Section 4

Using the MSDP Progress Note Group 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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Consultation- Collateral Contact Progress Note

Use the Consultation - Collateral Contact Progress Note to document Case Consultation, Family Consultation and Collateral Contact services. This form can be used for either billable or non-billable services.

Data Field	Person's Name, Record Number, Type of Scheduled Contact, Service, and Purpose 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.
Person's DOB	Record the person's date of birth.
Organization Name	Record the organization for whom you are delivering the service.
Type of Scheduled Contact	Indicate if contact was and *in-person meeting* or via *telephone.*
Service	Check **one** of the following services provided: **Case Consultation** (Code 90882)- a face-to-face or telephonic communication of at least 15 minutes duration, between the primary behavioral health clinician and another treating provider (not within the same agency) in order to identify, plan and coordinate treatment. Ex. PCP or Pediatrician, outside psychiatrist or therapist, state agency (DCF, DYS and DMH). Case consultation can be for persons 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** (Code 90887) – a face-to-face or telephonic communication of at least 15 minutes duration between primary behavioral health clinician and the person's family in order to identify, plan and coordinate treatment. **Consultation or Collateral Contact (Code H0046?)-** is a face-to-face or telephonic communication of at least 15 minutes duration by the primary behavioral health clinician and an individual or agency, in order to support and/or reinforce the treatment plan for Medicaid **members who are under 19 years of age.** Collateral contacts include: teachers, principals, guidance counselors, day care providers, previous therapists, after school programs and community centers.
Purpose	Check any of the following as relevant to the purpose(s) of this contact: *Assessment of the appropriateness of current services; Coordination/planning; Termination/Aftercare planning; Clinical consultation/Second Opinion (not supervision); Supporting Treatment objectives for the person's care; 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 represented, and relationship(s) to person served.
Summary of IAP goals/objectives/ interventions addressed with this contact	Indicate 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 PCC, change in frequency of therapy," etc.
Responsible Party	Indicate the person(s) responsible for carrying out the resulting action from this contact.
Data Field	**Staff Signatures Instructions**
Provider Name	**Legibly** print the provider's name.
Provider Signature/ Credentials/ Title & Date	**Legibly record provider's** signature, credentials and date. **Example**: William Jones, LICSW, 6/23/2008 Mary Calcaterra, Counselor
Supervisor Name	If required, **legibly** print name of supervisor. Check if "N/A". **Example: Jerry Smith, LMHC**
Supervisor Signature/ Credentials & Date	If required, **legibly record supervisor's** signature, credentials and date.

Group Psychotherapy Progress Note

The Group Psychotherapy Progress Note is used for billable outpatient psychotherapy groups. Use the Intensive Services Progress Note form to document other groups offered as part of programs such as Partial Hospitalization (PHP), Community Based Adolescent Treatment (CBAT) and Transitional Support Services (TSS).

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.
Person's DOB	Record the person's date of birth to serve as another identifier.
Organization Name	Record the organization for whom you are delivering the service.
Group Name	Give the name of the specific group. Example: Anger Management.
Number of Attendees	Enter the number of persons attending the group on this date.
Person Served Did Not Attend	Indicate the reason the person served did not attend the group session.
Data Field	**Documentation of Person's Served Participation and Response to Group Treatment**
Behavior in Group	Check box(es) to document the person's observed behavior during the group session.
Person's Served Mood	Check box(es) to document the person's observed or reported mood during the group session.
Stressors/Extraordinary Events/New Issues Presented Today	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that was resolved during the session check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions section and indicate the resolution in the Response section of the progress note. If services are provided during the session that have not been previously ordered in the Individualized Action plan, then an explanation of the rationale for those services should be provided. 3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. **4.** If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA 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 therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form. ***Child Outpatient Example:*** Person reported that she experienced a flashback last week. Other group members were supportive. Group therapist asked her to identify any triggers and person was unable to do so at the moment. Group therapist will follow up with person after the group. ***Adult Outpatient Example:*** Mary began crying as another group member shared her story of witnessing her parent's fighting. Group therapist intervened and later provided Mary the

	opportunity to share some of her story. Mary reported that she had not thought of her experience in a long time and appreciated being able to verbalize how it has impacted her ***BSAS Example:*** The clinical assessment update disclosed snorting heroin and reported is worried he may start needle injection. (IVDU) Group discussion of heroin use. Client referred to psycho-pharm service. Robert disclosed that he sometimes uses Oxycontin by snorting. He has not injected, but reports being worried that he has been around folks who have. Others in group counseling discussed using heroin by injecting and client is scared. Robert is referred to Psycho-pharmacology assessment. **Example of New Issue needing CA Update:** ***Child Outpatient Example:*** Person was able to report that she recalled witnessing domestic violence between her parents when person was 5 years old. This was also documented on a CA update for this person. ***Adult Outpatient Example:*** After hearing a group member share about how his relationship with his girlfriend has impacted his level of anxiety, Mary reported that she is now interested and willing to discuss in treatment how her relationship with her husband has impacted her anxiety. ***BSAS Example:*** CA update client disclosed snorting Oxycodone and worried may start injecting drug Referred to medical doctor to address a need for a safe detox off of opiates. For services that are not specifically included in the recipient's treatment regimen, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's PoC should be submitted with bills. Similarly, a detailed explanation should accompany bills for a medical or remedial therapy, session, or encounter that departs from the PoC in terms of need, scheduling, frequency, or duration of services furnished (e.g., unscheduled emergency services furnished during an acute psychotic episode), explaining why this departure from the established treatment regimen is necessary in order to achieve the treatment objectives. This same is applicable to individual note. If a new issue were already documented in the Assessment, and resolved in the session, no CA update would be needed.

Data Field	Goals, Interventions and Progress Information
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.
Therapeutic Intervention(s) Delivered in Session	Describe the specific therapeutic interventions used in this particular group session to assist the person in realizing the goals and objectives listed above. All interventions must be targeted toward specific goals/objectives in the Individualized Action Plan. The intervention documented in this section would be the same for all persons served in the group. ***Child Outpatient Example:*** Being a Healing Group, group therapist taught group members to do diaphragmatic, deep breathing as well as practiced visualization skills. ***Adult Outpatient Example:*** Provided psychoeducation around common contributing factors to and forms of anxiety. Clinician lead group members in practicing several grounding exercises and then facilitated a discussion of group members' favorites. ***BSAS Example:*** Robert gained insight from group members after disclosing his extent of drug use and methods for using opiates.

Person's Response to Intervention and/or Progress Toward Goals and Objectives Today	Describe how the session has helped move the person closer to, further away from, or had no discernible impact on meeting his/her goals/objectives. If no progress is made over time, this section should address how the group leader intends to change his/her strategy. ***Child Outpatient Example:*** Group therapist asked the teenagers how they felt after doing these activities and they responded positively, with the exception of one teen who thought the exercises did not help her. Group therapist will follow up with this member after the group. ***Adult Outpatient Example:*** Mary noted that the grounding exercise of noticing 5 objects that are the color blue was her favorite. She remarked that she would practice it and try this exercise when she next gets overwhelmed in a heated discussion with her husband. ***BSAS Example:*** Client appeared relieved regarding the suggestion made by group members to consider Medicated Assisted Treatment (MAT) to detox from the opiate use.
Plan/Additional Information	The clinician should document future steps or actions planned with the person 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 counselor intends to change his/her strategy to produce positive change in the person. Document additional pertinent information that is not appropriate to document elsewhere. Example: ***Child Outpatient Example:*** Group was asked to practice new skill of deep breathing 3 times during the upcoming week and to record how they were feeling before and after and what the precipitating event was for them. ***Adult Outpatient Example:*** Mary will practice her favorite grounding exercise at least once daily until the next group session. She will come prepared to discuss what this experience was like for her and how effective it was for her. ***BSAS Example:*** Client will work with group facilitator to get referral for MAT.

Data Field	Signatures Information Instructions
Provider	Print provider name.
Provider Signature/Credentials	Legible signature and degree/license of provider.
Date	Record the date of each signature, including the month, day and year.
Supervisor (if needed)	Print the supervisor's name, if needed.
Supervisor Signature/Credentials	Legible signature and degree/license of supervisor, if needed.
Next Appointment	Record the date, including the month, day and year of the next appointment, and the time of day.
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 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.

Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
Date of Service	Date of session/service provided.
Provider Number	Specify the individual staff member's "provider number" as defined by the individual agency.
Location Code	Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Procedure Code	Identify the procedure code that identifies the service provided and documented. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Modifier 1, 2, 3 and 4	Identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
Start Time	Indicate actual time the session started. **Example: 3:00 PM**
Stop Time	Indicate actual time the session stopped. **Example: 3:34 PM**
Total Time	Indicate the total time of the session. **Example: 34 minutes**
Diagnostic Code	Use the numeric code for the primary diagnosis that is the focus of this session. Providers should use either ICD-9 or DSM code as determined by their agency's billing policies and procedures.

