-25-10*
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Organization Name:	**Program Name:**	
Individual's Name (First / MI / Last):	**Record #:**	**DOB**:
Admission Date:	**Service Plan Due:**	

Below 18 years of age? Yes ☐ No ☐ - If yes, identify collateral by name and relationship:

Does the Individual meet the criteria for SPMI/SED: ☐ **Yes** ☐ **No**

Alerts: Check all risk factors that apply. Provide details, as indicated, in the Comments Section:

- ☐ **Allergies**
- ☐ **Danger to Others**
- ☐ **Danger to Self**
- ☐ **Drug/Alcohol Use or Abuse**
- ☐ **Medical Conditions/Problems**
- ☐ **Medication Side Effects**
- ☐ **Needle Disposal Issue (e.g., Diabetes)**
- ☐ **Physical / Sexual Abuse or Neglect** (☐ Victim ☐Abuse)
- ☐ **Other:**

Comments:

Reason for admission:

Diagnosis: ☐ DSM Codes (or successor) ☐ ICD Codes (or successor)

Check Primary	Axis	Code	Narrative Description
☐	Axis I		
☐			
☐			
☐	Axis II		
☐			
	Axis III		
	Axis IV		
	Current GAF:		Highest GAF in Past Year (if known):



Admission Note – Residential Only
Revision Date: *11-25-10*

Individual's Name (First / MI / Last):	**DOB**:

Immediate and other services related needs: (Based on referral information and/or evaluation, describe the individual's needs or issues):

Initial services - Indicate the service(s) staff will provide to meet the individual's identified needs. Specify the activities that will make up the services:

Print Staff Name/Credentials/Title:	**Staff Signature:**	Date:
Print Supervisor Name/Credentials/Title (if applicable)**:**	**Supervisor Signature:**	Date:
Individual's Signature (Optional)**:**		Date:

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

Admission Note – Residential Only

Required for OMH Residential Programs.

Data Field	Identifying Information Instruction
Organization Name	Enter your organization name.
Program Name	Enter your program name.
Record Number	Record your agency's established record number for the Individual served.
DOB	Record the individual's date of birth. **Example : mm/dd/yyyy**
Admission Date	Record the admission date using the month, day and year. **Example : mm/dd/yyyy**
Individual's Name	Record the first name, middle initial, and last name of the Individual served. Order of name is at agency discretion.
Service Plan Due	Record the date the service plan is due. **Example : mm/dd/yyyy**
Below 18 years of age?	Check appropriate box and enter age and identify collateral by name and relationship. **Example: Jane Doe, Mother.**
Does the Individual meet the criteria for SPMI/SED?	Select yes or no based upon the Individual's status.
Alerts	Check all risk factors that apply. Provide details, as indicated, in the Comments section.
Reason for Admission	Based on referral information and /or evaluation, indicate why the resident requires this level of care.
Diagnosis	Complete all diagnosis codes as applicable.
Immediate and other services related needs	Based on referral information and/or evaluation, describe the Individual's needs or issues to be addressed.
Initial services	List the services that will be delivered to meet the assessed needs. Specify the activities that staff will use to implement the services. Substance abuse services, rehabilitation counseling, daily living skills training, etc.
Data Field	**Signature Instruction**
Print Staff Name/ Credentials/Title	Print staff name, credentials (degree/license), and title.
Staff Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Supervisor Name/Credentials/Title (if applicable)	Print the supervisor's name, credential (degree/license), and title of supervisor, if needed.
Supervisor Signature	Legible signature
Date	Record the date of signature, including the month, day and year. **Example : mm/dd/yyyy**
Individual's signature (optional)	Legible signature. This is encouraged, especially if the note was written collaboratively.

Date	Record the date of signature, including the month, day and year. **Example : m/dd/yyyy**

Contact Note
Revision Date: 11-25-10

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

Contact Type ☐ Onsite meeting ☐ Offsite meeting – Location: ☐ Telephone ☐ Follow Up Note

List All Individuals Present
☐ Individual Present
☐ Others Present (please identify name(s) and relationship(s) to individual):
☐ No Show ☐ Person Canceled ☐ Provider Canceled
Explanation:

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:

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

Intervention(s) / Method(s) Provided:

Response to Intervention / Progress Toward Goals and Objectives:

Plan / Additional Information (*Indicate action plan between sessions/meetings*):

Print Staff Name/Credentials/Title :	**Staff Signature:**	Date:
Print Supervisor Name/Credentials/Title (if applicable):	**Supervisor Signature:**	Date:
Individual's Signature (Optional):		Date:

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

Contact Note

Required for Case Management Programs, Partial Hospitalization Programs, *PROS, and Residential Programs.

Documentation links to specific goals in the IAP.

*PROS Progress notes are required monthly or more frequently when clinically appropriate including, but not limited to, crisis or relapse situations, and significant changes to individual's status.

Data Field	Identifying Information Instruction
Organization Name	Enter the 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.
DOB	Record the Individual's date of birth **Example : mm/dd/yyyy**
Contact type	Check the box that applies for the contact type. List location if offsite.
List all Individuals Present	Check appropriate box: "Individual Present"- If Individual served is present. "Others Present" – If others are present". Identify name(s) and relationship (s) to Individual served. "No Show" – If Individual served did not show. Follow-up as indicated by agency policy/ procedures "Individual Canceled" – If Individual served 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	New Issues, Goals and Interventions Instruction
New Issues/ Stressors/ Extraordinary Events Presented Today	There are three options available for staff using this section of the progress note (new issues refers to all **new** issues/stressors/extraordinary events). 1. If Individual served reports a new issue that was resolved during the contact, check the "New Issue resolved, No Update Required" box. Briefly document the new issue in this section and then identify the interventions used in the Interventions/Methods section and indicate the resolution in the Response section of the progress note. If services are provided during the contact that have not been previously ordered in the Individualized Action Plan, then an explanation of the rationale for those services should be provided. **Example of New Issue not needing CA/IAP update: Linda became uncharacteristically angry with another member during a group encounter and the two began arguing loudly. Group leader intervened and assisted Linda with identifying what had triggered excessive anger today. Linda was able to recognize that the other group member reminded her of her abusive uncle (already addressed in IAP) and apologized to the other member. Both participants agreed that the issue was resolved in group.**. 2. If individual presents any new issue(s) that represent a need that is not already being addressed in the IAP, check box indicating "New Issue, CA/IAP Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed issue(s) may require a new goal, objective, intervention or service that will require use of the IAP Review/Revision form. **Example of New Issue needing CA/IAP Update:** **Linda reported new symptoms of nightmares, intrusive memories, and feeling unsafe, triggered by an event that reminded her of an incident when she was a victim of abuse at age 12. This has not been previously reported. Both parties agreed that a CA and IAP update was needed, and was recorded on the CA and IAP Update forms on this date.** 3. If no new issues presented mark "None Reported" and proceed to planned intervention/goals.
Data Field	**Goal (s) Addressed as per Individualized Action Plan Instruction**
Goals/Objectives Addressed As Per Individualized Action Plan	Record the specific goals and objectives addressed by indicating the corresponding number(s) from the Individualized Action Plan. In an electronic record, the description of the actual goals and objectives may appear in this field once the box is checked. However, when using this form as a paper form, list the number(s) of the goals & objectives that are being addressed.

Intervention(s) / Methods Provided	Describe the specific interventions used to assist the Individual served in realizing the goals and objectives listed above. All interventions must be targeted toward specific goals/objectives in the Individualized Action Plan. **Example: Staff taught Jack relaxation breathing techniques.** **Using the example of Jack's stressful experience, staff asked him to verbalize positive ways to resolve the situation.**
Response to Intervention/ Progress Toward Goals and Objectives	Describe how the Individual served responded to the intervention today. Also describe the Individual's progress toward meeting his/her goals/objectives. If no progress is made over time, this section should address how staff intends to change his/her strategy. **Example: Jack listened attentively to feedback from staff about how he could handle the conflict with his wife differently, which is an improvement for him, but he seemed hesitant to try the suggestions made.**
Plan / Additional Information	If applicable the provider should document steps or actions planned with the individual for the next time frame. Plan to overcome lack of progress: If no progress is made over time, this section should also include how the worker intends to change his/her strategy to help the Individual work toward improvement. **Example: Jack agreed to practice using the skills he learned during this contact with regards to using a medication calendar.** **Example: Jack agreed to write a list of qualities he is looking for in a sponsor for us to review tomorrow.** Document additional pertinent information that is not appropriate to document elsewhere. **Example: Jack received a call from his wife and they discussed whether she should bring their children to her next visit.**
Data Field	**Signature Instruction**
Print Staff Name/ Credentials/Title	Print staff name, credentials (degree/license), and title.
Staff Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Supervisor Name/Credentials/Title (if applicable)	Print the supervisor's name, credential (degree/license), and title of supervisor, if needed.
Supervisor Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Individual's Signature (optional)	Legible signature. This is encouraged, especially if the note was written collaboratively.
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**

Coordination of Care Progress Note
Revision Date: *11-25-10*

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

Type of Scheduled Contact: ☐ In-Person Meeting: ☐ Onsite / ☐ Offsite – Location: ☐ Telephone

Service *(check ONE service only)*	**Purpose** *(check purpose(s) for the indicated service)*
☐ Case Consultation ☐ Family Consultation ☐ Collateral Contact ☐ Other:	☐ Assessment of the appropriateness of current services ☐ Coordination/Planning ☐ Discharge/Transition/Aftercare planning ☐ Clinical consultation ☐ Other:

	Name:	**Agency/Relationship to person served:**
List of Participants		

Summary of discussion with this contact:(for ex: IAP goals/objectives/ interventions)

Actions that will occur as a result of this contact:	**Responsible Party:**
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**

Print Staff Name/Credentials/Title:	**Staff Signature:**	Date:
Print Supervisor Name/Credentials/Title (if applicable):	**Supervisor Signature:**	Date:
Individual's Signature (Optional):		Date:

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

Coordination of Care Progress Note

Designed for use by PROS, Case Management Programs, and OMH Clinics, ACT Teams, CDT, and Partial Hospitalization Programs to document Case Consultation, Family Consultation or Collateral Contact services. This form can be used for either billable or non-billable services.

