Health Care Provider Medication Orders Progress Note

General Directions: To be used in DMH Residential/Supported Housing Programs in conjunction with all Health Care Providers.

- The Health Care Provider Medication Orders Progress Notes is a two-page form.
- It is to be completed by both the direct care program staff and the medical/prescribing staff providing the medication services.
- Direct care staff must have Health Care Provider (HCP) orders to administer medications.
- The HCP must sign and date both pages of the form.
- The non-shaded areas are for the program staff to complete.
- The shaded areas are for the medical/prescribing staff to complete.

Data Field	Identifying Information Instructions
The material in the non-shaded area of the form is generated and completed by the staff in the person's residential/supported housing program prior to the appointment and reviewed by the Health Care Provider during the visit.	
The shaded sections are for the Health Care Provider to complete.	
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth to serve as another identifier.
Organization Name:	Record the organization for whom you are delivering the service.
List of Names of Persons Present	Check appropriate box: *Person Present; Person No Show; Person Cancelled.* If *Provider Cancelled* is checked, document explanation as relevant. If *Others Present* is checked, identify name(s) and relationship(s) to person. In the checkbox field identifying various Health Care Provider types, check which provider type will be completing this form. Put the date of the last physical exam in the appropriate box.
Reason for Visit/Program Update	Document what the person and any collateral individuals have reported regarding the person's status, which may include progress made since last session related to symptoms, substance use, and overall functioning. Record any changes in behaviors, sleep, appetite, mental status, appearance, etc. Document the person's involvement in other treatment programs, work, day time activities, etc. If any blood work or tests were ordered at the last appointment, document if done.
Medication Update	Include any information related to missed dosages, any refusal to take the medications, any PRN's given including date and circumstances, PRN effectiveness, self-medication status, etc. Document any prescriptions needed, the current level of self-medicating status and if a change is indicated. If a new medication had been ordered/started, document observations. Document any circumstances that might impact the need for additional prescriptions or refills, such as the person is planning to be away on vacation. Document any quotes the person has made about the medications.

Data Field	Health Care Provider's Evaluation
1—Mixture of ALL medications ordered appropriate	Review the list of medications at the top of the second page that other HCP's have ordered for this person. Record whether ALL medications ordered are appropriate for this individual. If *No* is checked, then explain under *Comments*.
2—Medications Doses Prescribed by You	Record whether the medications doses you are prescribing are appropriate and effective. If *No* is checked, explain under *Comments*.
3—Tardive Dyskenesia /Side Effects	Record if there is any evidence of tardive dyskenesia or side effects. If *Yes* is checked, explain under *Comments*.
4—Vital Signs	Record if you are recommending that vital signs be monitored relative to a specific medication you are prescribing by checking *Yes*. Do not record comments on this page but on page 2 in the special instructions box connected with that specific medication.
5—Missed Medication Dose	If there are specific steps to be taken when a medication dose you ordered is missed, check *Yes* and explain those steps under *Comments*.
6—Adverse/Allergic Reactions or Contradictions	If there are any possible adverse or allergic reactions or contradictions for this specific person, check *Yes* and explain under *Comments*.
7—Specific Staff Instructions	If there are any specific staff responses you are recommending, such as when to hold a medication or when to contact an HCP, check *Yes* and explain under *Comments*.
Progress Note / Findings / Recommendations	Record in this section any lab results of concern, findings, recommendations, blood work or tests to be performed, or any visit information the HCP wants to communicate to the direct care staff.
Persons Concerns Questions	**Note any concerns or questions the persons served had/asked.**
DATA FIELD	**MEDICATION ADMINISTRATION**
Check and complete one of the three options listed below.	
1—Not Capable of Self-Medicating **2—Self -Medicating Training Plan**	1—If it is your assessment that the person is **not** capable of self-medicating at this time, then check this box. 2—If the person is learning or can partially self –medicate, then check this box and all applicable boxes below: • May pour but cannot hold medications under staff supervision • Able to package and self-medicate for: check the appropriate box of the specific dose or time period. • Other: if there are any other instructions for medication administration, check this box and record information.
3—Capable of Fully Self-Medicating	3—Check this box if your assessment is that the person understands all of the following: • his/her responsibility for storing medications • taking as ordered • the dosage, purpose and common side-effects of all medications prescribed • what might occur if he/she does not take as prescribed
Schedule Next Visit	Either check the box that matches the timeframe the person should return for

	the next appointment, or if known, specify the date of the next appointment.
Prescriber Name / Signature, Credential / Date	Print name, sign name with credentials, and record the date that the document is signed.