Health Care Provider Medication Orders Progress Note

General Directions: To be used in DMH Residential/Supported Housing Programs in conjunction with all Health Care Providers.

- The Health Care Provider Medication Orders Progress Notes is a two-page form.
- It is to be completed by both the direct care program staff and the medical/prescribing staff providing the medication services.
- Direct care staff must have Health Care Provider (HCP) orders to administer medications.
- The HCP must sign and date both pages of the form.
- The non-shaded areas are for the program staff to complete.
- The shaded areas are for the medical/prescribing staff to complete.

Data Field	Identifying Information Instructions
The material in the non-shaded area of the form is generated and completed by the staff in the person's residential/supported housing program prior to the appointment and reviewed by the Health Care Provider during the visit.	
The shaded sections are for the Health Care Provider to complete.	
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth to serve as another identifier.
Organization Name:	Record the organization for whom you are delivering the service.
List of Names of Persons Present	Check appropriate box: *Person Present; Person No Show; Person Canceled.* If *Provider Canceled* is checked, document explanation as relevant. If *Others Present* is checked, identify name(s) and relationship(s) to person. In the check box field identifying various Health Care Provider types, check which provider type will be completing this form. Put the date of the last physical exam in the appropriate box.
Reason for Visit/Program Update	Document what the person and any collateral individuals have reported regarding the person's status, which may include progress made since last session related to symptoms, substance use, and overall functioning. Record any changes in behaviors, sleep, appetite, mental status, appearance, etc. Document the person's involvement in other treatment programs, work, day time activities, etc. If any blood work or tests were ordered at the last appointment, document if done.
Medication Update	Include any information related to miss dosages, any refusal to take the medications, any PRN's given including date and circumstances, PRN effectiveness, self-medication status, etc. Document any prescriptions needed, the current level of self-medicating status and if a change is indicated. If a new medication had been ordered/started, document observations. Document any circumstances that might impact the need for additional prescriptions or refills, such as the person is planning to be away on vacation. Document any quotes the person has made about the medications.

Data Field	Health Care Provider's Evaluation
1—Mixture of ALL medications ordered appropriate	Review the list of medications at the top of the second page that other HCP's have ordered for this person. Record whether ALL medications ordered are appropriate for this individual. If *No* is checked, then explain under *Comments*.
2—Medications Doses Prescribed by You	Record whether the medications doses you are prescribing are appropriate and effective. If *No* is checked, explain under *Comments*.
3—Tardive Dyskenesia /Side Effects	Record if there is any evidence of tardive dyskenesia or side effects. If *Yes* is checked, explain under *Comments*.
4—Vital Signs	Record if you are recommending that vital signs be monitored relative to a specific medication you are prescribing by checking *Yes*. Do not record comments on this page but on page 2 in the special instructions box connected with that specific medication.
5—Missed Medication Dose	If there are specific steps to be taken when a medication dose you ordered is missed, check *Yes* and explain those steps under *Comments*.
6—Adverse/Allergic Reactions or Contradictions	If there are any possible adverse or allergic reactions or contradictions for this specific person, check *Yes* and explain under *Comments*.
7—Specific Staff Instructions	If there are any specific staff responses you are recommending, such as when to hold a medication or when to contact an HCP, check *Yes* and explain under *Comments*.
Progress Note / Findings / Recommendations	Record in this section any lab results of concern, findings, recommendations, blood work or tests to be performed, or any visit information the HCP wants to communicate to the direct care staff.
Persons Concerns Questions	**Note any concerns or questions the persons served had/asked.**
Data Field	**Medication Administration**
Check and complete one of the three options listed below.	
1—Not Capable of Self-Medicating	1—If it is your assessment that the person is **not** capable of self-medicating at this time, then check this box.
2—Self -Medicating Training Plan	2—If the person is learning or can partially self –medicate, then check this box and all applicable boxes below: • May pour but cannot hold medications under staff supervision • Able to package and self-medicate for: check the appropriate box of the specific dose or time period. • Other: if there are any other instructions for medication administration, check this box and record information.
3—Capable of Fully Self-Medicating	3—Check this box if your assessment is that the person understands all of the following: • his/her responsibility for storing medications • taking as ordered • the dosage, purpose and common side-effects of all medications prescribed • what might occur if he/she does not take as prescribed
Schedule Next Visit	Either check the box that matches the time frame the person should return for the next appointment, or if known, specify the date of the next appointment.

Prescriber Name / Signature, Credential / Date	Print name, sign name with credentials, and record the date that the document is signed.

Data Field	Identifying Information Instructions
The material in the non-shaded area of the form is generated and completed by the staff in the person's residential/supported housing program prior to the appointment and reviewed by the Health Care Provider during the visit.	
The shaded sections are for the Health Care Provider to complete.	
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Data Field	**Medications Ordered By Other Health Care Providers <u>Not by the above HCP</u>**
Medications **Dose** **Frequency** **HCP**	Prior to this HCP visit, the program staff will have entered all HCP medication updates into the program's database. The program staff will then verify that all medications are listed correctly by comparing to the most recent previous HCP order sheets from all providers. That updated information will then be entered into this section of the Progress Note. The name of each HCP who ordered each medication will be listed on the row of that specific medication.
Data Field	**Health Care Provider Orders**
Prior to the visit, the program staff will complete the non-shaded areas of this section.	
Allergies	List any allergies the person. If there are no known allergies, check *NKA* box.
HCP Name	Record the name of the Health Care Provider of today's visit.
• **Medications** • **Dose** • **Quantity Dispensed** • **Frequency** • **Route** • **Treatment Purpose** • **Special Instructions** • **# hrs late medication may be given** • **P (Posted)** • **V (Verified)**	Prior to this HCP visit, the program staff will have entered all HCP medication updates into the program's data base. The program staff will then verify that all medications are listed correctly by comparing to the most recent previous HCP order sheets from all providers. That updated information will then be entered into this section of the Progress Note. The two columns labeled "P" and "V" are to be used by the Residential/Supported Housing program when posting the data on this sheet and when being verified for accuracy prior to the appointment.
• **D/C** • **Scripts Given**	The HCP reviews the current Medications order and instructions for accuracy and makes any corrections if needed. If the HCP wants a medication discontinued, record D/C in the shaded box labeled "D/C" next to the medication name. If the HCP is writing a prescription for one of the medications listed in this section, then record *Yes* in the shaded box labeled *Scripts Given*.

Data Field	HCP Write New Medication Orders Today Here
• **Medications** • **Dose** • **Frequency** • **Route** • **Special Instructions** • **# Hours Late Medication May be Given**	If the HCP is adding a medication, including changing the dosage, frequency or any special instructions related to the medication, then this section must be used to order those medications. All sections of this grid must be completed. In the *Special Instructions* box, the HCP is required to specify the treatment purpose and complete instructions for administration. For PRN medications, specify the rationale for use and maximum number of doses in 24 hours. For PRN and standing doses of the same medication, indicate number of hours between doses.
Prescriber Name / Signature, Credentials / Date	Legibly print name, record signature with credentials, and provide date the document is signed
Data Field	**Residential/Supported Housing Follow-up**
• **P (Posted)** • **V (Verified)** • **Posted By** • **Verified By** • **Computer Updated By**	Upon return to the program offices, one staff will "post" the orders by checking the previous orders with the medication sheet and pharmacy label, and transcribe new orders, discontinued orders or changes in orders to the database. That staff person will check all boxes next to the orders posted and then sign the section *posted by* with the time and date. Once the logging into the database is completed, then the staff person will sign the *computer updated* section. A second staff will "verify" the orders by checking all of the orders with the medication sheet and pharmacy label. That staff person will then place check marks next to all orders verified and then sign the *verified by* with the time and date.

Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
Date of Service	Date of session/service provided
Provider Number	Specify the individual staff member's "provider number" as defined by the individual agency.
Location Code	Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Procedure Code	Identify the procedure code that identifies the service provided and documented. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Modifier 1, 2, 3 and 4	Identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
Start Time	Indicate actual time the session started. **Example: 3:00 PM**
Stop Time	Indicate actual time the session stopped. **Example: 3:34 PM**
Total Time	Indicate the total time of the session. **Example: 34 minutes**
Diagnostic Code	Use the numeric code for the primary diagnosis that is the focus of this session. Providers should use either ICD or DSM code as determined by their agency's billing policies and procedures.