Data Field	Identifying Information
Organization Name	Enter the organization's 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 the Individual's date of birth. **Example : mm/dd/yyyy**
Type of Scheduled Contact	Indicate if contact was an in-person meeting, and if so whether it was onsite or offsite (include location), or via telephone. If individual was not present explain in the Summary of Discussion section.
Service	Check **one** of the following services provided: **Case Consultation** - a face-to-face or telephone communication (note regulatory requirements for duration and billing if required), between staff and another treating provider in order to identify, plan, and coordinate treatment. (e.g. PCP, pediatrician, psychiatrist, therapist, case manager). Case consultation can be for individuals of any age (both children and adults in treatment) ***Please note****:* Clinical supervision or consultation with other clinicians within the same provider agency are not billable. **Family Consultation** - a face-to-face or telephone communication (note regulatory requirements for duration and billing if required) between staff and the individual's identified family in order to identify, plan, and coordinate treatment. **Collateral Contact** - is a face-to-face or telephone communication by the staff and/a person or agency, in order to support and/or reinforce the treatment plan. A collateral contact is a person or plan participant who is not paid with OMH, OASAS, or Medicaid Funding. **Other –** another type of coordination of care service not described by the categories noted above.
Purpose:	Check the relevant purpose(s) of this contact: Assessment of the appropriateness of current services; Coordination planning; Discharge/Transition/Aftercare planning; Clinical consultation (not supervision); Other. If Other, provide relevant information.

Data Field	List of Participants, Summary, Actions, and Responsible Party Instructions
List of Participants	Identify all who participated in the contact. List name(s), agency (s) represented, and relationship(s) to individual served.
Summary of discussion with this contact.	Indicate the coordination of care discussion (e.g. treatment goals, objectives, or interventions) addressed during contact.
Actions that will occur as a result of this contact	Indicate any resulting actions to occur from this contact, (e.g., new appointment scheduled with primary therapist, change in frequency of therapy, etc.). Write no action if none is needed.
Responsible Party	Indicate the person(s) responsible for carrying out the resulting action from this contact (correspond with numbers in the Actions section).
Data Field	**Staff Signatures and Billing Strip**
Print Staff Name/Credentials/Title:	Print the staff's name, credentials (degree/license), and title.
Staff Signature	Legible signature
Date	Record the date of the signature including month, day, and year. **Example : mm/dd/yyyy**
Supervisor Name/Credential/Title	Print the staff's name, credentials (degree/license), and title.
Supervisor Signature	Legible signature.
Date	Record the date of the signature including month, day and year. **Example : mm/dd/yyyy**
Individual's Signature (Optional)	Legible signature. This is encouraged, especially if the note was written collaboratively.

Individual Counseling/Psychotherapy Progress Note
Revision Date: *11-25-10*

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

Modality	☐ Individual ☐ Family ☐ Couple ☐ Phone
Individuals Present	☐ Individual Present / Contact Type: ☐ Onsite ☐ Offsite ☐ Phone Conversation ☐ Others Present (please identify name(s) and relationship(s) to individual): ☐ No Show ☐ Person Canceled ☐ Provider Canceled Explanation:

Individual's Report of Progress Towards Goals/Objectives Since Last Session:

Individual's Condition	No Significant Changes Reported or Observed	Notable	If Notable, List the Changes in Individual's Condition
Mood/Affect:	☐	☐	
Thought Process/ Orientation:	☐	☐	
Motor Activity and Speech:	☐	☐	
Behavior/Functioning:	☐	☐	
Medical Condition:	☐	☐	
Substance Use / Additive Behaviors: ☐ NA	☐	☐	

Risk Assessment

Danger To: ☐ None **OR** Check all that apply below and record action taken in Therapeutic Interventions section below

☐ **Self**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt - Comments:
☐ **Others**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt / ☐ **Property**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt

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:

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

Intervention(s) / Method(s) Provided:

Response to Intervention / Progress Toward Goals and Objectives:

Individual Counseling/Psychotherapy Progress Note
Revision Date: *11-25-10*

Individual's Name (First / MI / Last):	**DOB**:

Plan / Additional Information (Indicate action plan between sessions/meetings):		
Print Staff Name/Credentials/Title:	**Staff Signature:**	Date:
Print Supervisor Name/Credentials/Title (if applicable):	**Supervisor 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 Service	Staff Identifier	Loc. Code	Service Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Duration in Minutes

Individual Counseling/Psychotherapy Progress Note

This form to be used by OMH Mental Health Clinics, CDT, OASAS outpatient, OASAS Adolescent, Methadone programs, ACT Teams, PROS
Use this note to document individual, family or couples psychotherapy sessions. (PROS progress notes are required monthly or more frequently where clinically appropriate including, but not limited to, crisis or relapse situations and significant changes in individual's status).

Data Field	Identifying Information Instruction
Organization Name	Enter 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 the Individual's date of birth. **Example : mm/dd/yyyy**
Modality	Check appropriate box to indicate the type of session: individual, family, couple, or phone.
Individuals Present	Check the box that applies for the contact type. List location if offsite. Check appropriate box: "Individual Present"- If Individual served is present "Others Present" – If others are present. Identify name(s) and relationship (s) to the Individual served. "No Show" – If Individual served did not show. Follow-up as indicated by agency policy/ procedures "Individual Canceled" – If Individual served 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.
Individual's Report of Progress Toward Goals/Objectives Since Last Session	Document Individual's self-report of progress toward goals/ objectives since last session including other sources of information, such as family, case manager, etc.
Individual's Condition: **Mental Status**	This is a Mini-Mental Status Exam. Check appropriate box to indicate Individual's condition as "No Change" or "Notable". If "Notable" is checked, describe the changes. **Note**: Notable is defined as behavior or symptoms different from the individual's baseline status. These changes may be signs the individual is experiencing increased problems or distress or may indicate an improvement in functioning/symptoms/behavior. **Example: Thought process/orientation is marked *Notable* and the comments are: "John is distracted and responding to voices he is hearing today." However, if John's baseline is that he always hears some voices and responds, a *Notable* comment would not be needed unless the intensity or impact of the voices on John is significantly different than his baseline.**

Risk Assessment/ Danger To	Check appropriate box(s) to indicate area(s) and type(s) of risk or check *None*. Describe types of risk behavior such as cutting, mutilation, unsafe sex, etc. under Additional Comments. If any box except *None* is marked, be sure to document in the *Response to Interventions* section how this was addressed and resolved.
Data Field	**New Issues/Stressors/Extraordinary Events Instructions**
New Issues/ Stressors/ Extraordinary Events Presented Today	There are three options available for staff using this section of the progress note (new issues refers to all **new** issues/stressors/extraordinary events). 1. If individual reports a new issue that was resolved during the contact, check the "New Issue Resolved, No Update Required" box. Briefly document the new issue in this section and then identify the interventions used in the Interventions/Methods section and indicate the resolution in the Response section of the progress note. If services are provided during the contact that have not been previously ordered in the Individualized Action Plan, then an explanation of the rationale for those services should be provided. **Example of a New Issue not needing a CA/IAP update: During the counseling session John became angry and loud, counselor was able to have John explore his anger and John admitted to needing to use his calming techniques. Within 5 minutes, John was able to calm himself down and resume discussions with the counselor. NO CA/IAP update needed.** 2. If individual presents any new issue(s) that represent a need that is not already being addressed in the IAP, check box indicating "New Issue/ CA/IAP Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed issue(s) may require a new goal, objective, intervention or service that will require use of the IAP Review/Revision form. **Example of New Issue needing CA/IAP Update:** **Joan reported new symptoms of nightmares, intrusive memories, and feeling unsafe, triggered by an event that reminded her of an incident when she was a victim of abuse at age 12. This has not been previously reported. Both parties agreed that a CA and IAP update was needed, and was recorded on the CA and IAP Updates on this date.** **3.** If no new issues presented mark "None Reported" and proceed to planned intervention/goals. .

