CONTRA COSTA BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Progress Note / Service Entry Form

NAME/MRN

Facility Name: _____ ID: _____ Program Name: _____ ID: _____

Provider: _____ ID: _____ Number in Group: _____ Group ID: _____

Elapsed Time (Total Minutes): _____ Travel Time (Total Minutes): _____

Service (Begin) Date: _____ Begin Time: 12:00 am

Telehealth consent obtained (if applicable): ☐ **Yes** ☐ **No**

Service Code (check one)

☐ **371** Crisis Intervention	☐ **358** IHBS	☐ **331** Assessment	☐ **355** Group Rehab
☐ **300** No Show	☐ **564** ICC	☐ **341** Individual Therapy	☐ **357** Group Collateral
☐ **400** Client Cancel	☐ **565** ICC-CFT	☐ **351** Group Therapy	☐ **541** CM Placement Services
☐ **700** Staff Cancel	☐ **311** Collateral	☐ **319** Family Therapy-Client present	☐ **561** CM Linkage
☐ **540** Non-Bill	☐ **313** Evaluation	☐ **320** Family Therapy Without Client present	☐ **571** CM Plan Dev
☐ **580** IMD/JAIL/JUV SVC Lock-out	☐ **315** Plan Dev	☐ **317** Rehabilitation Support	

Location of Services (Please check one)

☐ Office	☐ Satellite	☐ Emergency Shelter	☐ Skilled nursing facility
☐ Field	☐ Inpatient Psychiatric	☐ Primary Care Health Clinic	☐ Mobile Service
☐ Phone	☐ Inpatient Health	☐ Res Tx Ctr (child)	☐ Job Site
☐ Home	☐ Emergency Room	☐ Res Tx Ctr (adult)	☐ Age Specialty Center
☐ School	☐ Jail	☐ Hospice	☐ Faith-Based Location
☐ Telehealth-Clt Home	☐ Telehealth-Other than Clt Home		

☐ Nontraditional Location ☐ Other _____ ☐ Unknown

Language

Language service provided in other than English: ☐ Spanish ☐ Other _____

☐ Interpreter Name of Interpreter: _____

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

Diagnosis:

DSM-5 Diagnosis: _____ ICD-10 Code: _____ (Primary)

DSM-5 Narrative Diagnosis: _____

DSM-5 Diagnosis: _____ ICD-10 Code: _____ (Secondary)

DSM-5 Narrative Diagnosis: _____

Problem/Behavioral Health Need Addressed. Describe problem/need, reason for contact, status update, clinical impression.

Client Name: _____ **Client MRN/ID:** _____

Focus of Activity. Describe type of service rendered, how the service addressed client's behavioral health need, how the client responded – symptoms, condition, diagnosis, and/or risk factors.

Plan. Describe next steps – action steps by provider or client, collaboration with the client or other providers.

Targeted Case Management Care Plan (if applicable).
(1) Describe goals, including client's participation in development goals. (2) List actions/interventions (3) Describe transition plan for when client has achieved goals.

Is this late documentation? ☐ Yes ☐ No **The Problem List/Care Plan has been updated as needed** ☐

_____	_____	_____
Signature/License/Designation	Printed Name	Date
_____	_____	_____
Co-Signature/license (if applicable)	Printed Name	Date

Data Entry Clerk Initials _____