Intensive Services Progress Note

This form is to be completed for all group and individual therapy sessions offered as part of comprehensive treatment for Intensive Service Programs such as Partial Hospitalization Program (PHP), Transitional Support Services (TSS). Community Based Adolescent Treatment and for Inpatient Detox Services.

Page one provides space to document two interventions and page two provides space for one more intervention and summary information for the day. If the person participated in more than three interventions for the day, add an additional page one to the day's note packet. At the bottom of the page, number each page according to the total number of pages used for documenting the interventions for the day.

Data Field	Identifying Information, Type of Service, Attendance and Time of Session Instruction
Person's Name	Record the first, 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 Service	Enter date of service.
Person's DOB	Record the person's date of birth to serve as another identifier.
Organization Name	Record the organization for whom you are delivering the service.
Type of Service **Group Name** **Individual Intervention**	If the service is a group, write the name the group in the first section and record the number of persons who attended. **Example: Anger Management Group No in Group: 6** If Medicare billing for PHP only, check appropriate group type. 915 = Group Therapy 942 = Education Training 904 = Activity Therapy If the service is an individual intervention, check the Individual Intervention box. If Medicare billing, check the Medicare only box 914. (PHP Only, not Medicare outpatient services)
Start Time/Stop Time	Record the time the session started and the time the session ended. If applicable only.
Person Served Did Not Attend	If the person did not attend this activity, please check the appropriate box: "Removed", "Refused Service", "No Show", or "Cancelled" with an explanation. If reason person did not attend is not known, write "unknown".
Data Field	**Goal(s) Information Instruction**
Goals/Objectives addressed from Individualized Action Plan	Identify specific goal(s) and objective(s) in the Individualized Action Plan addressed during this intervention. When using this form as a paper document, write only the number of the Goal(s) and Objective(s) and the description of those Goals and Objectives that are being addressed in this specific session.

Data Field	Interventions and Response Information Instruction
Therapeutic Interventions Delivered in Session	Document how the intervention is linked or targeted towards specific goal/objectives in the Individualized Action Plan. This section should describe the specific therapeutic interventions used in the group session to assist the person in realizing the goals and objectives listed above as the focus of this particular session. This intervention documented in this section would be the same for all persons served in the group. **Group Example:** ***Adult Outpatient Example:*** Clinician facilitated a discussion on relaxation and calming skills. Group was asked to brainstorm which skills would be most helpful to them and then identified criteria which would help them consider when to use the skills. ***BSAS Example:*** Group facilitator led a discussion on the costs and benefits of MAT. The group asked to assist each other In determining then listing the issued pertaining to MAT. Group participants shared comments on white board. If this section is being used to document an individual psychotherapy contact during the course of the day, then describe the specific therapeutic interventions used in the session to assist the person in realizing the goals and objectives addressed as the focus of this particular session. **Individual Example:** ***Adult Outpatient Example:*** Mary seemed more withdrawn today. Therapist met individually with Mary to discuss this. Mary noted that yesterday she thought another group member was rude to her, and now she felt less comfortable sharing her perspective with the group. Discussed with Mary what options she could think of as a response to her concern. Helped Mary role-play communicating her feelings to the group member who she viewed had been rude to her. ***BSAS Example:*** Robert was able to articulate how the MAT may be useful, but not sure if he wants to take the time to meet with another doctor/appointment. **If there is other pertinent content from the session that should be recorded in the record and it is not a new issue, then record that information here. If the content is a new issue, then it should be recorded below in the Daily Clinical Summary Section under "New Issue(s) Presented Today/Plan/Additional Information"**
Person's Served Response to Intervention and Progress towards Goals and Objectives OR Plan to Overcome Lack of Progress	This section should address **BOTH**: • The **person's response** to the intervention, including evidence of how the person participated in the session and how the person was able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • **Progress towards goals and objectives**. This should include an assessment of how the session has moved the person closer, further away or had no discernible impact on meeting the identified goal and objectives. If no progress is made over time, this section should also include a discussion of how the staff person intends to change his/her strategy. ***Adult Outpatient Example:*** Mary had ease in identifying relaxation skills in today's group; however, noted great difficulty in noticing the intensity level of her anxious emotions. Mary was willing to practice the relaxation skills. She agreed that she may need more specific help in learning skills associated with monitoring the intensity of her emotions. ***BSAS Example:*** Robert was able to engage in group activity and discussion. He listened to group examples of how attending

	Individual Example ***Adult Outpatient Example:*** Mary was able to practice interpersonal effectiveness skills while role-playing with clinician. She reported at the end of the practice that she still felt a little nervous, but felt prepared to have a potentially difficult conversation. ***BSAS Example:*** Robert reported that he has made an appointment with medical doctor to begin assessment for MAT and a safe detox.
Data Field	**Signature Instruction**
Provider Signature/ Credentials	The lead clinician for each group should write and sign each note with his/her credentials.
Co-Provider Signature/ Credentials (if applicable)	A co-provider of a group should sign note with his/her credentials, if applicable.
Data Field	**Supervisor/Designee Daily Clinical Summary Functioning Instruction**
Functioning: Observed or Reported (may include mood, affect, behavior, cognitive functioning, etc.)	Document, as appropriate, person's functioning, their signs and symptoms in one or more of the following areas: would expect in intensive services some note about signs and symptoms. 1. General ability of person to function in group/individual setting since last visit. This can be reported by person, or by others who have observed or interacted with person. ***Adult Outpatient Example:*** Mary participated quietly in all the exercises today, but did not engage with other group members as much as previous days. ***BSAS Example:*** Robert was able to actively participate in the group. He took particular note of example of other group members experience with MAT. 2. Observed or reported functioning of person in area of focus for today's group activities/topics/interactions. ***Adult Outpatient Example:*** Mary reported how difficult it was for her to identify the intensity level of her emotions. Mary seemed willing to learn more in this area. ***BSAS Example:*** *Robert took notes during discussion of others experiences.* 3. Observed functioning of person in group session that would impact his/her ability to participate in the session or to benefit from the session. ***Adult Outpatient Example:*** Mary seemed more withdrawn today than yesterday in group contexts. ***BSAS Example:*** Robert appeared eager to learn from others.
Data Field	**Stressors Instruction**
Stressors/ Extraordinary Events	Identify any current, notable stressors or any unusual events that have occurred in the person's life outside of the program that may have an impact on the person's behavior and interaction in the group, may need to be addressed in group, or may need another type of intervention. If none were identified, check *None reported* box. ***Adult Outpatient Example:*** Mary reported that her son is staying with her mother (who is in town visiting) while Mary is in the partial hospitalization program. Mary's mother reported that her son seemed really sad and missed Mary a lot yesterday. She shared with the group that it was hard to be away from him; but that she thought it was important for her health and functioning to attend the groups today.

	BSAS Example: none reported
Data Field	**New Issue(s) and Additional Information Instruction**
New Issue(s) Presented Today/ Additional Information/Plan	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that can be resolved during the session, check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions Section and indicate the resolution in the Response Section of the progress note. 3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. 4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA 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 therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form. ***Adult Outpatient Example:*** Mary reported that when she was 7 her father "disciplined" her in a way that she now recognizes as physical abuse. See further explanation on the Comprehensive Assessment Update on this date. ***BSAS Example:*** 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 produce positive change in the person. This section can be used to document additional information the staff person identifies as important and is not appropriate document elsewhere. **Example #1:** ***Adult Outpatient Example:*** Mary seemed resistant and/or distant in the past day. Clinician will meet with Mary to discuss her goals and assess whether any modifications should be made to improve her functioning in this setting. ***BSAS Example:*** none reported
Data Field	**Signatures and Medicare Information Instruction**
Supervisor/Designee Signature/ Credentials	**Legibly** record signature and credentials of either the program's supervising staff licensed to supervise provider staff or the supervisor's designee. Name should also be printed.
Date	The date of the signature
Physician's signature/ credential (if applicable)	If physician signature is required, then it should be a Legible signature and credentials. Name should also be printed.
Date	The date of the signature.
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 Provider on Site	Enter the name of the 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. Providers should consult with their Medicare Carrier's Local Medical Review Policies.

Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
Date of Service	Date of session/service provided.
Provider Number	Specify the individual staff member's "provider number" as defined by the individual agency.
Location Code	Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Procedure Code	Identify the procedure code that identifies the service provided and documented. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Modifier 1, 2, 3 and 4	Identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
Start Time	Indicate actual time the session started. **Example: 3:00 PM**
Stop Time	Indicate actual time the session stopped. **Example: 3:34 PM**
Total Time	Indicate the total time in the program today. **Example: 5 hours**
Diagnostic Code	Use the numeric code for the primary diagnosis that is the focus of this session. Providers should use either ICD-9 or DSM code as determined by their agency's billing policies and procedures.