Data Field	Goal(s) Addressed as Per Individualized Action Plan
Goal(s) Addressed as Per Individualized Action Plan	Identify the specific goal(s) and objective(s) in the Individualized Action Plan being addressed during this intervention. All interventions must be documented in a progress note and must be targeted toward specific goal(s)/objective(s) in the Individualized Action Plan except as noted above under new issues.
Data Field	**Interventions, Progress, and Response to Interventions Instructions**
Intervention(s) / Methods Provided	Describe the specific therapeutic interventions used in the psychotherapy session to assist the Individual in realizing the goals and objectives addressed as the focus of this particular session. **Individual Example: Helped Larry to develop a list of those situations at work which most often result in him becoming angry and acting out. Demonstrated and role-played de-escalation technique of leaving area and self-calming, using relaxation techniques.** **Family Example: Family members were asked to take turns saying something positive about each other and then to express how difficult that is. Then they were asked to talk about what impact doing that has upon the individual's depressed mood.** **Couples Example: Provider asked the Larry and his partner to listen to each other for five minutes and then to tell the other individual what they heard.**

Response to Intervention/ Progress Toward Goals and 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). **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.** **Family Example: Amy was able to tell her parents that their criticisms of her schoolwork made her feel bad and she needed more positive feedback and support from them. Her parents could not recognize that their comments were critical and insisted she was misunderstanding them. Although Amy did not receive the support she requested, she showed good progress as she was able to continue discussing the issue with her parents without escalating.** **Couples Example: As Allen described a recent argument with his partner, he was able to recognize how their communication style exacerbates his anxiety. Allen reported becoming increasingly anxious in the session each time his partner interrupted him. Once identified, Allen was better able to assert himself while his partner was able to decrease the number of interruptions.**
Plan / Additional Information	The clinician should document future steps or actions planned with the Individual such as homework, plans for the next session, etc. *Plan to overcome lack of progress* - If no progress is made over time, this section should also include how the counselor intends to change his/her strategy to help the Individual work toward improvement. Document additional pertinent information that is not appropriate to document elsewhere. **Example: John will keep a mood journal to identify triggers to explosive episodes and bring to next session to review and discuss alternative responses.**

Data Field	Signature Instructions
Print Staff Name/ Credentials/Title	Print staff name, credentials (degree/license), and title.
Staff Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Supervisor Name/Credentials/Title (if needed)	Print the supervisor's name, credential (degree/license), and title of supervisor, if needed.
Supervisor Signature	Legible signature
Date	Record the date of signature, including the month, day and year. **Example : mm/dd/yyyy**
Individual's Signature (optional)	Legible signature. This is encouraged, especially if the note was written collaboratively.
Guardian's Signature (optional)	Signature. This is encouraged, especially if the note was written collaboratively.
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 Authorized Supervising Professional on Site:	Enter the name of the appropriate supervising professional who provided the on-site supervision of the "incident to" service. **Note:** The presence of an appropriate licensed supervising professional is one of the key requirements for an "*incident to"* service. In some cases, the service is billed under the number of the supervising professional. In others, the attending professional's number should be used.

Group Progress Note
Revision Date: *11-25-10*

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

Individual Did Not Attend: ☐ **No Show** ☐ **Canceled - Explanation:**

DOCUMENTATION OF PARTICIPATION AND RESPONSE OF INDIVIDUAL TO GROUP TREATMENT

Behavior in Group (*Check All that Apply*):

☐ **Showed insight**	☐ **Active in discussion**	☐ **Offered constructive input**	☐ **No apparent interest**
☐ **Showed interest**	☐ **Non-verbal but engaged**	☐ **Supportive to others**	☐ **Appeared distracted**
☐ **Showed leadership**	☐ **Withdrawn**	☐ **Not supportive to others**	☐ **Disruptive**

Individual's Mood: ☐ **Stable** ☐ **Depressed/Sad** ☐ **Anxious** ☐ **Angry** ☐ **Other:**

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:

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

Intervention(s) / Method(s) Provided:

Response to Intervention / Progress Toward Goals and Objectives:

Plan / Additional Information (Indicate action plan between sessions/meetings):

Print Staff Name/Credentials/Title:	**Staff Signature:**	Date:
Print Supervisor Name/Credentials/Title (if applicable)**:**	**Supervisor Signature:**	Date:
Individual's Signature (Optional)**:**		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

Group Progress Note

The Group Progress Note is used for groups for the following programs: OMH Mental Health Clinics, Residential Programs, ACT Teams, CDT, OASAS and Methadone Clinics.

Data Field	Identifying Information Instructions
Organization Name	Enter your organization name.
Program Name	Enter your program name.
Individual's Name	Record the first name, last name, and middle initial of the Individual served. Order of name is at agency discretion.
Record #	Record your agency's established Record number for the Individual.
DOB	Record the Individual's date of birth. **Example : mm/dd/yyyy**
Group Name	Give the name of the specific group. Example: Anger Management.
Number of Attendees	Enter the number of Individuals attending the group on this date.
Individual Did Not Attend	If the Individual did not attend the group on this date, indicate "No Show" or "Canceled" and the explanation if known.
Data Field	**Documentation of Participation and Response of Individual to Group Treatment**
Behavior in Group	Check box(s) to document the Individual's observed behavior during the group session.
Individual's Mood	Check box(s) to document the Individual's observed or reported mood during the group session.

Data Field	New Issues, Stressors, Extraordinary Events Instruction
New Issues/Stressors/ Extraordinary Events Presented Today	There are three options available for staff using this section of the progress note (new issues refers to all **new** issues/stressors/extraordinary events). 1. If Individual reports a new issue that was resolved during the contact, check the "New Issue resolved, No Update Required" box. Briefly document the new issue in this section and then identify the interventions used in the Interventions/Methods section and indicate the resolution in the Response section of the progress note. If services are provided during the contact that have not been previously ordered in the Individualized Action Plan, then an explanation of the rationale for those services should be provided. **Example of New Issue not needing a CA Update:** **Jane became uncharacteristically angry with another group member during the group session and the two began arguing loudly. Group therapist intervened and assisted Jane with identifying what had triggered excessive anger today. Jane was able to recognize that the other group member reminded her of her abusive uncle and apologized to the other member.** 2. If Individual presents any new issue(s) that represent a need that is not already being addressed in the IAP, check box indicating "CA/IAP Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed issue(s) may require a new goal, objective, intervention or service that will require use of the IAP Review/Revision form. **Example of New Issue needing CA Update:** **Jane reported new symptoms of nightmares, intrusive memories, and feeling unsafe, triggered by an event that reminded her of an incident when she was a victim of abuse at age 12. Record on the CA Update this date and update IAP as necessary.** 3. If no new issues presented mark "None Reported" and proceed to planned intervention/goals.
Data Field	**Goal (s) /Objectives Addressed as Per Individualized Action Plan**
Goals / Objectives Addressed as Per Individualized Action Plan	Identify the specific goal(s) and objectives(s) in the Individualized Action Plan being addressed during this group.

Intervention(s)/ Method(s) Provided	Describe the specific interventions used in this particular group session to assist the Individual in realizing the goals and objectives are current. All interventions must be targeted toward specific goals/objectives in the Individualized Action Plan. The intervention documented in this section may be the same for all Individuals served in the group and or may reflect individualized intervention for the Individual. **Examples: Clinician taught group members relaxation breathing techniques.** **Using the example of one individual's stressful experience, the clinician asked group members to verbalize positive ways to resolve the situation.**
Response to Intervention / Progress Toward Goals and Objectives	Describe how the Individual served responded to the intervention today. Also describe the Individual's progress toward meeting his/her goals/objectives. If no progress is made over time, this section should address how staff intends to change his/her strategy. **Example: Jack listened attentively to feedback from staff about how he could handle the conflict with his wife differently, which is an improvement for him, but he seemed hesitant to try the suggestions made.**
Plan / Additional Information	The clinician should document future steps or actions planned with the individual such as homework, plans for the next session, etc. ***OR*** *Plan to overcome lack of progress* - If no progress is made over time, this section should also include how the worker intends to change his/her strategy to help the individual work toward improvement. Document additional pertinent information that is not appropriate to document elsewhere. Example: Nancy reported she will miss next week's session due to planned vacation with family. During her trip she will use stress management techniques learned today and journal outcomes to share during session upon her return.
Data Field	**Signatures Information Instructions**
Print Staff Name/ Credentials/Title	Print staff name, credentials (degree/license), and title.
Staff Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Supervisor Name/ Credentials/Title (if needed)	Print the supervisor's name, if needed.
Supervisor Signature	Legible signature and degree/license of supervisor, if needed.
Individual's Signature (optional)	Legible signature. This is encouraged, especially if the note was written collaboratively.
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**

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	Enter the name and credentials 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. 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.