Data Field	**Identifying Information Instructions**
The material in the non-shaded area of the form is generated and completed by the staff in the person's residential/supported housing program prior to the appointment and reviewed by the Health Care Provider during the visit.	
The shaded sections are for the Health Care Provider to complete.	
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Data Field	**Medications Ordered By Other Health Care Providers <u>Not by the above HCP</u>**
Medications **Dose** **Frequency** **HCP**	Prior to this HCP visit, the program staff will have entered all HCP medication updates into the program's database. The program staff will then verify that all medications are listed correctly by comparing to the most recent previous HCP order sheets from all providers. That updated information will then be entered into this section of the Progress Note. The name of each HCP who ordered each medication will be listed on the row of that specific medication.
Data Field	**Health Care Provider Orders**
Prior to the visit, the program staff will complete the non-shaded areas of this section.	
Allergies	List any allergies the person. If there are no known allergies, check *NKA* box.
HCP Name	Record the name of the Health Care Provider of today's visit.
• **Medications** • **Dose** • **Quantity Dispensed** • **Frequency** • **Route** • **Treatment Purpose** • **Special Instructions** • **# hrs late medication may be given** • **P (Posted)** • **V (Verified)**	Prior to this HCP visit, the program staff will have entered all HCP medication updates into the program's data base. The program staff will then verify that all medications are listed correctly by comparing to the most recent previous HCP order sheets from all providers. That updated information will then be entered into this section of the Progress Note. The two columns labeled "P" and "V" are to be used by the Residential/Supported Housing program when posting the data on this sheet and when being verified for accuracy prior to the appointment.
• **D/C** • **Scripts Given**	The HCP reviews the current Medications order and instructions for accuracy and makes any corrections if needed. If the HCP wants a medication discontinued, record D/C in the shaded box labeled "D/C" next to the medication name. If the HCP is writing a prescription for one of the medications listed in this section, then record *Yes* in the shaded box labeled *Scripts Given*.

Data Field	HCP Write New Medication Orders Today Here
• **Medications** • **Dose** • **Frequency** • **Route** • **Special Instructions** • **# Hours Late Medication May be Given**	If the HCP is adding a medication, including changing the dosage, frequency or any special instructions related to the medication, then this section must be used to order those medications. All sections of this grid must be completed. In the *Special Instructions* box, the HCP is required to specify the treatment purpose and complete instructions for administration. For PRN medications, specify the rationale for use and maximum number of doses in 24 hours. For PRN and standing doses of the same medication, indicate number of hours between doses.
Prescriber Name / Signature, Credentials / Date	Legibly print name, record signature with credentials, and provide date the document is signed
Data Field	**Residential/Supported Housing Follow-up**
• **P (Posted)** • **V (Verified)** • **Posted By** • **Verified By** • **Computer Updated By**	Upon return to the program offices, one staff will "post" the orders by checking the previous orders with the medication sheet and pharmacy label, and transcribe new orders, discontinued orders or changes in orders to the database. That staff person will check all boxes next to the orders posted and then sign the section *posted by* with the time and date. Once the logging into the database is completed, then the staff person will sign the *computer updated* section. A second staff will "verify" the orders by checking all of the orders with the medication sheet and pharmacy label. That staff person will then place check marks next to all orders verified and then sign the *verified by* with the time and date.

Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
Date of Service	Date of session/service provided
Provider Number	Specify the individual staff member's "provider number" as defined by the individual agency.
Location Code	Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Procedure Code	Identify the procedure code that identifies the service provided and documented. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Modifier 1, 2, 3 and 4	Identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
Start Time	Indicate actual time the session started. **Example: 3:00 PM**
Stop Time	Indicate actual time the session stopped. **Example: 3:34 PM**
Total Time	Indicate the total time of the session. **Example: 34 minutes**
Diagnostic Code	Use the numeric code for the primary diagnosis that is the focus of this session. Providers should use either ICD-9 or DSM code as determined by their agency's billing policies and procedures.