Monthly Progress Note—Summary

At the top of the page identify the specific time frame that is being documented and record the beginning and ending month, day & year.

Example: April 7, 2008 through May 6, 2008.

Data Field	Identifying Information Instruction
Person's Name	Record the first, 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.
Person's DOB	Record the person's date of birth to serve as another identifier.
Organization Name:	Record the organization for whom you are delivering the service.
Data Field	**New Issues Instructions**
New Issue(s) Presented This Month	1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that was resolved during the month, check box "New Issue resolved, no CA Update Required". Briefly document the new issue, identify the interventions used in the Therapeutic Interventions Section and indicate the resolution in the Response Section of the progress note. 3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. 4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA 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. The first section of the CA Update may be completed by an unlicensed provider. However, if there is a change to the diagnosis, then that section must be completed by a qualified provider. Also, the newly assessed therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form Record issues/events related to the person's social environment. If there are changes this month in Mental Status, Risk Issues, Service Providers, the person's Financial Status or Support Network, check the appropriate box(es), describe the change(s) and the person's response to the change(s). If there are other changes in the person's social environment, check the *Other* box and describe what has changed or is being updated. ***Adult Outpatient Example:*** Mary reported that she heard news this month that her father was diagnosed with lung cancer. Mary reported that she would like to use treatment to help her process her feelings and support her at this time. A CA Update (with today's date) has been completed and a new goal was developed to assist Mary in processing her grief regarding this diagnosis and its implications. ***BSAS Example:*** Robert has agreed to participate in Medicated Assisted Treatment services ***Adult Outpatient Example:*** Mary reported in the beginning of the month that her mother had experienced some memory difficulties. Mary was very upset and fearful at first that it could be Alzheimer's related. Mary utilized treatment support to brainstorm and develop problem solving skills, such as considering moving to Virginia to be with her mother, or having her mother move up to MA, or talking with her sisters about who would be a primary caregiver to her

	mother. Over the course of the month, Mary found out that her mother's memory difficulties had been medication-related, which eased many of her fears. No CA update necessary at this time. If the person being served does not present any new issues, check *None Reported.*

Data Field	Goals and Interventions Instructions
Goals & Objectives Status / Progress	Record the specific goals and objectives addressed this month by indicating the corresponding number(s)) from the Individualized Action Plan. Any *New* goal(s)will require a number. 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 documented this month and next to the corresponding goal & objective, write the description. To indicate the status of each goal and objective, check the corresponding box using the following key: A = Active N = New D = Discontinued C = Completed R = Revised If the goal and/or objective have been Discontinued or Completed, it would not appear again in a Monthly Progress Note. It would appear in a Quarterly Summary in the Quarter that it was completed/discontinued.
Narrative	For each goal provide a summary of the (program staff's) specific therapeutic interventions made this month with, or on behalf of the person being served to assist him or her in realizing each goal and objective. Additionally, the narrative should include measurable data of the person's response to the intervention(s) and progress made toward that goal and objective(s) this month. If no progress is made over time, this section should also include a discussion of how the staff person intends to change his/her strategy. ***Adult Outpatient Example:*** Staff met with Mary weekly to discuss her difficulty sleeping. Provided psychoeducation about sleep hygiene. Mary came up with a plan as to how to implement suggestions into her evening routine. Mary reported some increased ability to fall asleep in less time than last month. ***BSAS Example:*** Robert continues to regularly attend Recovery Skills groups. He is an active participant and takes notes when others are expressing their experiences. He asks good questions and does not have conflicts with any other participants. **Example # 2** ***Adult Outpatient Example:*** Mary reported having two more panic attacks this month. At first, Mary reported that they were "out of the blue." Staff discussed the circumstances and Mary's feelings prior to these panic attacks and Mary was able to have insight into what may have triggered the attacks. Mary noticed another time later in this month when her level of anxiety was elevated and she was able to reach out to staff at that time before having a panic attack.
Data Field	**Health-related Activities -Updates/Changes in the Person's Environment and Plan/Additional Information Instructions**
Summarize Health-related Activities, Concerns, Changes and Follow-Up This Month	Record issues/events related to the served person's health this month that are not directly related to the individualized action plan, but are significant. Information documented here might become a part of the individualized action plan at a future date. Include things such as the person's exercise regime, diet, physical health issues, medication he/she is taking or other treatments as appropriate.

	Adult Outpatient Example: Mary reported that, with the support of her primary care doctor, she lost 4 pounds this past month. She also reported that she now feels more interested and ready to try to quit smoking. She stated that last week she called 1-800-QUIT-NOW and began the telephone counseling to support her in this transition with a quit date next month. ***BSAS Example:*** Robert is planning to engage in Medicated Assisted Treatment and has made an appointment with physician referred to by his group facilitator.
Plan/Additional Information	The provider should document future steps or actions planned with the person such as skills to practice, tasks to be completed during the next month. Document additional pertinent information that is not appropriate to document elsewhere. Information documented here might become a part of the individualized action plan at a future date. ***Adult Outpatient Example:*** Mary will continue to work with her primary care doctor and nutritionist towards her goal of losing more weight in the next month. ***BSAS Example:*** Robert has received names of physicians available for MAT services. He will work with his counselor on making an initial assessment appointment. **Example #2** ***Adult Outpatient Example:*** Mary reported being hopeful about quitting smoking in the next 30 days. She will be tracking her cigarettes in a "pack wrap" in the next couple weeks in preparation for the quit attempt. ***BSAS Example:*** Robert reports making plans for social activities with group members. **Example #3** ***Adult Outpatient Example:*** Mary reported having a heated phone argument with her husband, which she reported distressed her. Check back in with Mary to see if the disagreement has been resolved or whether she needs additional support. **Example #4** ***Adult Outpatient Example:*** Mary reported beginning to be a part of the choir at her church in the past two weeks, which she noted was encouraging to her. Mary plans to sing again in two weeks.

Data Field	Response to Intervention and Signatures Instruction
Print Provider Name Signature/ Credentials/Title	Print & write a legible signature of provider. **Example: Jerry Smith** Indicate the credentials and title of the provider. **Example: BS add title**
Date	Indicate the date of this signature
Print Supervisor Name Signature/ Credentials	When circumstances dictate a supervisory signature, then the following applies: Print & write a legible signature of the supervisor. **Example**: Mary Jones Indicate the credentials of the supervisor **Example**: LICSW
Date	Indicate the date of this signature

Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
Date of Service	N/A Date range covered by Progress Note is listed above.
Provider Number	Specify the individual staff member's "provider number" as defined by the individual agency of the staff member who is writing this note.
Location Code	If applicable, identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Procedure Code	If applicable, identify the procedure code that identifies the service provided and documented. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Modifier 1, 2, 3 and 4	If applicable, identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
Start Time	N/A
Stop Time	N/A
Total Time	N/A
Diagnostic Code	Use the numeric code for the primary diagnosis of the individual being served.. Providers should use either ICD-9 or DSM code as determined by their agency's billing policies and procedures.

Outreach Services Progress Note

- ✓ Used in home visits or community visits as well community support interactions with the person receiving services and that person's family, even if the family doesn't receive services, There must be an identified client with exclusive benefit otherwise there is a billing concern.
- ✓ Required for Community Rehabilitation Services (CRS), Community Support Program (CSP), Family Stabilization Team (FST), Flex Support Program, and Program of Assertive Community Treatment (PACT)

Documentation links to specific goals in the IAP.

Data Field	Identifying Information Instruction
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth to serve as another identifier.
Organization Name	Record the organization for whom you are delivering the service.
Data Field	**Contact Type and Present at Session Instruction**
Contact Type	Check appropriate box to indicate the type of contact. For indirect work done on behalf of the individual receiving services, the Consultation/Collateral Contact form can be used.
List All Persons Present	Check appropriate box: *Person Present; Person No Show; Person Canceled.* If *Provider Canceled* is checked, document explanation as relevant. If *Others Present* is checked, identify name(s) and relationship(s) to person.
Data Field	**Functioning, New Issue(s) Goals and Therapeutic Interventions Instruction**
Functioning: (observed or reported)	Document as appropriate person's functioning in one or more of the areas listed below. The information can be as reported by person or by others who have observed or interacted with person. Reporting on the person's functioning provides important data that can either positively or negatively impact the person's response to the interventions in this session, as well as the person's overall progress toward his/her goals/objectives. 1. General ability of person to function in community since last visit. ***Adult Outpatient Example:*** Mary continues to live with her husband and children. She reports no outbursts or crisis intervention needed since beginning couples counseling with her husband two weeks ago. Mary reports she has been able to fall asleep more quickly ***BSAS Example:*** Robert reports to be functioning well with no conflict either at home or in treatment. 2. Functioning of person in area of focus for today's interaction. ***Adult Outpatient Example:*** Mary reported that she continues to struggle with moderate panic attacks about once a week. 3. Observed functioning of person in session that would impact his/her ability to participate in session or to benefit from the session. ***Adult Outpatient Example:*** Mary reported difficulty focusing on her symptoms of anxiety and coping strategies as she was very upset about her father's recent diagnosis of lung cancer ***BSAS Example:*** Robert continues to do well in group.