Nursing Progress Note - Long
Revision Date: *11-25-10*

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

List of Individuals present	☐ Individual Present / **Contact Type:** ☐ Onsite ☐ Offsite ☐ Phone Conversation ☐ Others Present (please identify name(s) and relationship(s) to individual): ☐ No Show ☐ Person Canceled ☐ Provider Canceled Explanation:

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

New Issues / Stressors / Extraordinary Events Presented Today: ☐ New Issue Resolved, No Update Required
☐ New Issue, CA/IAP Update Required ☐ None Reported
Explanation:

Does the person require a full Mental Status Exam? ☐ No ☐ yes – **If yes,** ***please attach the completed MSE to this form and skip the Mini-Mental Status section.*** **If No,** ***please complete the Mini-Mental Status section below:***

Mini-Mental Status

Individual's Condition	No Significant Changes Reported or Observed	Notable	If Notable, List the Changes in Individual's Condition
Mood/Affect:	☐	☐	
Thought Process /Orientation:	☐	☐	
Motor Activity and Speech:	☐	☐	
Behavior/Functioning:	☐	☐	
Medical Condition:	☐	☐	
Substance Use/ Addictive Behaviors: ☐ NA	☐	☐	

Risk Assessment
Danger To: ☐ None **OR** Check all that apply below and record action taken in the Interventions section below
☐ **Self**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt
☐ **Others**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt
☐ **Property**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt
Actions taken:

Takes meds as prescribed: ☐ **yes** ☐ **no** ☐ **n/a** ☐ **Comments:**

Side effects reported: ☐ **yes** ☐ **no - if Yes, Please Comment on Review:**

Allergic reactions: ☐ **yes** ☐ **no** ☐ **n/a** **Comments:**

Nursing Progress Note - Long
Revision Date: *11-25-10*

Individual's Name (First / MI / Last):	**DOB**:

Changes in Medical Status: ☐ **yes** ☐ **no** ☐ **N/A** **Comments:**

Reviewed Medication Name(s), Dosage, Purpose and Frequency: ☐ **yes** ☐ **no** ☐ **N/A** **Comments:**

Were meds delivered today? ☐ **NA** ☐ **No** ☐ **Yes – If yes, for what duration:** ☐ **Weekly** ☐ **Monthly** ☐ **Other:**

Other meds: ☐ **Over the counter** ☐ **herbal** ☐ **none** ☐ **other** **Comments:**

Measurements: If appropriate, please complete the following pertinent information:

Vital Signs: TPR/BP	Height/Weight:

Goal(s)/Objective(s) Addressed As Per Individualized Action Plan:

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

Intervention(s) / Method(s) Provided:

Response to Intervention / Progress Toward Goals and Objectives (e.g. medication monitoring, Rx, review of lab tests, education, and support):

Issues referred to Physician/Psychiatrist for consideration:

Plan / Additional Information (referrals, labs to be ordered, Medical Strategies, other types of treatment, frequency/interval or next visit and duration)**:**

Print Staff Name/Credentials/Title :	**Staff Signature:**	**Date:**
Print Supervisor Name/Credentials/Title (if applicable)**:**	**Supervisor Signature:**	**Date:**
Individual's Signature (Optional)**:**		**Date:**

☐ Medicare "Incident to" Services Only	**Name and Credentials of Medicare Supervising Professional on Site (if applicable)**

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

Nursing Progress Note - Long

This form is to be completed by an LPN, RN, BSN, or MSN when providing nursing services. There are two different versions of the Nursing Progress Note – a short and long version. The short version is to provide adequate documentation for short length services such as injections, etc. while the long version has additional data fields that support the focus of the Psychopharmacology Progress Note including an interim history and mini mental status section.

Data Field	Identifying Information Instructions
Organization Name	Enter your organization name
Program Name	Enter your program name
Individual's Name	Record the first name, last name, and middle initial of the Individual served. Order of name is at agency discretion.
Record Number	Record your agency's established record number for the Individual served.
DOB	Record the individual's date of birth. **Example : mm/dd/yyyy**
List of Individuals present	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 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	**Evaluation**
Interim Update	Record a review of the Individual's condition, medications, dosages, any allergic reactions, and health changes since last encounter, Individual's assessment of progress related to symptoms, side effects, overall functioning, effectiveness of medications and medication compliance. If no changes are reported or observed, indicate whether Individual is at baseline, no progress made, meds still working, etc.

Data Field	New Issues, Stressors, Extraordinary Events Instruction
New Issue(s) / Stressors/ Extraordinary Events Presented Today	There are three options available for staff using this section of the progress note (new issues refers to all **new** issues/stressors/extraordinary events). 1. If Individual reports a new issue that was resolved during the contact, check the "New issue resolved, No Update Required" box. Briefly document the new issue in this section and then identify the interventions used in the Interventions/Methods section and indicate the resolution in the Response section of the progress note. If services are provided during the contact that have not been previously ordered in the Individualized Action Plan, then an explanation of the rationale for those services should be provided. **Example of new issue not requiring a CA/IAP Update:** **John reported harassment by neighbor, leading to increase in worry and anxiety symptoms. Referred John to Legal Services and left message for John's therapist to coordinate care around legal issues and work with John on anxiety management skills.** 2. If individual presents any new issue(s) that represent a need that is not already being addressed in the IAP, check box indicating "New Issue, CA/IAP Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed issue(s) may require a new goal, objective, intervention or service that will require use of the IAP Review/Revision form. **Example of new issue that may require a CA/IAP Update:** **Jane reported that last week she was involved in a car accident and since that time she is having nightmares and memories of physical abuse when she was in elementary school.** 3. If no new issues presented mark "None Reported" and proceed to planned intervention/goals.
Does the Person require a full Mental Status Exam?	If Yes, please attach the completed MSE to this form and skip the Mini Mental Status section. If No, complete the Mini Mental Status below.
Mini Mental Status	This is a Mini-Mental Status Exam. Check appropriate boxes to indicate Individual's condition as "No Change" or "Notable". If "Notable, describe any changes. **Note**: Notable is defined as behavior or symptoms different from the individual's baseline status. These changes may be signs the individual is experiencing increased problems or distress or may indicate an improvement in functioning/symptoms/behavior. **Example: Thought process/orientation is marked *Notable* and the comments are: "John is distracted and responding to voices he is hearing today." However, if John's baseline is that he always hears voices and responds, a *Notable* comment would not be needed unless the intensity or impact of the voices on John is significantly different than his baseline.**

Risk Assessment **Danger to**	Check appropriate box(s) and indicator(s). If any box except "none" is marked, be sure to document in the intervention section how the issue was addressed and resolved. **Example: Danger to others; ideation and plan.** If there are any risk issues identified, then document action plan in the Plan / Additional Information section below.
Takes medications as prescribed	Indicate yes, no, or NA. If applicable, please comment.
Side effects reported	Indicate yes or no. If applicable, please comment.
Allergic reactions	Indicate yes, no, or NA. If applicable, please comment.
Changes in medical status	Indicate yes, no, or NA. If applicable, please comment.
Reviewed medication name(s), dosages, purpose and frequency	Indicate yes, no, or NA. If applicable, please comment.
Were meds delivered today?	Indicate yes or no. If yes, for what duration.
Other meds	Indicate if other type(s) of meds are taken
Data Field	**Measurements**
Vital Signs	Indicate individual's vital signs: temperature, pulse, respiration, and blood pressure.
Height/Weight	Indicate individual's height/weight if appropriate. Leave blank if not performed during visit.
Data Field	**Goals, Interventions, Response to Intervention, Referred Issues and Plan/Additional Information**
Goal(s)/Objective(s) Addressed as Per Individualized Action Plan	Identify the specific goal(s) and objective(s) in the Individualized Action Plan being addressed in this note. (Progress notes must be linked to specific goal/objectives in the IAP).
Intervention(s)/ Method(s) provided	Summarize the interventions provided during this appointment, including medication and symptom monitoring, education, medication administration, recommendations, referrals, etc. List injections, site, dosage, and drug. Wellness, safety/safe housing, medication management, coping, social skills, assertiveness, community resources, relapse prevention, sleep hygiene, nutrition. Record linkage between therapeutic interventions and goals/objectives from the IAP. **Example: Provided education to Angela about potential side effects of new medication. Recommended that she continue to work on her goal of improving anxiety management skills with her individual therapist. Made referral to Legal Services for help with harassment by neighbor.**

Response to Intervention and Progress Toward Goals and 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). **Example: Angela was able to correctively identify medications and dosages. She has an understanding of potential side effects and agrees to report same to staff.**
Issues Referred to Physician/Psychiatrist	Note issues, concerns, and/or information to be brought to the attention of the physician (e.g. Positive lab results, medication problems, etc.) and time frame to do that.
Plan / Additional Information	The nurse should document future steps or actions planned with the individual such as homework, plans for the next session, etc. *Plan to overcome lack of progress* - If no progress is made over time, this section should also include how the worker intends to change his/her strategy to help the individual work toward improvement. Document additional pertinent information that is not appropriate to document elsewhere. **Example: Angela was not able to correctly identify medications and dosages, so index cards were utilized to give more explicit instructions for each of the medications.**

Data Field	Signature, Medicare Services and Billing Strip Instructions
Print Staff Name/ Credentials/Title	Print staff name, credentials (degree/license), and title.
Staff Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Supervisor Name/Credentials/Title (if needed)	Print the supervisor's name, credential (degree/license), and title of supervisor, if needed.
Supervisor Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Individual's signature (optional)	Legible signature. This is encouraged, especially if the note was written collaboratively.

