



# Nursing Progress Note/Billing 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)

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> 300 No Show       | <input type="checkbox"/> 362 RN/Inj     | <input type="checkbox"/> 311 Collateral          | <input type="checkbox"/> 541 Case Mgmt - Placement      |
| <input type="checkbox"/> 400 Client Cancel | <input type="checkbox"/> 363 Evaluation | <input type="checkbox"/> 341 Indiv. Therapy      | <input type="checkbox"/> 561 Case Mgmt - Linkage        |
| <input type="checkbox"/> 700 Staff Cancel  | <input type="checkbox"/> 364 Plan/Dev   | <input type="checkbox"/> 351 Group Therapy       | <input type="checkbox"/> 540 Non-Billable – MH Services |
| <input type="checkbox"/> 361 Eval/Rx       | <input type="checkbox"/> 369 Med Group  | <input type="checkbox"/> 371 Crisis Intervention | <input type="checkbox"/> 580 Non-Billable – Lockouts    |

### Location of Services (check one)

- |                                      |                                |  |   |
|--------------------------------------|--------------------------------|--|---|
| <input type="checkbox"/> Office      | <input type="checkbox"/> Phone | <input type="checkbox"/> School                | <input type="checkbox"/> Telehealth-Clt Home            |
| <input type="checkbox"/> Field       | <input type="checkbox"/> Home  | <input type="checkbox"/> Correctional Facility | <input type="checkbox"/> Telehealth-Other than Clt Home |
| <input type="checkbox"/> Other _____ |                                | <input type="checkbox"/> 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)

### Interim History And Observations

### Mental Status Exam

Appearance/Grooming (*appears stated age, good grooming/hygiene, disheveled, malodorous, etc.*)

Behavioral Relatedness (*NAD, cooperative, playful, difficult to redirect, inappropriately laughing/smiling, etc.*)

Client Name: \_\_\_\_\_

Client MRN/ID: \_\_\_\_\_

Motor Activity (*normokinetic, gait, posturing, tics/tremors/EPS, psychomotor agitation or retardation, etc.*)

Speech (*fluent, rate/rhythm/volume, spontaneous, hyperverbal, dysarthric, mute, etc.*)

Mood/Affect (*Congruent/incongruent, full, flat, blunted, restricted, elated, dysphoric, labile, inappropriate, etc.*)

Thought Process (*linear, goal-oriented, tangential, flight of ideas, circumstantial, thought blocking, loose associations, etc.*)

Thought Content (*suicidal/homicidal/paranoid ideations, grandiose/persecutory delusions, etc.*)

Perceptual Content (*Auditory/visual hallucinations, responding to internal stimuli, etc.*)

Cognition/Orientation

Attention/Concentration

Memory

Abstract Reasoning

Insight/Judgment

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

Medication Consents are current

Adherence / Side Effects / Adverse Effects Discussed

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

**OBJECTIVE DATA**

AIMS Performed  Ht \_\_\_\_\_ Wt \_\_\_\_\_ BMI \_\_\_\_\_ Waist \_\_\_\_\_ BP/P \_\_\_\_\_ Labs/Other Studies Reviewed

**Results**

Client Name: \_\_\_\_\_

Client MRN/ID: \_\_\_\_\_

**Diagnosis**

DSM-5 Diagnosis: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_ (Primary)

DSM-5 Narrative Diagnosis: \_\_\_\_\_

DSM-5 Diagnosis: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_ (Secondary)

DSM-5 Narrative Diagnosis: \_\_\_\_\_

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 \_\_\_\_\_