



Person's Name (First / MI / Last):		Record #:	DOB:
Organization Name:			
List Names of Persons Present:	<input type="checkbox"/> Person Served Present <input type="checkbox"/> No Show <input type="checkbox"/> Person Served Cancelled <input type="checkbox"/> Provider Cancelled Explanation: <input type="checkbox"/> Others Present (please identify name(s) and relationship(s) to persons served):		
Interim History (Include the person's and collateral's report on their status, the effectiveness of medications, progress related to symptoms, substance use, any significant new issues and overall functioning since last visit):			
Prescriber's Evaluation			
Mental Status Exam (If risk issues are present, document the actions taken):			
Takes meds as prescribed: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a <input type="checkbox"/> Comments:			
Side effects: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a Comments:			
Allergic Reactions: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a Comments:			
Changes in Medical Status: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a Comments:			
Other Meds: <input type="checkbox"/> Over the counter <input type="checkbox"/> herbal <input type="checkbox"/> none <input type="checkbox"/> other Comments:			
Goal(s)/Objective(s) Addressed As Per Psychopharmacology Plan:			
<input type="checkbox"/> Goal ____ <input type="checkbox"/> Objective 1 ____ <input type="checkbox"/> Objective 2 ____ <input type="checkbox"/> Objective 3 ____ <input type="checkbox"/> Objective ____		<input type="checkbox"/> Goal ____ <input type="checkbox"/> Objective 1 ____ <input type="checkbox"/> Objective 2 ____ <input type="checkbox"/> Objective 3 ____ <input type="checkbox"/> Objective ____	
Lab Tests Ordered/Reviewed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA - If Labs not received, describe action to be taken:			
AIMS findings (if applicable):			
Weight / height / waist measurement / BMI (if applicable):		Blood Pressure/VS's (if applicable):	
PCP Contacted? <input type="checkbox"/> Yes <input type="checkbox"/> Not Indicated			
Diagnosis since last visit: <input type="checkbox"/> No Change <input type="checkbox"/> Yes, CA Updated Required			
Medication Orders Today <input type="checkbox"/> None Prescribed			
Rationale for changes in medication(s): <input type="checkbox"/> n/a			
Renew/Change	New	D/C	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			If New, Informed Consent?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Instructions/Comments, as applicable:			



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Goal(s) Addressed as Per Individualized Action Plan:

- Goal _____
- Objective 1 _____
- Objective 2 _____
- Objective 3 _____
- Objective _____

Therapeutic Interventions Delivered in Session: Psychotherapy Evaluation and Management
 Medication Education/Symptom /Illness Management Injections Coordination
 Other:

Describe Interventions:

Person's Served Response to Intervention and/or Progress Toward Goals and Objectives:

Plan / Additional Information (*Indicate action plan between sessions*):

Provider (Print name):

MD - Print Name (if needed):

Provider Signature/Credentials:

Date:

MD Signature (Required For Opiate Treatment Programs):

Date:

Supervisor - Print Name/Credential (if needed):

Supervisor - Signature (if needed):

Date:

Date of Service	Provider Number	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code