|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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): | | | EBP (Homework/CFT): | |
| Diagnosis At Service: ICD-10 Code(s): | | | | Service: | |

**STRTP MEDICATION NOT PRESCRIBED – SERVICE CODE 11 – MEDICATION EVALUATION.**

**\*Completed at a minimum of every 90 days for youth residing in an STRTP**

**Diagnosis** (Include rule out(s). Include status: improved, well controlled, resolving or resolved; or inadequately controlled, worsening, or failing to change as expected):

**Psychiatric Exam** (Description of speech, thought process, associations, abnormal or psychotic thoughts, judgment and insight, MSE, SI/HI, etc.):

**Plan of Care** (Include recommendations for care, psychotherapeutic needs, progress on recovery/resiliency goals etc.):

**The Psychiatrist has reviewed the course of treatment/considered the goals and objectives of the Client Plan** (YES/NO)       If no, psychiatrist must review client plan per STRTP requirements:

\* Client Plan used in place of Needs and Services Plan for the STRTP Mental Health Program

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| --- | --- | --- |
|  |  |  |
| \*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# |