Progress Note / Service Entry Form

Consumer Name
_____________________________

Consumer 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

Was this service done with a Co-Staff? Override Required Yes ☐ No ☐

Service Code (check one)
☐ 371 Crisis Intervention ☐ 358 IHBS ☐ 315 Plan Development ☐ 355 Group Rehab
☐ 300 No Show ☐ 564 ICC ☐ 317 Rehabilitation Sup ☐ 357 Group Collateral
☐ 400 Client Cancel ☐ 565 ICC-CFT ☐ 331 Assessment ☐ 541 CM Placement Services
☐ 700 Staff Cancel ☐ 311 Collateral ☐ 341 Individual Therapy ☐ 561 CM Linkage
☐ 540 Non-Bill ☐ 313 Evaluation ☐ 351 Group Therapy ☐ 571 CM Plan Development
☐ 580 IMD/JAIL/JUV SVC Lock-out

Place of Service (check one)
☐ Office ☐ Inpatient Psychiatric ☐ Residential Txt Center (Child) ☐ Job Site
☐ Field ☐ Inpatient Health ☐ Residential Txt Center (Adult) ☐ Age Specialty Center
☐ Phone ☐ Emergency Room ☐ Hospice ☐ Faith Based Location
☐ Home ☐ Jail ☐ Skilled Nursing Facility ☐ Non Traditional Location
☐ School ☐ Emergency Shelter ☐ Mobile Service ☐ Other Location
☐ Satellite ☐ Primary Care Health Clinic

Is the Client pregnant? Yes ☐ No ☐ Language service provided in other than English: ☐ Spanish
☐ Other: __________________________________________

Interpreter ☐ Name of Interpreter: __________________________

Service Strategies (check up to two, if applicable)
☐ 50-Peer/Family Delivered Services ☐ 54-In Partnership w/Law Enforcement
☐ 51-Psychoeducation ☐ 55-In Partnership w/Health Care
☐ 52-Family Support ☐ 56-In Partnership w/Social Services
☐ 53-Supportive Education ☐ 57- In Partnership w/SA Services

DSM5 Code: ☐ 58-Integrated Services for MH/Aging
☐ 59-Integrated Services for MH/DD
☐ 60-Ethnic-Specific Service Strategy
☐ 61-Age-Specific Services Strategy
☐ 99-Unknown Service Strategy

ICD-10 Code:

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.)

________________________________________________________________________
________________________________________________________________________
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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 consumer/family/providers are to do.

   

___________________________________________________________________________________________
Signature/License/Designation    Print Name    Date

___________________________________________________________________________________________
Co-Signature/license (if applicable)    Date    Data Entry Clerk Initials