Psychiatric/Medication-Psychotherapy Progress Note

This form is to be completed ONLY by psychiatrist or advanced practice nurse with prescribing privileges when providing a service which includes psychopharmacology (the code name includes the terms evaluation and management) and psychotherapy. Each service must be documented and the psychotherapy must conform to the time requirements of the code being used.

Data Field	Identifying Information Instructions
Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Date of Admission	Record the date of admission per agency policy (this should be the first service date for this service episode).
Organization/Program Name	Record the organization and Program for whom you are delivering the service.
DOB	Record the person's date of birth
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
List of Names of Persons Present	Check appropriate box: *Person Present; No Show; Person Canceled.* If *Provider Canceled* is checked, document explanation as relevant. If *Others Present* is checked, identify name(s) and relationship(s) to person.
Interim History	Document an interval history of client including progress made since last session, effectiveness of medications, progress related to symptoms, substance use, significant new issues, changes in family and social history and overall functioning.
Mental Status	Comment on current areas of mental status evaluation, including significant changes since last visit. Document any risk issues and if present, document action plan to address. The mental status exam is a required for and E&M service.
Takes Meds as Prescribed	Record whether medication was taken as prescribed since last session, *yes/no* or *n/a*. Provide additional relevant information after *Comments*.
Side Effects	Record whether side effects are present or occurred since last session, *yes/no* or *n/a*. Provide additional relevant information after *Comments*, e.g. increased thirst, dizziness, decreased sexual function.
Allergic Reactions	Record any reported or observed allergic reactions to medications. As appropriate, provide additional relevant information after *Comments.*
Changes in Medical Status	Record whether there have been any changes in medical status since last session, *yes/no or n/a*. Provide additional relevant information after *Comments*.
Other Meds	Record any other medications the person is/was taking since last session, *over the counter/herbal/ none/other*. Provide additional relevant information after *Comments*.
Goal(s) Addressed as per Psychopharmacology Plan	Identify the specific goal(s) and objectives in the Psychopharmacology Plan or IAP being addressed during this intervention.
Therapeutic Interventions Delivered in Session	Check one or more of the following interventions that were delivered in the session. Options include: *Psychotherapy, Counseling/Coaching, Collaborative Medication Management, Collaborative Medication Education/Symptom/Illness Management, Injections, Physical Assessment, Coordination of Care.* For additional interventions utilized check *other*. Provide additional relevant information as appropriate.

Lab Tests Ordered	Summarize key laboratory test results received and reviewed. Check appropriate box to indicate whether key laboratory test results were *ordered* or*, reviewed* (with person). If lab results were *not received*, describe action to be taken to obtain results.
AIMS Findings	If AIMS (Abnormal Involuntary Movement Scale) test was administered, document findings.
Height/Weight/BMI Blood Pressure/VS	Record information pertaining to person's height, weight, body mass index, blood pressure, and vital signs as relevant. Document if contact with the PCP has occurred (if appropriate). Provide additional relevant information as appropriate.
Diagnosis	Document whether the person's diagnosis has changed or not. If diagnosis has changed, check *yes* and proceed to Comprehensive Assessment Update form.

Data Field	Medication Orders Today
None Prescribed	Check box if no medications are prescribed today.
Rationale for Changes in Medications	Document rationale for any medication changes or for leaving medications as is. This is a required section for evaluation and management and should reflect the prescriber's medical decision making. For each medication prescribed, indicate if the medication is renewed *(renew*) newly prescribed *(new*) or discontinued (*d/c*). Write the name of the medication (*med*), dosage (*dose*), frequency (*frequency*), # of Days, quantity (*qty*), and number of refills *(refills*) prescribed. For each new medication prescribed, the person should be given information about medication risks and benefits. Check the appropriate box indicating whether person has given "informed consent", i.e. demonstrated an understanding of medication's risks and benefits. Documentation of "Informed Consent" is mandatory. If the person does not demonstrate an understanding of the risks and benefits, then the prescriber should indicate in the Instructions /Comments Section what steps should be taken.
Instructions/Comments, as applicable	Document any additional relevant instructions or psycho-educational information.

Data Field	Psychotherapy Progress Note Instructions
Page 2 of 2	This page is used to document the psychotherapy provided in the session.
Goal(s) Addressed as Per Individualized Action Plan:	Identify the specific goal(s) and objectives in the Individualized Action Plan being addressed during this intervention. All interventions must be documented in a progress note and must be targeted towards specific goal(s)/objective(s) in the Individualized Action Plan except as noted above under new issues.
Person's Response to Intervention Delivered in Session and/or Progress Towards Goals and Objectives	This section should address **BOTH**: • *The person's response to the intervention delivered in the session* - Include evidence the person participated in the session and how, and information about how the person was able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • *Progress towards goals and objectives* - Include an assessment of how the session has moved the person closer, further away, or had no discernible impact on meeting the session's identified goal(s) and objective(s). **OR** . *Plan to overcome lack of progress* - If no progress is made over time, this section should also include how the counselor intends to change his/her strategy to produce positive change in the person. **Individual Example: The person actively participated by listing triggers. Agreed to practice de-escalation and calming techniques during the next two weeks, particularly on the job; he is very anxious about this. The person agrees identifying those situations in which his anger is a problem is a big step forward for him. Agrees he must continue to work on this or possibly lose his job.**

	Couples Example: The person served was able to say that it was quite difficult to listen without interrupting. His partner reported that he became anxious trying to do the exercise but wants to be supportive.
Plan/Additional Information	The clinician should document the date of the next session and future steps or actions planned with the person such as homework, plans and approximate time for the next session, etc. *Plan to overcome lack of progress* - If no progress is made over time, this section should also include how the counselor intends to change his/her strategy to produce positive change in the person. Document additional pertinent information that is not appropriate to document elsewhere. **Example: Person will keep a mood journal to identify triggers to explosive episodes and bring to next session to review and discuss alternative responses. RTC in 2 weeks.**

Data Field	Signature, Medicare Services and Billing Strip Instructions
Person's Signature (optional, if clinically appropriate)	Record person's signature, if clinically appropriate.
Clinician/Provider Name/Credentials (Print name)	**Legibly** print the Clinician/Provider's name, credentials and date.
Supervisor - Print Name/Credential (If needed)	If required, **legibly** print name of supervisor, credentials and date.
Clinician/Provider Signature	**Legibly record provider's** signature and date.
Supervisor Signature (If needed)	If required, legible record Supervisor Signature.
Psychiatrist/MD/DO	If required, **legibly** print name of MD and date.
Next Appointment	Record the data and time of the next appointment.