New Issue(s) Presented Today	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, check "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that can be resolved during the session, check box **"New Issue resolved, no CA Update required"**. Briefly documents the new issue, identify the interventions used in the Therapeutic Interventions Section and indicate the resolution in the Response Section of the progress note. 3. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA 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. The first section of the CA Update may be completed by an unlicensed provider. However, if there is a change to the diagnosis, then that section must be completed by a qualified provider. Also, the newly assessed therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form 4. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. ***Adult Outpatient Example:*** Mary reported that her father was diagnosed with lung cancer. Mary reported that she would like to use treatment to help her process her feelings and support her at this time. A CA Update (with today's date) has been completed and a new goal was developed to assist Mary in processing her grief regarding this diagnosis and its implications. ***BSAS Example:*** Robert reports he participated in initial evaluation for induction to MAT.
Goals/Objectives Addressed as Per Individualized Action Plan	Record the specific goals and objectives addressed this session 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 service and next to the corresponding goal & objective, write the description.
Therapeutic Interventions Provided	First check all activity(ies)/interventions provided during the service based on the following definitions: • Assessment of Needs: Ongoing assessment of needs. • Monitoring: Symptom monitoring • Eliminating Barriers: Mental health interventions that assist an individual in eliminating barriers to due to symptoms, behaviors and dysfunctional thought processes. • Coordinating/Linkages: Coordination of Individualized Action Plan (IAP). • Crisis Management: Coordination or assistance in crisis management. • Advocacy: Advocacy in the community on behalf of the person served with community resources. • Outreach: Outreach can be to the person served and the family. • Education/Training: Education and Training to the person served and/or family. • Empowerment/Skills Building: Assistance with achieving personal independence in managing basic needs, facilitation of further development of ADLs and/or activities that increase the person's capacity to positively impact his/her own environment such as empowerment, education and self-esteem activities. • Other: If another activity/intervention is provided during the session, check this box and label it. Describe the specific therapeutic interventions used in the session which assist the person to realize the identified goals and objectives referred to above as the focus of this particular session. ***Adult Outpatient Example:*** Utilized reflective listening skills and allowed Mary some time to share her experience in hearing about her father's diagnosis of lung cancer. Explored how this information has affected Mary's level of anxiety (especially in light of her trauma history with her father and her own health concerns). Provided psychoeducation about having mixed feelings and the process of grief.

Data Field	Response to Intervention
Person's Response to Intervention/ Progress Toward Goals and Objectives	This section should address **BOTH**: • *The person's response to the intervention* - Include evidence the person participated in the session and how, and information about how the person was able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • *Progress towards goals and objectives* - Include an assessment of how the session has moved the person closer, further away, or had no discernible impact on meeting the session's identified goal(s) and objective(s). ***Adult Outpatient Example:*** Mary seemed comforted in being able to talk about how the news of her father's diagnosis is impacting her. Mary made some progress in being able to recognize her feelings during this session. She also was able to be insightful about how this stressful experience has impacted her anxiety levels this week. Mary reported that she will be attempting to quit smoking in the next two weeks – will continue to discuss/monitor what supports Mary may need in this transition. • If no progress is made over time, this section should also include a discussion of how the staff person intends to change his/her strategy.

Data Field	Additional Information/Plan
Plan Additional / Information	The staff providing the service should document future steps or actions planned with the person such as homework, plans for the next session, etc. Document additional pertinent information that is not appropriate to document elsewhere. ***Adult Outpatient Example:*** Mary will monitor her level of anxiety at several times throughout the day. Mary will read handout on grief and discuss the grief process more next session.
Data Field	**Signatures Instruction**
Print Provider Name Signature/ Credentials	Legibly record the name and signature of provider including his/her credentials. **Example: Jerry Smith, BS**
Print Supervisor Name Signature/ Credentials	If the provider is an intern or other circumstances dictate a supervisory signature, the following applies: Legibly record the name and signature of supervisor including his/her credentials. **Example: Mary Jones, LICSW**
Date	Indicate the date of the signature
Person Signature/ Date	Optional - If clinically appropriate, the person signs and dates. Consult agency practice and regulatory requirement(s).
Next Appointment Date	Write both the date and time of the next appointment.

Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
Date of Service	Date of session/service provided.
Provider Number	Specify the individual staff member's "provider number" as defined by the individual agency.
Location Code	Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.

Procedure Code	Identify the procedure code that identifies the service provided and documented. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Modifier 1, 2, 3 and 4	Identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
Start Time	Indicate actual time the session started. **Example: 3:00 PM**
Stop Time	Indicate actual time the session stopped. **Example: 3:34 PM**
Total Time	Indicate the total time of the session. **Example: 34 minutes**
Diagnostic Code	Use the numeric code for the primary diagnosis that is the focus of this session. Providers should use either ICD-9 or DSM code as determined by their agency's billing policies and procedures.

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: *Person Present; No Show; Person Canceled.* If *Provider Canceled* is checked, document explanation as relevant. If *Others Present* 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, *yes/no* or *n/a*. Provide additional relevant information after *Comments*.
Side Effects	Record whether side effects are present or occurred since last session, *yes/no* or *n/a*. 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. 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 or n/a*. Provide additional relevant information after *Comments*.
Other Meds	Record any new medications the person has been taking since the last session, e.g. *over the counter/herbal/ none/other*. Provide additional information after Comments. .
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: *Psychotherapy, Counseling/Coaching, Collaborative Medication Management, Collaborative Medication Education/Symptom/Illness Management, Injections, Physical Assessment, Coordination of Care.* For additional interventions utilized check *other*. 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 *ordered* or, *reviewed* (with person). If lab results were *not received*, 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 *yes* 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*(renew*) /changed, newly prescribed *(new*) or discontinued (D/*C*). Write the name of the medication (*med*), dosage (*dose*), frequency (*frequency*), # of Days, quantity (*qty*), and number of refills *(refills*) 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.

Psychiatric/Medication-Psychotherapy Progress Note

This form is to be completed ONLY by psychiatrist or advanced practice nurse with prescribing privileges when providing a service which includes psychopharmacology (the code name includes the terms evaluation and management) and psychotherapy. Each service must be documented and the psychotherapy must conform to the time requirements of the code being used.

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: *Person Present; No Show; Person Canceled.* If *Provider Canceled* is checked, document explanation as relevant. If *Others Present* 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. The mental status exam is a required for and E&M service.
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	Record whether side effects are present or occurred since last session, *yes/no* or *n/a*. 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. 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 or n/a*. Provide additional relevant information after *Comments*.
Other Meds	Record any other medications the person is/was taking since last session, *over the counter/herbal/ none/other*. Provide additional relevant information after *Comments*.
Goal(s) Addressed as per Psychopharmacology Plan	Identify the specific goal(s) and objectives in the Psychopharmacology Plan or IAP being addressed during this intervention.
Therapeutic Interventions Delivered in Session	Check one or more of the following interventions that were delivered in the session. Options include: *Psychotherapy, Counseling/Coaching, Collaborative Medication Management, Collaborative Medication Education/Symptom/Illness Management, Injections, Physical Assessment, Coordination of Care.* For additional interventions utilized check *other*. Provide additional relevant information as appropriate.

Lab Tests Ordered	Summarize key laboratory test results received and reviewed. Check appropriate box to indicate whether key laboratory test results were *ordered* or*, reviewed* (with person). If lab results were *not received*, 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 contact with the PCP has occurred (if appropriate). Provide additional relevant information as appropriate.
Diagnosis	Document whether the person's diagnosis has changed or not. If diagnosis has changed, check *yes* and proceed to Comprehensive Assessment Update form.

Data Field	Medication Orders Today
None Prescribed	Check box if no medications are prescribed today.
Rationale for Changes in Medications	Document rationale for any medication changes or for leaving medications as is. This is a required section for evaluation and management and should reflect the prescriber's medical decision making. For each medication prescribed, indicate if the medication is renewed *(renew*) newly prescribed *(new*) or discontinued (*d/c*). Write the name of the medication (*med*), dosage (*dose*), frequency (*frequency*), # of Days, quantity (*qty*), and number of refills *(refills*) 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.
Instructions/Comments, as applicable	Document any additional relevant instructions or psycho-educational information.