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.

Nursing Contact Progress Note - Short
Revision Date: 11-25-10

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

List of Individuals Present	☐ 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:

Measurements: If appropriate, please complete the following pertinent information:

Vital Signs: TPR/BP	**Height/Weight**:

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:

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

Intervention(s) / Method(s) Provided (e.g. medication monitoring, Rx, review of lab tests, education, support):

Response to Intervention / Progress Toward Goals and Objectives:

Plan / Additional information (*Indicate action plan between sessions/meetings*):

Print Staff Name/Credentials/Title :	**Staff Signature:**	Date:
Print Supervisor Name/Credentials/Title (if applicable):	**Supervisor Signature:**	Date:
Individual's Signature (Optional):		Date:

☐ Medicare "Incident to" Services Only	**Name and Credentials of Medicare Supervising Professional on Site (if applicable)**

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

Nursing Progress Note – Short

This form is to be completed by a LPN, RN, BSN, or MSN when providing nursing services. There are two different versions of the Nursing Progress Note – a short and long version. The short version is to provide adequate documentation for short length services such as injections, etc. while the long version has additional data fields that support the focus of the Psychopharmacology Progress Note including an interim history and mini mental status section.

Data Field	Identifying Information Instructions
Organization Name	Enter your organization name
Program Name	Enter your program name
Individual's Name	Record the first name, last name, and middle initial 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 the Individual's date of birth. **Example: mm/dd/yyyy**
List of Individuals Present	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 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	**Measurements**
Vital Signs	Indicate Individual's vital signs: temperature, pulse, respiration, and blood pressure.
Height/Weight	Indicate Individual's height/weight if appropriate. Leave blank if not performed during visit.

Data Field	New Issues, Stressors, Extraordinary Events Instruction
New Issue(s)/Stressors/ Extraordinary Events Presented Today	There are three options available for staff using this section of the progress note (New Issues refers to all **new** issues/stressors/extraordinary events). 1. If Individual reports a new issue that was resolved during the contact, check the "New Issue resolved, No Update Required" box. Briefly document the new issue in this section and then identify the interventions used in the Interventions/Methods section and indicate the resolution in the Response section of the progress note. If services are provided during the contact that have not been previously ordered in the Individualized Action Plan, then an explanation of the rationale for those services should be provided. **Example of new issue not requiring a CA/IAP Update:** **John reported harassment by neighbor, leading to increase in worry and anxiety symptoms. Referred Individual to Legal Services and left message for individual therapist to coordinate care around legal issues and work with individual on anxiety management skills.** 2. If individual presents any new issue(s) that represent a need that is not already being addressed in the IAP, check box indicating "New Issue, CA/IAP Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed issue(s) may require a new goal, objective, intervention or service that will require use of the IAP Review/Revision form. **Example of new issue that may require a CA/IAP Update:** **Jane reported that last week she was involved in a car accident and since that time she is having nightmares and memories of physical abuse when she was in elementary school.** 3. If no new issues presented mark "None Reported" and proceed to planned intervention/goals.
Data Field	**Goals, Interventions, Response to Intervention, Plan/Additional Information**
Goal(s)/Objective(s) Addressed as Per Individualized Action Plan	Identify the specific goal(s) and objectives in the Individualized Action Plan being addressed in this note. (Progress notes must be linked to specific goal/objectives in the IAP).
Intervention(s) / Method(s) provided	Summarize the interventions provided during this appointment, including medication and symptom monitoring, education, medication administration, recommendations, referrals, etc. List injections, site, dosage, and drug. Wellness, safety/safe housing, medication management, coping, social skills, assertiveness, community resources, relapse prevention, sleep hygiene, nutrition. Record linkage between therapeutic interventions and goals/objectives from the IAP. **Example: Provided education to Jane about potential side effects of new medication. Recommended that she continue to work on her goal of improving anxiety management skills with her individual therapist. Made referral to Legal Services for help with harassment by neighbor.**

Response to Intervention/ Progress Toward Goals and 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). **Example: Angela was able to correctively identify medications and dosages. She has an understanding of potential side effects and agrees to report same to staff.**
Plan / Additional Information	The nurse should document future steps or actions planned with the individual such as homework, plans for the next session, etc. *Plan to overcome lack of progress* - If no progress is made over time, this section should also include how the counselor intends to change his/her strategy to help the individual work toward improvement. Document additional pertinent information that is not appropriate to document elsewhere. **Example: John was not able to correctly identify medications and dosages, so index cards were utilized to give more explicit instructions for each of the medications.**
Data Field	**Signature, Medicare Services and Billing Strip Instructions**
Print Staff Name Credentials/Title	Print staff name, credentials (degree/license), and title.
Staff Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Supervisor Name/ Credentials/Title (if needed)	Print the supervisor's name, credential (degree/license), and title of supervisor, if needed.
Supervisor Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Individual's signature (optional)	Legible signature. This is encouraged, especially if the note was written collaboratively.

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.

Partial Hospitalization Progress Note
Revision Date: *11-25-10*

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

Type of Service ☐ Group – Name: ☐ Individual Intervention ☐ Individual No Show/Canceled	**From:**	**To:**	**Total Time**
	No. in Group	**No. of Staff**	

Activity/Topic/Interaction

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:

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

Intervention(s) / Method(s) Provided:

Response to Intervention / Progress Toward Goals and Objectives:

Plan / Additional Information (*Indicate action plan between sessions/meetings*)**:**

Staff Signature/Credentials/Title	**Date**	**Co-Staff Signature/Credentials/Title** (if applicable)	**Date**

Partial Hospitalization Progress Note
Revision Date: *11-25-10*

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

Type of Service ☐ Group – Name: ☐ Individual Intervention ☐ **Individual No Show/Canceled**	From:	To:	Total Time
	No. in Group	No. of Staff	

Activity/Topic/Interaction

New Issues / Stressors / Extraordinary Events Presented Today: ☐ New Issue resolved, no updates required
☐ New Issue, CA/IAP Update Required? ☐ None Reported
Explanation:

Goal(s)/Objective(s) Addressed As Per Individual's Action Plan:

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

Intervention(s) / Method(s) Provided:

Response to Intervention / Progress Toward Goals and Objectives:

Plan / Additional Information (*Indicate action plan between sessions/meetings*)**:**

Staff Signature/Credentials/Title	**Date**	**Co-Staff Signature/Credentials/Title** (if applicable)	**Date**

Partial Hospitalization Progress Note
Revision Date: *11-25-10*

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

Type of Service ☐ Group – Name: ☐ Individual Intervention ☐ **Individual No Show/Canceled**	**From:**	**To:**	**Total Time**
	No. in Group	**No. of Staff**	

Activity/Topic/Interaction

New Issues / Stressors / Extraordinary Events Presented Today: ☐ New Issue resolved, no updates required
☐ New Issue, CA/IAP Update Required? ☐ None Reported
Explanation:

Goal(s)/Objective(s) Addressed As Per Individual's Action Plan:

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

Intervention(s) / Method(s) Provided:

Response to Intervention / Progress Toward Goals and Objectives:

Plan / Additional Information (*Indicate action plan between sessions/meetings*)**:**

Staff Signature/Credentials/Title	**Date**	**Co-Staff Signature/Credentials/Title** (if applicable)	**Date**

Partial Hospitalization Progress Note
Revision Date: *11-25-10*

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

Type of Service ☐ Group – Name: ☐ Individual Intervention ☐ Individual No Show/Canceled	From:	To:	Total Time
	No. in Group	No. of Staff	

Activity/Topic/Interaction

New Issues / Stressors / Extraordinary Events Presented Today: ☐ New Issue resolved, no updates required
☐ New Issue, CA/IAP Update Required? ☐ None Reported
Explanation:

Goal(s)/Objective(s) Addressed As Per Individual's Action Plan:

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

Intervention(s) / Method(s) Provided:

Response to Intervention / Progress Toward Goals and Objectives:

Plan / Additional Information (*Indicate action plan between sessions/meetings*)**:**

Staff Signature/Credentials/Title	**Date**	**Co-Staff Signature/Credentials/Title** (if applicable)	**Date**

Functioning - Observed or Reported (may include mood, affect, behavior, cognitive functioning, etc.) ☐ No Significant Change

Stressors/Extraordinary Events ☐ None Reported

Print Staff Name/Credentials/Title:	**Staff Signature:**	**Date:**
Print Supervisor Name/Credentials/Title (if applicable)**:**	**Supervisor Signature:**	**Date:**
Individual's Signature (Optional)**:**		**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

Partial Hospitalization Progress Note

To be completed for all Partial Hospitalization (PH) group and individual activities. This note is a four page note with the first three pages consisting of space to capture individual PH interventions as needed. The fourth page also offers a summary section and acts as a signature page for all of the notes; if only one PH intervention is completed, then you would only utilize page four.

