|  |  |  |
| --- | --- | --- |
| Client:       | Case #:       | Program:       |
| Date of Service:       | Unit:        | SubUnit:        |
| Server ID:       | Service Time:        | Travel Time:        | Documentation Time:       |
| Person Contacted:       | Place:       | Outside Facility:       | Contact Type:       | Appointment Type:       |
| Billing Type (Language Service  Provided In):       | Intensity Type (Interpreter Utilized):       |
| Diagnosis At Service: ICD-10 Code(s):        | Service:        |

**MEDICATION PROGRESS NOTE**

**Diagnosis/Problem List:**

**Brief History** (summary of client’s overall course of treatment, identifying information, hospitalizations, medication changes):

**Subjective** (interval history, clinical update, medication compliance, medication side effects, any past/current substance use)**:**

**Objective:**

**MSE –**

 **Vitals & Measurements –**

 **Laboratory and Other Testing:**

**Assessment** (overall clinical impressions with updates to Problem List as needed, how the service addressed the client’s behavioral health needs):

**Acute/Chronic Risk Factors:**

**Plan** (planned action steps by provider or client, collaboration with client, collaboration with other providers, medication changes, new lab orders, education provided about medications/substance use)

**Informed Consent Completed?**

**[ ]  No** **[ ]  Yes, if yes; date complete:**

**CURES Database Reviewed?**

 **[ ]  No [ ]  Yes, if yes; date complete:**

**Answer the Following Question(s) for Children or Youth Residing in a Short-Term Residential Therapeutic Program** (Not applicable if client is not residing in an STRTP. The client plan is used in place of the Needs and Services Plan for the purpose of the STRTP Mental Health Program):

**1.The Psychiatrist has considered the goals and objectives of the Client Plan and**

**medication prescribed is consistent with this Plan** (Provide a YES or NO answer)

 **2. If No, provide an explanation of needed updates to the Client Plan**:

|  |  |  |
| --- | --- | --- |
|  |  |       |
| \*Signature/Title/Credential Date |  | Printed Name/Credential/Server ID# |
| \* I certify that the service/s shown on this sheet was provided by me personally and the service/s were medically necessary. |
|  |  |       |
| Co-Signature/Title/Credential Date |  | Printed Name/Credential/Server ID# |