Data Field	Psychotherapy Progress Note Instructions
Page 2 of 2	This page is used to document the psychotherapy provided in the session.
Goal(s) Addressed as Per Individualized Action Plan:	Identify the specific goal(s) and objectives in the Individualized Action Plan being addressed during this intervention. All interventions must be documented in a progress note and must be targeted towards specific goal(s)/objective(s) in the Individualized Action Plan except as noted above under new issues.
Person's Response to Intervention Delivered in Session and/or Progress Towards Goals and Objectives	This section should address **BOTH**: • *The person's response to the intervention delivered in the session* - Include evidence the person participated in the session and how, and information about how the person was able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • *Progress towards goals and objectives* - Include an assessment of how the session has moved the person closer, further away, or had no discernible impact on meeting the session'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 counselor intends to change his/her strategy to produce positive change in the person. **Individual Example: The person 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. The person 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: The person 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.
Plan/Additional Information	The clinician should document the date of the next session and future steps or actions planned with the person such as homework, plans and approximate time 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 produce positive change in the person. Document additional pertinent information that is not appropriate to document elsewhere. **Example: Person will keep a mood journal to identify triggers to explosive episodes and bring to next session to review and discuss alternative responses. RTC in 2 weeks.**

Data Field	Signature, Medicare Services and Billing Strip Instructions
Person's Signature (optional, if clinically appropriate)	Record person's signature, if clinically appropriate.
Clinician/Provider Name/Credentials (Print name)	**Legibly** print the Clinician/Provider's name, credentials and date.
Supervisor - Print Name/Credential (If needed)	If required, **legibly** print name of supervisor, credentials and date.
Clinician/Provider Signature	**Legibly record provider's** signature and date.
Supervisor Signature (If needed)	If required, legible record Supervisor Signature.
Psychiatrist/MD/DO	If required, **legibly** print name of MD and date.
Next Appointment	Record the data and time of the next appointment.

Psychotherapy Progress Note

Use this note to document individual, family or couples psychotherapy sessions and person's response to the intervention during a specific contact.

Data Field	Identifying Information Instructions
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth.
Organization Name	Record the organization for whom you are delivering the service.
Modality	Check appropriate box to indicate the type of session: *individual, family or couple*.
List Name(s) of Person(s) Present	Check appropriate box to indicate whether the person is *Present*, is a *No Show/Cancelled* or the *Provider Cancelled*. For cancellations, complete *Explanation* as needed. Check appropriate box to indicate if others are present, list name(s) and relationship(s) to person.
Person's Report of Progress Towards Goals/Objectives Since Last Session	Document person's self-report of progress towards goals since last session including other sources of information, such as family, case manager, etc..
New Issue(s) Presented Today	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that was resolved during the session check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions Section and indicate the resolution in the Response Section of the progress note. Example: Person described being involved in a minor car accident today. Person was not hurt but expressed concern regarding expense of car repair. Person felt more relieved after identifying ways to cover expense over the next two weeks. 3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. **4.** If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA 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 therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form. ***Child Outpatient Example:*** Joel's mother reported that Joel had a sick child visit due to upper respiratory infection and that the pediatrician did some testing and diagnosed Joel with asthma and put him on Albuteral, which the MD stated could cause some hyperactivity and increased stimulation for Joel. ***Adult Outpatient Example:*** Mary reported an increase in the frequency of mild-to-moderate panic attacks in the past two weeks.

	BSAS Example: Robert is now participating in MAT treatment in addition to his recovery skills building group.
Data Field	**Person's Condition Instructions**
Person's Condition: **Mood/affect** **Thought Process/Orientation** **Behavior Functioning** **Medical Condition** **Substance Use**	This is a mini-mental status exam. Check appropriate box to indicate person's condition or to indicate *No Change*. Also, describe any changes. **Note**: Notable is defined as behavior or symptoms different from the person's baseline status. These changes may be signs the person is experiencing increased problems or distress or may indicate an improvement in functioning/symptoms/behavior. **Example:** ***Child Outpatient Example: No change*** ***Adult Outpatient Example:*** Mary seemed more fidgety and distractible than previous sessions. Mary was eager to discuss her week. ***BSAS Example:*** Robert appeared anxious regarding the need for MAT.
Risk Assessment	Check appropriate box(es) to indicate area(s) and type(s) of risk or check *None*. Describe types of risky behavior such as cutting, mutilation, unsafe sex etc. under Additional Comments. If any box except *None* is marked, be sure to document in the *Therapeutic Interventions Delivered in Session* section how this was addressed and resolved.
Data Field	**Goal(s) Addressed as Per Individualized Action Plan**
Goal(s) as Addressed Per Individualized Action Plan	Identify the specific goal(s) and objectives in the Individualized Action Plan being addressed during this intervention. All interventions must be documented in a progress note and must be targeted towards specific goal(s)/objective(s) in the Individualized Action Plan except as noted above under new issues.
Data Field	**Therapeutic Interventions and Progress Instructions**
Therapeutic Interventions Delivered in Session	Describe the specific therapeutic interventions used in the psychotherapy session to assist the person in realizing the goals and objectives addressed as the focus of this particular session. ***Child Outpatient Example:*** Joel was actively engaged in practicing his deep breathing. He did this 3 times and brought a favorite stuffed animal with him to practice, too. Joel taught his stuffed animal how to do deep breathing and was able to reinforce his own skills by demonstrating this. Throughout the session, Joel was cued to look at this clinician while speaking to her. This clinician praised Joel every time he was able to do this. Joel, with verbal cues, was also able to use his talking object (he chose a male doll) when it was his turn to talk. ***Adult Outpatient Example:*** Explored Mary's level of anxiety and several important stressors, including finances and her daughter's cold, this week. Discussed and provided psychoeducation around coping strategies and self-care behaviors. ***BSAS Example:*** Robert was assisted in referral process need for MAT and given appointment for assessment for induction. He also discussed need for family support that might assist in support for his treatment plans.

Person's Response to Intervention/ Progress Toward Goals and Objectives	This section should address **BOTH**: • *The person's response to the intervention* - Include evidence the person participated in the session and how, and information about how the person was able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • *Progress towards goals and objectives* - Include an assessment of how the session has moved the person closer, further away, or had no discernible impact on meeting the session's identified goal(s) and objective(s). ***Child Outpatient Example:*** Joel was able to follow a visual cue to look at this clinician 3 times during the session. In addition, he was able to utilize his doll to be a talking object for him and he was successful in using this object for the majority of the session, with prompts. ***Adult Outpatient Example:*** Mary was able to recognize how difficult it was for her to practice self-care behaviors in the midst of this week. She noted that when she became overwhelmed, she hit "survival mode." Mary noticed how disconnected she was with her body and monitoring her level of anxiety this week. However, she was able to notice one of her panic attacks coming on and use coping strategies in order to lessen the intensity of it. ***BSAS Example:*** Robert actively participated and reported he would keep MAT appointment.
Data Field	**Additional Information/Plan**
Plan Additional Information	The clinician should document future steps or actions planned with the person 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 produce positive change in the person. Document additional pertinent information that is not appropriate to document elsewhere. ***Child Outpatient Example:*** Joel will continue to practice his deep breathing at home 4 times during the week with his mother's coaching. He will also use his talking object at home when he needs to communicate. ***Adult Outpatient Example:*** Mary will log the intensity of her anxiety in the upcoming two weeks and will bring it to the next session to discuss. She will practice coping and self-care behaviors when she notices her anxiety rising. ***BSAS Example:*** Robert's session included the discussion with mother for further support.
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 Provider on Site	Enter the name of the 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. Providers should consult with their Medicare Carrier's Local Medical Review Policies.
Data Field	**Signature Instructions**
Provider Name	**Legibly** print the provider's name.
Provider Signature/ Credentials	**Legibly record provider's** signature, credentials and date.
Supervisor Name	If required, **legibly** print name of supervisor.

Supervisor Signature/Credentials	If required, **legibly record supervisor's** signature, credentials and date.
Person's Signature and date	The person is given the option to sign the Progress Note. If completing the note after the session and/or if using electronic notes, person can sign at next session.
Next Appointment	Indicate the date and time of the next scheduled appointment.

Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
Date of Service	Date of session/service provided
Provider Number	Specify the individual staff member's "provider number" as defined by the individual agency.
Location Code	Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Procedure Code	Identify the procedure code that identifies the service provided and documented. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Modifier 1, 2, 3 and 4	Identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
Start Time	Indicate actual time the session started. **Example: 3:00 PM**
Stop Time	Indicate actual time the session stopped. **Example: 3:34 PM**
Total Time	Indicate the total time of the session. **Example: 34 minutes**
Diagnostic Code	Use the numeric code for the primary diagnosis that is the focus of this session. Providers should use either ICD-9 or DSM code as determined by their agency's billing policies and procedures.

Nursing Progress Note (Long Version)

This form is to be completed by a LPN, RN, BSN, or MSN when providing **nursing services primarily in residential or inpatient substance use treatment programs, such as TSS, Detox, etc**. Nurses with a RNCS or an APRN with prescribing privileges should complete the Psychopharmacology Progress Note.

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
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth.
Organization Name	Record the organization for whom you are delivering the service.
List of Names of Persons Present	Check appropriate box: *Person Present; Person No Show; Person Cancelled.* If *Provider Cancelled* is checked, document explanation as relevant. If *Others Present* is checked, identify name(s) and relationship(s) to person.
Interim History	Record a review of the person's condition, medications, dosages, any allergic reactions, and health changes since last encounter, person'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 person is at baseline, no progress made, meds still working, etc.
Person's Condition: **Mood/affect** **Thought Process/Orientation** **Behavior Functioning** **Medical Condition** **Substance Use**	This is a mini-mental status exam. Check appropriate box to indicate person's condition or to indicate *No Change*. Also, describe any changes. **Note**: Notable is defined as behavior or symptoms different from the person's baseline status. These changes may be signs the person 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.**
New Issue(s) Presented Today	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that was resolved during the session check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions Section and indicate the resolution in the Response Section of the progress note. 3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. 4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA 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 therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form.

	Example: Person reported harassment by neighbor, leading to increase in worry and anxiety symptoms. Referred person to Legal Services and left message for individual therapist to coordinate care around legal issues and work with person on anxiety management skills. **Example: Person 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. See CA Update written today.**

Danger to	• Check appropriate box and indicator. • If other, please specify • If any box except "none" is marked, be sure to document in the therapeutic intervention section how this 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.**
Measurements	Record vital signs, height, weight, BMI and/or AIMS, check as pertinent.
Data Field	**Goals, Interventions and Response to Intervention**
Goal(s)/Objective(s) Addressed from IAP	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).
Therapeutic Interventions Provided	Summarize the therapeutic interventions from this appointment, including medication and symptom monitoring, education, medication administration, recommendations, referrals, etc. List injections, site, dosage, and drug. Record linkage between therapeutic interventions and goals/objectives from the IAP. **Example: Provided education to person 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.**
Data Field	**Response to Intervention Instruction**
Person's Response to Intervention and Progress towards Goals and Objectives	This section should address **BOTH**: • The **person's response** to the intervention, including evidence of how the person participated in the session and how the person was able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • **Progress towards goals and objectives**. This should include an assessment of how the session has moved the person closer, further away or had no discernible impact on meeting the identified goal and objectives. If no progress is made over time, this section should also include a discussion of how the staff person intends to change his/her strategy. **Example: Person was able to correctly 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 person 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 nurse intends to change his/her strategy to produce positive change in the person. Document additional pertinent information that is not appropriate to document elsewhere. **Example: Person 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	Issues to be Referred a to Physician / APRN Instructions
Issues to be Referred to the Physician/APRN	Note issues, concerns, and/or information to be brought to the attention of the physician and time frame to do that. **Example**: Positive lab results, medication problems, etc.

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 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 APRN (okay). 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.
Data Field	**Signature, Medicare Services and Billing Strip Instructions**
Provider (Print name)	**Legibly** print the provider's name and date.
Provider Signature/ Credentials	**Legibly record provider's** signature credentials and date.
Supervisor Name	If required, **legibly** print name of supervisor and date.
Supervisor Signature/Credentials	If required, **legibly record supervisor's** signature credentials and date.
Person's Signature	If appropriate, or clinically indicated, record the person's signature.
Next Appointment	Note date and time of next session when appropriate. Otherwise, check box N/A

Nursing Progress Note (Short Version)

This form is to be completed by a LPN, RN, BSN, or MSN when providing **nursing services primarily in residential or inpatient substance use treatment programs, such as TSS, Detox, etc**. Nurses with a RNCS or an APRN with prescribing privileges should complete the Psychopharmacology Progress Note.

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
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth.
Organization Name	Record the organization for whom you are delivering the service.
List of Names of Persons Present	Check appropriate box: *Person Present; Person No Show; Person Cancelled.* If *Provider Cancelled* is checked, document explanation as relevant. If *Others Present* is checked, identify name(s) and relationship(s) to person.
Data Field	**Interim Update**
Interim History see long note manual	Record a review of the person's condition, medications, dosages, any allergic reactions, and health changes since last encounter, person'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 person is at baseline, no progress made, meds still working, etc.
New Issue(s) Presented Today	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that was resolved during the session check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions Section and indicate the resolution in the Response Section of the progress note. 3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. **4.** If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA 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 therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form. **Example: Person reported harassment by neighbor, leading to increase in worry and anxiety symptoms. Referred person to Legal Services and left message for individual therapist to coordinate care around legal issues and work with person on anxiety management skills.** **Example: Person reported that last week she was involved in a car accident and since that time she is having nightmares and memories or physical abuse when**

	she was in elementary school. See CA Update written today.
Measurements	Record vital signs, height, weight, BMI and/or AIMS, check as pertinent.

Data Field	Goals, Interventions and Response to Intervention
Goal(s)/Objective(s) Addressed from IAP	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).
Person's Response to Intervention and Progress toward Goals and Objectives	This section should address **BOTH**: • The **person's response** to the intervention, including evidence of how the person participated in the session and how the person was able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • **Progress towards goals and objectives**. This should include an assessment of how the session has moved the person closer, further away or had no discernible impact on meeting the identified goal and objectives. If no progress is made over time, this section should also include a discussion of how the staff person intends to change his/her strategy. **Example: Person was able to correctly identify medications and dosages. Has an understanding of potential side effects and agrees to report same to staff.**
Plan / Additional Information	The clinician should document future steps or actions planned with the person 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 produce positive change in the person. Document additional pertinent information that is not appropriate to document elsewhere. **Example: Person was not able to correctly identify medications and dosages, so index cards were utilized to give more explicit instructions for each of the medications.**
Issues to be Referred to Physician/APRN	Note issues, concerns, and/or information to be brought to the attention of the physician and time frame to do that. **Example**: **Positive lab results, medication problems, etc.**
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 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. 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.
Data Field	**Signature, Medicare Services and Billing Strip Instructions**
Provider (Print name)	**Legibly** print the provider's name..
Provider Signature/ Credentials	**Legibly record provider's** signature credentials and date.
Supervisor Name	If required, **legibly** print name of supervisor.

Supervisor Signature/Credentials:	If required, **legibly record supervisor's** signature credentials and date.
Person's Signature:	If appropriate, or clinically indicated, record the person's signature.

Shift/Daily Progress Note

- ✓ Required for Crisis Stabilization Unit (CSU), Detox Level III, CSS, Intensive Residential Treatment Program (IRTP), Respite and other 24 hour/overnight programs.
- ✓ Documentation links to specific goals in the IAP.

Data Field	Identifying Information Instruction
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth to serve as another identifier.
Organization Name	Record the organization for whom you are delivering the service.
Data Field	**Type of Program, Time Period and Date Instruction**
Type of Program	**Check type of program:** • **Crisis Stabilization Unit (CSU)** • **Respite Bed** • **DMH-funded Supervised Living Program** • **Detox** • **Other: Identify the program, such as: EATS, DDART, CBAT, ICBAT,STIT, CSS**
Shift Note Type	Depending upon the requirements of your program, check appropriate box to indicate what time frame 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 Issue(s) Presented Today	For substance abuse programs, it is important that the staff filling out his form be aware they should be looking for any changes in medical condition, symptoms, side effects, significant events, and changes in mental status that might occur during the shift and document them in this section. There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that can be resolved during the shift/day, check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions Section and indicate the resolution in the Response Section of the progress note. 3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. 4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA 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. The first section of the CA Update may be completed by an unlicensed provider. However, if there is a change to the diagnosis, then that section must be completed by a qualified provider. Also, the newly assessed therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form **Example: Person reported that she had been taking 25 mg of benzodiazepine daily. Not reported at admission; recorded on CA Update of this date.** **Example: Person reported earlier treatment episode for cocaine addiction prior to admission as recorded on CA Update of this date.**

