|  |  |
| --- | --- |
| Client Name: | Date of Service: |
| Length of Session: | Location of Service: |
| CPT Code: | Diagnosis/ICD Code: |
| **Services Needed or Problem Being Addressed** | |
| (Documentation should support why this service is necessary as it relates to current impact on client mental health impairments and/or progress toward goals) | |
| **Action Taken** | |
| (Describe actions or interventions taken to address the client’s current need for services and how service addresses impact to client’s mental health problem list or progress toward goals) | |
| **Response** | |
|  | |
| **Plan of Care** | |
|  | |
| **Follow up** | |
|  | |
| Client agreed to plan of care:  Yes  No | |
| Clinician Signature: | |
| Clinician Printed Name: | Date: |