



Psychiatrist 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)

Brief Description Of Client

Interim History And Observations

Client Name: _____

Client MRN/ID: _____

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.*)

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):

Client Name: _____

Client MRN/ID: _____

OBJECTIVE DATA

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

Results

Diagnosis

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

DSM-5 Narrative Diagnosis: _____

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

DSM-5 Narrative Diagnosis: _____

Current Assessment

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

Labs/Other Studies ordered Referral to PCP Referral for Psychotherapy Coordination with PCP

Medications Ordered This Visit

No Changes # Refills Authorized _____ Medication Record Updated
 Medication Changes and Rationale Justification of Continued Use of Benzodiazepines

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 _____