



Progress Note / Service Entry Form

Client Name _____

Client MRN/ID _____

Facility Name _____ ID _____ Program _____ ID _____
 Provider _____ ID _____ Number in Group _____ Group ID _____
 Elapsed Time (Total Minutes): _____ Travel Time (Total Minutes): _____
 Service (Begin) Date: _____ Begin Time: 12:00 am

Service Code (check one)

<input type="checkbox"/> 371 Crisis Intervention	<input type="checkbox"/> 358 IHBS	<input type="checkbox"/> 317 Rehabilitation Sup	<input type="checkbox"/> 341 Individual Therapy
<input type="checkbox"/> 300 No Show	<input type="checkbox"/> 564 ICC	<input type="checkbox"/> 319 Family Therapy With Client present	<input type="checkbox"/> 351 Group Therapy
<input type="checkbox"/> 400 Client Cancel	<input type="checkbox"/> 565 ICC-CFT	<input type="checkbox"/> 320 Family Therapy Without Client present	<input type="checkbox"/> 355 Group Rehab
<input type="checkbox"/> 700 Staff Cancel	<input type="checkbox"/> 311 Collateral	<input type="checkbox"/> 331 Assessment	<input type="checkbox"/> 357 Group Collateral
<input type="checkbox"/> 540 Non-Bill	<input type="checkbox"/> 313 Evaluation		<input type="checkbox"/> 541 CM Placement Services
<input type="checkbox"/> 580 IMD/JAIL/JUV SVC Lock-out	<input type="checkbox"/> 315 Plan Development		<input type="checkbox"/> 561 CM Linkage
			<input type="checkbox"/> 571 CM Plan Development

Place of Service (check one)

<input type="checkbox"/> Office	<input type="checkbox"/> Inpatient Psychiatric	<input type="checkbox"/> Residential Txt Center (Child)	<input type="checkbox"/> Job Site
<input type="checkbox"/> Field	<input type="checkbox"/> Inpatient Health	<input type="checkbox"/> Residential Txt Center (Adult)	<input type="checkbox"/> Age Specialty Center
<input type="checkbox"/> Phone	<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Hospice	<input type="checkbox"/> Faith Based Location
<input type="checkbox"/> Home	<input type="checkbox"/> Jail	<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Non Traditional Location
<input type="checkbox"/> School	<input type="checkbox"/> Emergency Shelter	<input type="checkbox"/> Mobile Service	<input type="checkbox"/> Other Location
<input type="checkbox"/> Satellite	<input type="checkbox"/> Primary Care Health Clinic	<input type="checkbox"/> Telehealth – COVID-19	

Is the Client pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	Language service provided in other than English: <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
	Interpreter <input type="checkbox"/> Name of Interpreter: _____

Service Strategies (check up to two, if applicable)

<input type="checkbox"/> 50-Peer/Family Delivered Services	<input type="checkbox"/> 54-In Partnership w/Law Enforcement	<input type="checkbox"/> 58-Integrated Services for MH/Aging
<input type="checkbox"/> 51-Psychoeducation	<input type="checkbox"/> 55-In Partnership w/Health Care	<input type="checkbox"/> 59-Integrated Services for MH/DD
<input type="checkbox"/> 52-Family Support	<input type="checkbox"/> 56-In Partnership w/Social Services	<input type="checkbox"/> 60-Ethnic-Specific Service Strategy
<input type="checkbox"/> 53-Supportive Education	<input type="checkbox"/> 57- In Partnership w/SA Services	<input type="checkbox"/> 61-Age-Specific Services Strategy
		<input type="checkbox"/> 99-Unknown Service Strategy

DSM5 Code: _____	ICD-10 Code: _____
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1a. Treatment goal(s) addressed, if appropriate. (Chart to: Goals/Strategies on Plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.)

Client Name: _____

Client MRN/ID: _____

1b. Description of Current Situation/Reason for Contact: (Status update, needs, clinical impression)

2. Focus of Activity: (Intervention and Response to intervention, what did you do? What is the consumer's response?)

3. Plan (e.g. Coordinator of Care, Referrals, Follow-up) Specialty what the Client/family/providers are to do.

Signature/License/Designation

Print Name

Date

Co-Signature/license (if applicable)

Date

Data Entry Clerk Initials