CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Network Provider Progress Note

Beneficiary:_____ MRN:_____
Last name, First Name (Please Print)

Date of Session:_____ Start Time:_____ End Time:_____ Total Minutes:_____

Type of MH Service:
- ☐ Individual
- ☐ Group
- ☐ Family w/client
- ☐ Assessment
- ☐ Collateral
- ☐ Family w/o client
- ☐ Not Billable Service
- ☐ No Show
- ☐ Cancelled

Location of Service: _____
(Indicate: School, Office, Phone, Home, School, Other-State)

Diagnostic Impression:

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

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

Interpreter Services Provided: ☐ Yes ☐ No

Name of Interpreter: _____ Language: _____

☐ Service provided in another language by clinician: ☐ Spanish ☐ Other: _____

Does client have restricted pregnancy-only Medi-Cal? ☐ Yes ☐ No

If yes, please document how service was pregnancy related: _____

Individuals/Relationship to Beneficiary Present at Session:

_____ _____ _____

1. **Problem/Behavioral Health Need: (**e.g., Reason for contact, Beneficiary's concern(s), status update since last contact, clinical/behavioral acuity, current stressors, and/or needs, etc.)

2. **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.)

3. **Plan: (**e.g., Coordination of care, referrals, and/or follow-up. Include person's planned action and staff's planned action, as appropriate.)

CLINICIAN: _____ _____ _____
(Print) (Signature, Registration/License #) Date

☐ **Late Entry (entered after 3 business days of the service provided)**