Data Field	Identifying Information Instruction
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	Indicate the Individual's date of birth **Example : mm/dd/yyyy**
Type of Service	Check Type of Service delivered. Check box that applies. If group, give name of the specific group. **Example: Anger Management Group** If "No Show" or "cancellation", explain reason. **Example: Individual overslept and missed meeting.**
From - To	Enter the beginning and ending times the individual participated in the activity.
Total Time	Enter total hours and minutes individual was engaged in this activity.
No. in Group	Enter number of individual's attending the group.
No. of Staff	Enter number of staff providing services in the group.
Data Field	**Activity/Topic and Goal(s) Information Instruction**
Activity/Topic/ Interaction	Describe the planned activity/topic/Interaction of the group. **Example: Group members will discuss coping mechanisms for stress & select one to try on their own in the upcoming week.**

Data Field	New Issues, Stressors, Extraordinary Events Instruction
New Issues/Stressors/ Extraordinary Events Presented Today	There are three options available for staff using this section of the progress note (new issues refers to all **new** issues/stressors/extraordinary events). 1. If Individual reports a new issue that was resolved during the contact, check the "New Issue resolved, No Update Required" box. Briefly document the new issue in this section and then identify the interventions used in the Interventions/Methods section and indicate the resolution in the Response section of the progress note. If services are provided during the contact that have not been previously ordered in the Individualized Action Plan, then an explanation of the rationale for those services should be provided. 2. If Individual presents any new issue(s) that represent a need that is not already being addressed in the IAP, check box indicating "New Issue, CA/IAP Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed issue(s) may require a new goal, objective, intervention or service that will require use of the IAP Review/Revision form. 3. If no new issues presented mark "None Reported" and proceed to planned intervention/goals. **Example: During the counseling session John became angry and loud; counselor was able to have John explore his anger and John admitted to needing to use his calming techniques. Within 5 minutes, John was able to calm himself down and resume discussions with the counselor. NO CA/IAP update needed.**
Goals/Objectives addressed as Per Individualized Action Plan:	Identify the specific goal(s) and objective(s) in the Individualized Action Plan being addressed during this intervention. (All interventions and, therefore, the documentation of the intervention in a progress note must be targeted toward specific goal/objectives in the IAP).
Data Field	**Interventions and Response to Intervention and Progress Toward Goals and Objectives Instruction**
Intervention(s)/ Method(s) Provided:	This section must be completed to support "medical necessity" and must be person specific. This section should describe the specific therapeutic interventions used in the PH group session to assist the individual in realizing the goals and objectives listed above as the focus of this particular session. **Example: Discussed daily menus with Angela. We then went through her cabinets together to make this week's grocery list. Provided feedback on healthy choices and taught individual food inventory skills.**

Response to Intervention/Progress Toward Goals and 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). **Example: Jack listened to feedback from the group about how he can handle the conflict with his wife differently, which is an improvement for him, but he seemed hesitant to try the suggestions made.**
Plan/Additional Information	The nurse should document future steps or actions planned with the individual such as homework, plans for the next session, etc. *Plan to overcome lack of progress* - If no progress is made over time, this section should also include how the worker intends to change his/her strategy to help the individual work toward improvement. Document additional pertinent information that is not appropriate to document elsewhere. **Example: John was not able to correctly identify medications and dosages, so index cards were utilized to give more explicit instructions for each of the medications.**
Staff Signature/ Credentials/Title:	Legibly record staff's signature, credentials, and degree/license.
Date:	Record the date of signature, including the month, day, and year. **Example: mm/dd/yyyy**
Co-Staff Signature/ Credentials/Title	If required, legibly record staff's signature, credentials, and degree/license.
Date:	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Data Field	**Summary Information**
Functioning	Summarize the day's events; indicate observed or reported mood, affect, behavior, cognitive functioning etc. If no significant change, indicate in box provided.
Stressors/ Extraordinary Events	Indicate any stressors or extraordinary events that happened during the day. If none, indicate in box provided
Data Field	**Signature Fields**
Print Staff Name/ Credentials/Title	Print staff name, credentials (degree/license) and title.
Staff Signature	Legible signature
Date	Record the date of signature, including the month, day and year. **Example : mm/dd/yyyy**
Supervisor Name/Credentials/Title (if needed)	Print the supervisor's name, credentials (degree/license) and title of supervisor, if needed.
Supervisor Signature	Legible signature

Date	Record the date of signature, including the month, day and year. **Example : mm/dd/yyyy**
Individual Signature (optional)	Legible signature. This is encouraged, especially if the note was written collaboratively.

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.

Progress Note Summary
Revision Date: *11-25-10*

Note Type: ☐ **Weekly** ☐ **Bi-Weekly** ☐ **Monthly** / **Date Range**: **From** _____ **through** _____

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

Goal(s)/Objective(s) Addressed As Per Individual's Individualized Action Plan: Yes ☐ / **No** ☐

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

Summary of Services / Interventions Provided During This Period:

Response to Services / Intervention(s) Provided:

Plan / Additional Information (Identification of any changes to the IAP and services related to such changes):

Print Staff Name/Credentials/Title:	**Staff Signature:**	**Date:**
Print Supervisor Name/Credentials/Title (if applicable):	**Supervisor Signature:**	**Date:**

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

Progress Note Summary

Designed for use by CDT, PROS, Partial Hospitalization Programs, and Residential Programs. Documentation links to specific goals in the IAP.

*PROS Progress notes are required monthly, or more frequently when clinically appropriate; including but not limited to crisis or relapse situations, and significant changes to individual's status.

Data Field	Identifying Information Instruction
Note Type	Check the box that applies for the note type.
Date Range	Enter the first date of the timeframe and the last day of the timeframe the summary will cover. Example 9/01/2009 to 9/15/2009
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. Order of name is at agency discretion.
Record #	Record your agency's established record number for the Individual.
DOB	Record the Individual's date of birth. **Example : mm/dd/yyyy**
Data Field	**Goals, Interventions, Response to Services and Plan/Additional Information**
Were Goals/Objectives Addressed as Per Individualized Action Plan	Check yes or no
Goals/Objectives Addressed As Per Individualized Action Plan	Record the specific goals and objectives addressed during this timeframe by indicating the corresponding number(s) from the Individualized Action Plan. In an electronic record, the actual goals and objectives descriptions would appear in this field once the box is checked. However, when using this form as a paper form, list the number of the goals & objectives that are being addressed during this timeframe.
Summary of Services/Interventions Provided During This Period	Summarize the services and interventions provided during this period.
Response to Services/ Intervention(s) Provided	Describe the individual's response to the interventions and/or services provided during this period.

Plan/ Additional Information	If applicable the provider should document steps or actions planned with the Individual for the next time frame. This section should also include any significant events that occurred during this period. **Example: Jack agreed to practice using the skills he learned this shift with regards to using a medication calendar.** **Example: Jack agreed to write a list of qualities he is looking for in a sponsor for us to review tomorrow.** Document additional pertinent information that is not appropriate to document elsewhere. **Example: Jack received a call from his wife and they discussed whether she should bring their children to her next visit.**
Data Field	**Signature Instruction**
Print Staff Name/ Credentials/Title	Print staff name, credentials (degree/license), and title.
Staff Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Print Supervisor Name/Credentials/Title (if applicable)	Print the supervisor's name, credential (degree/license), and title of supervisor, if applicable.
Supervisor Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**

Psychopharmacology-Psychotherapy Progress Note
Revision Date: *11-25-10*
Page 1 of 2

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 ☐ Person Canceled ☐ Provider Canceled Explanation:

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

Does the Individual require a full Mental Status Exam? ☐ No ☐ Yes – **If yes,** ***please attach the completed MSE to this form and skip the Mini-Mental Status section.*** **If No,** ***please complete the Mini-Mental Status section below:***

Mini-Mental Status

Individual's Condition	No Significant Changes Reported or Observed	Notable	If Notable, List the Changes in person's Condition
Mood/Affect:	☐	☐	
Thought Process/ Orientation:	☐	☐	
Motor Activity and Speech	☐	☐	
Behavior/Functioning:	☐	☐	
Medical Condition:	☐	☐	
Substance Use / Addictive Behaviors: ☐ NA	☐	☐	

