

Psychiatry/Medication Progress Note

This note is to be completed **ONLY** by a psychiatrist or advanced practice nurse with prescribing privileges for a psychopharmacology service.

Data Field	Identifying Information Instructions
Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Date of Admission	Record the date of admission per agency policy (this should be the first service date for this service episode).
Organization/Program Name	Record the organization and Program for whom you are delivering the service.
DOB	Record the person's date of birth
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
List of Names of Persons Present	Check appropriate box: <i>Person Present; No Show; Person Canceled</i> . If <i>Provider Canceled</i> is checked, document explanation as relevant. If <i>Others Present</i> is checked, identify name(s) and relationship(s) to person.
Interim History	Document an interval history of client 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.
Mental Status	Comment on current areas of mental status evaluation, including significant changes since last visit. Document any risk issues and if present, document action plan to address.
Takes meds as prescribed	Record whether medication was taken as prescribed since last session, <i>yes/no</i> or <i>n/a</i> . Provide additional relevant information after <i>Comments</i> .
Side Effects	Record whether side effects are present or occurred since last session, <i>yes/no</i> or <i>n/a</i> . Provide additional relevant information after <i>Comments</i> , e.g. increased thirst, dizziness, decreased sexual function.
Allergic Reactions	Record any reported or observed allergic reactions to medications. As appropriate, provide additional relevant information after <i>Comments</i> .
Changes in Medical Status	Record whether there have been any changes in medical status since last session, <i>yes/no</i> or <i>n/a</i> . Provide additional relevant information after <i>Comments</i> .
Other Meds	Record any new medications the person has been taking since the last session, e.g. <i>over the counter/herbal/ none/other</i> . Provide additional information after <i>Comments</i> .
Goal(s) Addressed as Per Psychopharmacology Plan	Identify the specific goal(s) and objectives in the Psychopharmacology Action Plan or Individual Action Plan being addressed during this intervention.

Therapeutic Interventions Delivered in Session	Check one or more of the types of interventions delivered in the session: <i>Psychotherapy, Counseling/Coaching, Collaborative Medication Management, Collaborative Medication Education/Symptom/Illness Management, Injections, Physical Assessment, Coordination of Care.</i> For additional interventions utilized check <i>other</i> . Describe the content of the interventions. If any off-label usage or more than one anti-psychotic is prescribed it is suggested that the decision-making of the prescriber be carefully documented.
Response to Intervention Delivered in Session and Progress Toward Goals and Objectives	Document person's response to intervention(s) delivered in the session and person's progress towards goals and objectives. If no progress is made over time, this section should also address changes in strategy to produce positive change in the person.
Lab Tests Ordered	Summarize key laboratory test results received and reviewed. Check appropriate box to indicate whether key laboratory test results were <i>ordered</i> or, <i>reviewed</i> (with person). If lab results were <i>not received</i> , describe action to be taken to obtain results.
AIMS Findings	If AIMS (Abnormal Involuntary Movement Scale) test was administered, document findings.
Height/Weight/BMI Blood Pressure/VS	Record information pertaining to person'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 the person's diagnosis has changed or not. If diagnosis has changed, check <i>yes</i> and proceed to Comprehensive Assessment Update form.
Data Field	Medication Orders Today
None Prescribed	Check box if no medications are prescribed today. If so, proceed to Next Appointment data field.
Rationale for Changes in Medications	Document rationale for any medication changes. For each medication prescribed, indicate if the medication is renewed(<i>renew</i>) /changed, newly prescribed (<i>new</i>) or discontinued (D/C). Write the name of the medication (<i>med</i>), dosage (<i>dose</i>), frequency (<i>frequency</i>), # of Days, quantity (<i>qty</i>), and number of refills (<i>refills</i>) prescribed. For each new medication prescribed, the person should be given information about medication risks and benefits. Check the appropriate box indicating whether person has given "informed consent", i.e. demonstrated an understanding of medication's risks and benefits. Documentation of "Informed Consent" is mandatory. If the person 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 should not be a substitute for a complete listing of medications.
Instructions/Comments, as applicable:	Document any additional relevant instructions or psycho-educational information.
Next Appointment	Document time frame when the person should return to see the prescriber.
MD/DO/APN (Print Name)	Legibly print the MD/DO/APN's name.
MD/DO/APN Signature & Credentials	Legibly record provider's signature, credentials and date.
Supervisor - Print Name/Credential (If needed)	If required, legibly print name of supervisor, credentials and date.
Supervisor - Signature (If needed)	If required, legible record Supervisor Signature.