

## Nursing Progress Note/Service Entry

NAME / MRN \_\_\_\_\_

Facility Name: \_\_\_\_\_ ID: \_\_\_\_\_ Program Name: \_\_\_\_\_ ID: \_\_\_\_\_

Provider: \_\_\_\_\_ ID: \_\_\_\_\_ Service Date: \_\_\_\_\_

**Service Category:**

CPT/HCPC Service Provided  Lockout - CPT/HCPC Service Provided

**Other Nonbillable Service Provided:**

Money Management  Providing transportation  Leaving voicemails

Coordination of logistics  Clerical work  Other \_\_\_\_\_

Direct Service  
Time (Min): \_\_\_\_\_

Documentation  
Time (Min): \_\_\_\_\_

Travel  
Time (Min): \_\_\_\_\_

Number in Group: \_\_\_\_\_

CPT/HCPC Code: \_\_\_\_\_

**Location of Service (Please check one)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Age-Specific Community Center | <input type="checkbox"/> Homeless/Emergency Shelter       | <input type="checkbox"/> Phone-provided other than in client's home            |
| <input type="checkbox"/> Client's Job Site             | <input type="checkbox"/> Inpatient                        | <input type="checkbox"/> Residential Care - Adults                             |
| <input type="checkbox"/> Correctional Facility         | <input type="checkbox"/> Mobile Service                   | <input type="checkbox"/> Residential Care - Children                           |
| <input type="checkbox"/> Faith-Based                   | <input type="checkbox"/> Non-Traditional service location | <input type="checkbox"/> School  |
| <input type="checkbox"/> Field                         | <input type="checkbox"/> Office                           | <input type="checkbox"/> Telehealth/Video-provided in client's home            |
| <input type="checkbox"/> Health Care/Primary Care      | <input type="checkbox"/> Other Community Location         | <input type="checkbox"/> Telehealth/Video-provided other than in Client's home |
| <input type="checkbox"/> Home                          | <input type="checkbox"/> Phone-provided in client's home  | <input type="checkbox"/> Unknown/Not Reported                                  |
| <input type="checkbox"/> Nontraditional Location       | <input type="checkbox"/> Other _____                      | <input type="checkbox"/> Unknown   |

Did this service involve interactive complexity?  Yes  No

Did this service include the interpretation of results and explanation to the client/family?  Yes  No

**For Clients Under 21 only:**

Is this an ICC Service?  Yes  No

Is this service linked to a Child and Family Team?  Yes  No

**COUNTY STAFF ONLY:** Does this service fall under FFPSA (Qualified Individual?  Yes  No

Was an Interpreter used?  Yes  No

Name of Interpreter: \_\_\_\_\_

**Language**

Language service provided in other than English:  Spanish  Other \_\_\_\_\_

Is the client pregnant?  Yes  No (If yes, please document how service was pregnancy-related)

**EBP/Service Strategies:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Assertive Community Treatment       | <input type="checkbox"/> Therapeutic Foster Care           | <input type="checkbox"/> In Partnership w/ Health Care     |
| <input type="checkbox"/> Supportive Employment               | <input type="checkbox"/> Multisystemic Therapy             | <input type="checkbox"/> In Partnership w/ Social Services |
| <input type="checkbox"/> Supportive Housing                  | <input type="checkbox"/> Functional Family Therapy         | <input type="checkbox"/> In Partnership w/ SA Services     |
| <input type="checkbox"/> Family Psychoeducation              | <input type="checkbox"/> Peer/Family Delivered Services    | <input type="checkbox"/> Integrated Services for MH/Aging  |
| <input type="checkbox"/> Integrated Dual Diagnosis Treatment | <input type="checkbox"/> Psychoeducation                   | <input type="checkbox"/> Integrated Services for MH/DD     |
| <input type="checkbox"/> Illness Management and Recovery     | <input type="checkbox"/> Family Support                    | <input type="checkbox"/> Ethnic-Specific Service Strategy  |
| <input type="checkbox"/> Medication Management               | <input type="checkbox"/> Supportive Education              | <input type="checkbox"/> Age-Specific Service Strategy     |
| <input type="checkbox"/> New Generation Medications          | <input type="checkbox"/> In Partnership w/ Law Enforcement | <input type="checkbox"/> Unknown Service Strategy          |

NAME / MRN \_\_\_\_\_

Evidence-based practice/tracking program?  Yes  No Program \_\_\_\_\_

This service was provided via telehealth with the consent of the client or authorized representative.

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**Interim History And Observations**

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**Mental Status Exam**

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**CURRENT MEDICATIONS:** *Please list all Psychiatric and non-Psychiatric medications at each visit.*

Medication Consents are current

Adherence / Side Effects / Adverse Effects Discussed

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Medication or non-medication allergies/serious reactions?  No  Yes (if so, please describe):

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**OBJECTIVE DATA**

AIMS Performed  Ht \_\_\_\_\_ Wt \_\_\_\_\_ BMI \_\_\_\_\_ Waist \_\_\_\_\_ BP/P \_\_\_\_\_

Labs/Other Studies Reviewed

**Results:**

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**Diagnosis**

Primary  
ICD-10 Code: \_\_\_\_\_ DSM-5 Narrative: \_\_\_\_\_

Secondary  
ICD-10 Code: \_\_\_\_\_ DSM-5 Narrative: \_\_\_\_\_

**Patient-Stated Goals and Concerns**

**Nursing Intervention**

**Plan For Continued Service (Include care plan, if needed)**

**Medications Administered This Visit**

**Future Appointments**

with MD/DO: \_\_\_\_\_ With RN: \_\_\_\_\_ With Case Manager/Other: \_\_\_\_\_

Is this late documentation?  Yes  No

The problem list/Care Plan has been updated as needed:  Yes  No

Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

Printed Name and Licensure: \_\_\_\_\_

Data Entry Clerk Initials \_\_\_\_\_