Risk Assessment
Danger To: ☐ None **OR** Check all that apply below and record action taken in the Interventions section below
☐ **Self**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt
☐ **Others**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt
☐ **Property**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt
Actions taken:

Takes meds as prescribed: ☐ **yes** ☐ **no** ☐ **n/a - Comments:**

Side effects reported: ☐ **yes** ☐ **no - if Yes, Please comment on review:**

Allergic reactions: ☐ **yes** ☐ **no - Comments:**

Changes in Medical Status: ☐ **yes** ☐ **no – If yes, please comment on plan:**

Other meds: ☐ **Over the counter** ☐ **herbal** ☐ **none** ☐ **other - Comments:**

Psychopharmacology-Psychotherapy Progress Note
Revision Date: *11-25-10*

Individual's Name (First / MI / Last):	**DOB**:

Goal(s)/Objective(s) Addressed As Per Psychopharmacology/Individualized Action Plan:

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

Therapeutic Interventions Delivered in Session

Psychopharmacology Only: ☐ Medication Education/Counseling ☐ Symptom/Illness Management ☐ Injections

Describe All / Other Interventions:

Response to Intervention / Progress Toward Goals and Objectives:

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

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

Medication Renewal / Changes

Rationale for changes in medication(s): ☐ not indicated

Renew	Change	New	D/C	Medication	Dosage	Freq.	# of Days	QTY	Refills
☐	☐	☐	☐						
☐	☐	☐	☐						
☐	☐	☐	☐						
☐	☐	☐	☐						
☐	☐	☐	☐						
☐	☐	☐	☐						

Instructions/Comments/Plan, as applicable:

Next Appointment:

Prescriber - Print Name/Credentials/Title	**Prescriber Signature & Credentials**	**Date:**
Supervisor - Print Name/Credentials/Title (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

Psychopharmacology-Psychotherapy Progress Note

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

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 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 the Risk Assessment Section. If No is checked, complete the Mini-Mental Status.
Mini-Mental Status Examination	Comment on current areas of the 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 now or since last session, *yes/no*. 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 objective(s) in the Psychopharmacology Plan/IAP addressed during this session.
Data Field	**Therapeutic Interventions Delivered in session**
Therapeutic Interventions Delivered in Session	Check appropriate interventions delivered.
Describe All/Other Interventions	Describe all/other interventions.
Response to Interventions/ 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 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 Individual). If lab results were *not received*, describe action to be taken to obtain results.

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 in medication 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*), changed (C*hange),* 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.
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.
Data Field	**Signature, Medicare Services, and Billing Strip Instructions**
Prescriber - Print Name/Credentials/Title	Legibly print Prescriber's name including credentials and title.
Prescriber Signature and Credentials	Legible signature including, credentials (degree/license).
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Supervisor Name/Credentials/Title (if applicable)	Print the supervisor's name, credentials (degree/license) and title of supervisor, if applicable.
Supervisor Signature	Legible signature
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.

Psychopharmacology-Psychotherapy ACT Only Progress Note
Revision Date: *11-25-10*

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 ☐ Person Canceled ☐ Provider Canceled Explanation:

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

Does the Individual require a full Mental Status Exam? ☐ No ☐ Yes – **If yes,** ***please attach the completed MSE to this form and skip the Mini-Mental Status section.*** **If No,** ***please complete the Mini-Mental Status section below:***

Mini-Mental Status

Individual's Condition	No Significant Changes Reported or Observed	Notable	If Notable, List the Changes in Individual's Condition
Mood/Affect:	☐	☐	
Thought Process/ Orientation:	☐	☐	
Motor Activity and Speech:	☐	☐	
Behavior/Functioning:	☐	☐	
Medical Condition:	☐	☐	
Substance Use/ Addictive Behaviors: ☐ NA	☐	☐	

Risk Assessment
Danger To: ☐ None **OR** Check all that apply below and record action taken in the Interventions section below
☐ **Self**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt - Actions Taken:
☐ **Others**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt
☐ **Property**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt

Takes meds as prescribed: ☐ **yes** ☐ **no** ☐ **n/a - Comments:**

Side effects reported: ☐ **yes** ☐ **no - if Yes, Check all that apply:**
☐ EPS Severity ☐ Tardive Dsykinesia ☐ Weight Gain ☐ Tremors ☐ Sexual Dysfunction
☐ New Onset ☐ Glucose ☐ DM ☐ Other:
Comments on selections:

Allergic reactions: ☐ **yes** ☐ **no - Comments:**

Changes in Medical Status: ☐ **yes** ☐ **no – If yes, please comment on plan:**

Other meds: ☐ **Over the counter** ☐ **herbal** ☐ **none** ☐ **other - Comments:**

Goal(s)/Objective(s) Addressed As Per Psychopharmacology/Individualized Action Plan:

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

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

Psychopharmacology-Psychotherapy ACT Only Progress Note
Revision Date: *11-25-10*

Individual's Name (First / MI / Last):	**DOB**:

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

Lab Tests Ordered ☐ Yes ☐ No - Labs Reviewed ☐ Yes ☐ No, 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

Rational for changes in medication(s): ☐ not indicated

Renew	Change	New	D/C	Medication	Dosage	Freq.	# of Days	QTY.	Refills
☐	☐	☐	☐						
☐	☐	☐	☐						
☐	☐	☐	☐						
☐	☐	☐	☐						
☐	☐	☐	☐						
☐	☐	☐	☐						

Psychopharmacology-Psychotherapy ACT Only Progress Note
Revision Date: *11-25-10*

Individual's Name (First / MI / Last):	**DOB**:
Were meds delivered today? ☐ **NA** ☐ **Yes** ☐ **No –** **If yes, for what duration:** ☐ **Weekly** ☐ **Monthly** ☐ **Other:** **Prescription Written** ☐ **Yes** ☐ **No - Called into the Pharmacy?:** ☐ **Yes** ☐ **No**	
Instructions/Comments/Plan as applicable:	
Next Appointment:	

Prescriber - Print Name/Credentials/Title	**Prescriber Signature & Credentials**	**Date:**
Supervisor - Print Name/Credential (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

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.

Psychopharmacology-Psychotherapy Progress Note with Evaluation & Management
Revision Date: *11-25-10*
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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 ☐ Person Canceled ☐ Provider Canceled Explanation:

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

Does the Individual require a full Mental Status Exam? ☐ No ☐ Yes – **If yes, *please attach the completed MSE to this form and skip the Mini-Mental Status section.* If No, *please complete the Mini-Mental Status section below:***

Mini-Mental Status

Individual's Condition	No Significant Changes Reported or Observed	Notable	If Notable, List the Changes in Individual's Condition
Mood/Affect:	☐	☐	
Thought Process/ Orientation:	☐	☐	
Motor Activity and Speech	☐	☐	
Behavior/Functioning:	☐	☐	
Medical Condition:	☐	☐	
Substance Use / Addictive Behaviors: ☐ NA	☐	☐	

Risk Assessment
Danger To: ☐ None **OR** Check all that apply below and record action taken in the Interventions section below
☐ **Self**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt
☐ **Others**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt
☐ **Property**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt
Actions taken:

Takes meds as prescribed: ☐ **yes** ☐ **no** ☐ **n/a - Comments:**

Side effects reported: ☐ **yes** ☐ **no - if Yes, Please comment on review:**

Allergic reactions: ☐ **yes** ☐ **no - Comments:**

Changes in Medical Status: ☐ **yes** ☐ **no – If yes, please comment on plan:**

Other meds: ☐ **Over the counter** ☐ **herbal** ☐ **none** ☐ **other - Comments:**



Psychopharmacology-Psychotherapy Progress Note with Evaluation & Management
Revision Date: *11-25-10*

Individual's Name (First / MI / Last):	**DOB**:

Goal(s)/Objective(s) Addressed As Per Psychopharmacology/Individualized Action Plan:

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

Therapeutic Interventions Delivered in Session

Psychopharmacology Only: ☐ Medication Education/Counseling ☐ Symptom/Illness Management ☐ Injections

Counseling Provided with Client/Family/Caregiver (For each counseling topic checked, describe specific details below):

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

Response to Intervention / Progress Toward Goals and Objectives:

Coordination of Care Provided (Must be with person present and involves coordination of care with staff outside 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

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

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

Medication Renewal / Changes

Rationale for changes in medication(s): ☐ not indicated

Renew	Change	New	D/C	Medication	Dosage	Freq.	# of Days	QTY	Refills
☐	☐	☐	☐						
☐	☐	☐	☐						
☐	☐	☐	☐						
☐	☐	☐	☐						
☐	☐	☐	☐						

Psychopharmacology-Psychotherapy Progress Note with Evaluation & Management
Revision Date: *11-25-10*

Individual's Name (First / MI / Last):	**DOB**:
Instructions/Comments/Plan, as applicable:	
Next Appointment:	

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

☐ Medicare "Incident to" Services Only	**Name and Credentials of Medicare Supervising Professional on Site**