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 and next to the corresponding goal & objective, write the description of the goal & objective.
Functioning (observed or reported)	Record all pertinent observations of the person'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 person receiving services or by others who have observed or interacted with the person, as well.*** **Example: Person raised his voice and left dinner abruptly when another resident asked him to keep his voice down during dinner.** Suggest use a detox example as well. ***Example: In the afternoon, person 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 person slept throughout, make note of that.
Therapeutic Interventions Provided	Describe the specific therapeutic interventions used during this time period to assist the person in realizing the goals and objectives listed above. **1--Example: Person had difficulty sleeping during this shift. She got up frequently and was agitated when talking about recent events in her life. Provider listened reflectively, encouraged her to do deep breathing exercises and redirected her.** **2--Example: Monitored the person 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 this person and another resident. Need more information.** **4--Example: The person went to the daily community meeting and met with this staff person afterward to discuss his strong reactions to other individuals in the meeting.** **5--Example: Gave this individual feedback on how he reacted negatively to another resident and helped him identify alternate responses.** **6--Example: Taught the individual how to use a calendar to track his medication refills.**
Data Field	**Response to Intervention**
Person's Response to Intervention/ Progress Toward Goals and Objectives	This section should address **BOTH**: • *The person's response to the intervention –* **Example*:* The person 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 session described here, but to the milieu and interventions provided throughout the day by various staff).** • *Progress towards goals and objectives* - Include an assessment of how the intervention has moved the person closer, further away, or had no discernible impact on meeting the session's identified goal(s) and objective(s). **1--Example: Person 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 has been doing earlier. She agreed do contact staff if she felt unsafe. **2--Example: Person expressed thanks to provider for listening to her and made a good effort to practice deep breathing.** **3--Example: The person slept through the night.** **4--Example: The person took the redirection given by staff and kept his distance from the other resident involved for the rest of the shift.** **5--Example: Client was absent from the unit during this shift as he planned to attend Day Treatment and the Clubhouse.** **6--Example: The person 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: The person 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: The person 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 person intends to change his/her strategy.
Plan/Additional Information	If applicable the provider should document steps or actions planned with the person for the next shift. **Example: The person agreed to practice using the skills he learned this shift with regards to using a medication calendar.** **Example: The person 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: The person received a call from his wife and they discussed whether she should bring their children to her next visit.**
Data Field	**Signature Instruction**
Print Provider Name Signature/ Credentials/Title	Legibly print the name of the provider and a signature with credentials. If the individual providing the services does not have a credential (such as a professional license or certification), then the person's Job Title should be recorded after the name. **Example: Jerry Smith, BS, Counselor**
Date	Indicate the date of the signature
Print Supervisor Name Signature/ Credentials	When needed, the supervisor should legibly print his/her name and sign the note with credentials. **Example: Betty Jones, LICSW** **For shift notes need time of note!!!!!!*(SEE BELOW)***
Date	Indicate the date of the signature
Time	For Substance Use Programs, document the time that this note was written.

Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
Date of Service	Date of shift/day being documented.
Provider Number	Specify the individual staff member's "provider number" as defined by the individual agency of the individual staff who is writing this note.
Location Code	Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Procedure Code	Identify the procedure code that identifies the service provided and documented when needed. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Modifier 1, 2, 3 and 4	When needed identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
Start Time	Indicate actual time the shift or day began. **Example: 3:00 PM**
Stop Time	Indicate actual time the shift or day ended. **Example: 11:00 PM**
Total Time	Indicate the total time of the shift/day. **Example: 8 hours**
Diagnostic Code	Use the numeric code for the primary diagnosis of the individual being served. Providers should use either ICD-9 or DSM code as determined by their agency's billing policies and procedures.

Weekly Services Progress Note

- ✓ Used to document therapeutic interventions over the course of a week and person's response to the interventions
- ✓ Documentation links to specific goals in IAP
- ✓ Summarizes services/interventions and the person's responses/progress.
- ✓ Required for Psychiatric Day Treatment and Transitional Support Services (TSS)

Data Field	Identifying Information Instruction
Person Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record #	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth to serve as another identifier.
Organization Name	Record the organization for whom you are delivering the service.
Data Field	**Type of Program and Services Provided**
Type of Program	Check type of program: • Day Treatment • TSS • Other: and identify the program
Services Provided This Week	Check all appropriate boxes of the services delivered to the person during the week. If there were other services provided but are not listed, check "Other" and specify the service provided.
Data Field	**New Issues, Attendance, Goals, Functioning and Therapeutic Interventions Instruction**
New Issue(s) Presented	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that can be resolved during the week, check the "New Issues resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions Section and indicate the resolution in the Response Section of the progress note. 3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. 4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA 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. The first section of the CA Update may be completed by an unlicensed provider. However, if there is a change to the diagnosis, then that section must be completed by a qualified provider. Also, the newly assessed therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form **Example: Person reported he has begun to have nightmares related to the trauma as reported on the CA Update of this date.**

Date(s) Attended By Week & Hours Attended By Week	Write the beginning date of the week the person attended the program in the column labeled "Date(s) Attended By Week" on the first line. In the second column labeled "Hours Attended By Week", list the number of hours attended on that date on the corresponding line. Continue recording the person's attendance for the week in the same fashion. Use agency specific policy re: start and end dates of week.
Goals/Objectives Addressed as Per Individualized Action Plan	Record the specific goals and objectives addressed during this week 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 week and next to the corresponding goal & objective, write the description of the goal & objective.
Functioning (observed or reported)	Record all pertinent observations (seen or reported) of the person's functioning and interactions during the week that may have an impact on his/her participating in the program. Reporting on the person's functioning provides important data that can either positively or negatively impact the person's responses to the interventions in the program, as well as the person's overall progress toward his/her goals/objectives **Example: Person was arrested with her boyfriend over the weekend for being in a stolen car. That event dominated her attention and focus during the beginning of the week. In groups she seemed distracted from the topics of the groups and wanted to focus on the details of this event. When the event was discussed, she avoided talking about whether this event has had an impact upon her ongoing depressed moods.**
Therapeutic Interventions Provided	This section summarizes the specific therapeutic interventions used during this time period to assist the person in realizing the goals and objectives listed above as the focus of this week's treatment. Identify all interventions that program staff used during this week. **Example: Multiple approaches (reframing, redirecting, role playing, and DBT skills building) were used in group and individual sessions, to help the person refocus upon her depressed mood and to manage her affective instability related to her recent legal events.**
Data Field	**Response to Intervention**
Person's Response to Intervention/Progress Toward Goals/Objectives	This section should address **BOTH**: • *The person's response to the intervention* - Include evidence the person participated in the session and how, and information about how the person was able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • *Progress towards goals and objectives* - Include an assessment of how the session has moved the person closer, further away, or had no discernible impact on meeting the session's identified goal(s) and objective(s). . **Example: Earlier in the week, the person focused much of her energy on her legal situation and found it difficult to engage with the other clients in the groups and to stay focused on the group topics. In some groups she opted not to participate directly in the scheduled group activities but observed other group members and gave feedback to them about their participation. By Thursday she began to use the interventions in the group to problem solve and to calm her agitation. She was able to then talk more directly about how this event has affected her depressed mood this week and the strategies she needs to use over the weekend to prevent herself from becoming more depressed.** • If no progress is made over time, this section should also include a discussion of how the staff person intends to change his/her strategy.

Plan / Additional Information	The clinician should document future steps or actions planned with the person such as homework, plans for the next week, etc. Document additional pertinent information that is not appropriate to document elsewhere. **Example: Nancy reported she will miss next week due to planned vacation with family. She will use stress management techniques learned in groups this week during her trip and journal the outcomes to share during her first session when she returns.**

Data Field	Signature Instructions
Provider Name	**Legibly** print the provider's name and date.
Provider Signature/ Credentials/Title	**Legibly record provider's** signature credentials and date. . If the individual providing the services does not have a credential (such as a professional license or certification), then the person's Job Title should be recorded after the name.
Supervisor Name	If required, **legibly** print name of **supervisor** and date.
Supervisor Signature/Credentials Title	If required, **legibly record supervisor's** signature credentials and date.

Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
Total Hours Attended This Week	Total the number of hours listed in the column labeled "Hours Attended By Week" and enter that number in this field.
Provider Number	Specify the individual staff member's "provider number" as defined by the individual agency of the staff person who is writing this note.
Location Code	Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Procedure Code	Identify the procedure code that identifies the service provided and documented. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Modifier 1, 2, 3 and 4	Identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
Start Time	N/A
Stop Time	N/A.
Total Time	N/A
Diagnostic Code	Use the numeric code for the primary diagnosis of the individual being served. Providers should use either ICD-9 or DSM code as determined by their agency's billing policies and procedures.