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

Psychopharmacology - Psychotherapy
Progress Note with Evaluation and Management

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

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 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 the Risk Assessment Section. If No is checked, complete the Mini-Mental Status.
Mini-Mental Status Examination	Comment on current areas of the 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*. Provide additional relevant information after *Comments*, e.g. increased thirst, dizziness, decreased sexual function.
Allergic reactions	Record any reported or observed allergic reactions to medication, 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.
Data Field	**Therapeutic Interventions Delivered in Session**
Psychopharmacology Only	Check appropriate interventions delivered.
Counseling Provided	Check the appropriate box for each type of counseling provided. Provide details for each option checked.
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 worker 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 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.**

Coordination of Care Provided	**Must be <u>with Individual present.</u>** Check appropriate box to indicate with whom coordination of care was provided. For all boxes checked, include name and phone number of person with whom coordinating care.
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 individual). If lab results were *not received*, describe action to be taken to obtain results.
Diagnosis	Document whether or not 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 in medication 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*), changed (C*hange),* newly prescribed *(New*) or discontinued (D/*C*). Write the name of the medication, dosage, freq. (*frequency*), # of Days, QTY, (quantity), and number of Refills *(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.
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 Name/Credentials/Title	Legibly print Prescriber's name including credentials and title.
Prescriber Signature and Credentials	Legible signature including, credentials (degree/license).
Date	Record the date of signature, including the month, day and year. **Example : mm/dd/yyyy**
Supervisor Name/Credentials/Title (if applicable)	Print the supervisor's name, credentials (degree/license), and title of supervisor, if applicable.

Supervisor Signature	Legible signature
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.

Shift/Daily Progress Note
Revision Date: *11-25-10*

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

Type of Program:
☐ **CSU** ☐ **Respite Bed** ☐ **Overnight Substance Use Program** ☐ **Overnight Child/Adolescent Program**
☐ **Other:**

☐ **Shift Note:** ☐1st Shift (Day) ☐ 2nd Shift ☐ 3rd Shift (Night) ☐ **Daily Note**

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:

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

Functioning (observed or reported):

Intervention(s) / Method(s) Provided:

Response to Intervention / Progress Toward Goals and Objectives:

Plan / Additional Information:

Print Staff Name/Credentials/Title :	**Staff Signature:**	Date:
Print Supervisor Name/Credentials/Title (if applicable):	**Supervisor Signature:**	Date:

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

Shift/Daily Progress Note

Documentation links to specific goals in the IAP. Designed for use by programs that serve children (Residential, OASAS)

Data Field	Identifying Information Instruction
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. Order of name is at agency discretion.
Record #	Record your agency's established identification number for the Individual.
DOB	Record the Individual's date of birth. **Example : mm/dd/yyyy**
Data Field	**Type of Program, Time Period and Date Instruction**
Type of Program	Check type of program: • Crisis Stabilization Unit (CSU) • Respite Bed • Overnight Substance Use Program • Overnight Child/Adolescent Program • Other: Identify the program.
Shift Note Type	Depending upon the requirements of the program, check appropriate box to indicate what timeframe is being documented. If it is a Shift Note, check *Shift Note* and the appropriate shift box. If it is a Daily Note, check *Daily Note*.

Data Field	New Issue(s), Functioning, Goals and Interventions Instruction
New Issues/ Stressors/ Extraordinary Events Presented Today	It is important that the staff filling out this form be aware they should be looking for any changes in behavior, symptoms, side effects, significant events, and changes in mental status that might occur during the shift and document them in this section. There are three options available for staff using this section of the progress note (new Issues refers to all **new** issues/stressors/extraordinary events). 1. If individual reports a new issue that was resolved during the note time period, check the "New Issue resolved, No Update Required" box. Briefly document the new issue in this section and then identify the interventions used in the Interventions/Methods section and indicate the resolution in the Response section of the progress note. If services are provided during the note period that have not been previously ordered in the Individualized Action Plan, then an explanation of the rationale for those services should be provided. **Example of New Issue not needing CA/IAP update: Jane became uncharacteristically angry with another individual during the shift and the two began arguing loudly. Staff intervened and assisted Jane with identifying what had triggered excessive anger today. She was able to recognize that the other individual reminded her of her abusive uncle (already addressed in IAP) and apologized to the other individual. Both participants agreed that the issue was resolved during shift.** 2. If individual presents any new issue(s) that represent a need that is not already being addressed in the IAP, check box indicating "New Issue, CA/IAP Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed issue(s) may require a new goal, objective, intervention or service that will require use of the IAP Review/Revision form. **Example of New Issue needing CA/IAP Update:** **Jane reported new symptoms of nightmares, intrusive memories, and feeling unsafe, triggered by an event that reminded her of an incident when she was a victim of abuse at age 12. This has not been previously reported. Both parties agreed that a CA/IAP update was needed, and was recorded on the CA/IAP Update of this date.** 3. If no new issues presented mark "None Reported" and proceed to planned intervention/goals.
Goals/Objectives Addressed As Per Individualized Action Plan	Record the specific goals and objectives addressed during this shift/day by indicating the corresponding number(s)) from the *Individualized* Action Plan. In an electronic record, the actual goals and objectives descriptions would appear in this field once the box is checked. However, when using this form as a paper form, list the number of the goals & objectives that are being addressed during this shift/day.

Functioning (observed or reported)	Record all pertinent observations of the Individual's functioning and interactions during the time period of the progress note that impact his/her placement in this program. ***The information can be as reported by the Individual receiving services or by others who have observed or interacted with the Individual, as well.*** **Example: John raised his voice and left dinner abruptly when another resident asked him to keep his voice down during dinner.** ***Example: In the afternoon, John attempted to watch TV and then to play video games but was constantly distracted, had difficulty focusing, paced the floor and eventually sat down in a chair and fell asleep.*** If documenting 3rd shift and the Individual slept throughout, make note of that.
Intervention(s) / Method(s) Provided	Describe the specific interventions used during this time period to assist the Individual in realizing the goals and objectives listed above. **1--Example: Angela had difficulty sleeping during this shift. She got up frequently and was agitated when talking about recent events in her life. Staff listened reflectively, encouraged her to do deep breathing exercises and redirected her.** **2--Example: Monitored Angela through the night and she appeared to sleep soundly and without interruption.** **3--Example: Staff intervened with verbal redirection to defuse a volatile situation between Angela and another resident.** **4--Example: John went to the daily community meeting and met with this staff afterwards to discuss his strong reactions to other individuals in the meeting.** **5--Example: Gave John feedback on how he reacted negatively to another resident and helped him identify alternate responses.** **6--Example: Taught the John how to use a calendar to track his medication refills.**

Data Field	Response to Intervention
Response to Intervention/ Progress Toward Goals and Objectives	This section should address **BOTH**: • *The Individual's response to the intervention –* **Example*:* John took redirection and a five minute break and was able to come back and talk about his angry feelings. (Responses may not be to a specific meeting described here, but to the interventions provided throughout the day by various staff).** • *Progress toward goals and objectives* - Include an assessment of how the intervention has moved the Individual closer, further away, or had no discernable impact on meeting the Individual's identified goal(s) and objective(s). **1--Example: Angela was able to take redirection and to use some breathing exercises to help calm herself and eventually to go to sleep. She did not threaten to harm herself as she had been doing earlier. She agreed to contact staff if she felt unsafe.** **2--Example: Angela expressed thanks to provider for listening to her and made a good effort to practice deep breathing.** **3--Example: Angela slept through the night.** **4--Example: John took the redirection given by staff and kept his distance from the other resident involved for the rest of the shift.** **5--Example: John was absent from the unit during this shift as he planned to attend Day Treatment and the Clubhouse.** **6--Example: John did not want to engage in a conversation that focused on his feelings and minimized the impact of his strong feelings toward others in the house.** **7--Example: John was able to listen to the feedback about his negative reactions. He then talked about ways he could respond differently the next time he begins to feel negatively about others.** **8--Example: John liked the idea of using a medication calendar to track refills but worried he would lose the calendar. He then identified a consistent place to keep his calendar.** • If no progress is made over time, this section should also include a discussion of how the staff intends to change his/her strategy.

Plan/Additional Information	If applicable the staff should document steps or actions planned with the Individual for the next shift. **Example: John agreed to practice using the skills he learned this shift with regards to using a medication calendar.** **Example: John agreed to write a list of qualities he is looking for in a sponsor for us to review tomorrow.** Document additional pertinent information that is not appropriate to document elsewhere. **Example: John received a call from his wife and they discussed whether she should bring their children to her next visit.**
Data Field	**Signature Instruction**
Print Staff Name	Print staff name, credentials (degree/license), and title.
Staff Signature	Legible signature.
Date	Record the date of signature, including the month, day and year. **Example : mm/dd/yyyy**
Print Supervisor Name Signature/ Credentials/Title	Print the supervisor's name, credentials (degree/license) and title of supervisor, if needed.
Date	Indicate the date of the signature. **Example : Mm/dd/yyyy**