

**SAMPLE**  
**SUD TREATMENT PROGRESS NOTE**

Client Name: Minnie Mouse

Client ID: 321

<b>Service Date*:</b> 7/02/18		<b>Start Time of Service:</b> 9:30 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm		<b>End Time of Service:</b> 10:15 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm		<b>Total Service Time:</b> 45 mins		
<b>Is service billable?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, is service DMC-billable?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>Doc Start Time:</b> 10:45 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm		<b>Doc End Time:</b> 10:55 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm		<b>Total Doc Time:</b> 10 mins		
<b>Travel To Location Start Time:</b> 9:15 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm		<b>Travel To Location End Time:</b> 9:30 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm		<b>Travel From Location Start Time:</b> 10:15 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm		<b>Travel From Location End Time:</b> 10:30 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm		<b>Total Travel Time:</b> 30 mins
<b>Language of Service (if other than English):</b> <input checked="" type="checkbox"/> N/A		<b>Translator Utilized?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A		<b>Contact Type:</b> FF		<b>Service Type:</b> CM		<b>Total Time (including service, doc, travel):</b> 85 minutes
<b>Topic of Session or Purpose of Service:</b> Case Management support for Family Resource Center (FRC) appt						<b>EBP Utilized:</b> <input type="checkbox"/> Motivational Interviewing <input type="checkbox"/> Other <input type="checkbox"/> Relapse Prevention <input checked="" type="checkbox"/> N/A		

**Contact Type:** F-F = Face-to-Face TEL = Telephone TH = Telehealth COM = In Community

**Service Type:** AS= Assessment GR = Group CO = Collateral CM = Case Mngt TP = Tx Planning DC = Discharge  
CR = Crisis MAT = Medication Assisted Tx IND = Ind. Counseling FT = Family Therapy PC = Physician Consultation O = Other

**Narrative Must Include:** 1) provider support and interventions 2) description of client's progress on treatment plan problems, goals, action steps, objectives, and/or referrals 3) client's ongoing plan including any new issues 4) if service was provided in the community, identify location and how confidentiality was maintained.

Travel to/From: Residential program in La Mesa to FRC in El Cajon and return trip back to program.

Total billable time of service includes support/advocacy provided to the client at the FRC, travel to and from the FRC and documentation to write the note.

Client requested assistance with completing Medi-cal renewal and submitting CalFresh/GR paperwork to the Family Resource Center (related to treatment plan goal #1 of maintaining Medi-Cal benefits and obtaining financial and food support for basic needs). Client has difficulty following through with various tasks due to symptoms associated with her history of Amphetamine usage, including disorganized thinking and poor focus. In addition, client has no means of transportation and is currently without a bus pass. AOD counselor assisted client in completing the necessary paperwork while at the FRC and helped her to identify which questions she would need to ask her FRC worker. AOD counselor advocated on behalf of the client during her appointment with the staff at FRC.

The Client presented AOD counselor with several incomplete forms. Client appeared confused as to how to complete and turn in documents. However, the client was able to navigate the FRC process with the assistance from AOD counselor. Client thanked counselor for the support and expressed relief in completing the appointment/documents and believes she will be able to complete the paperwork on her own in the future or with minimal assistance. Client has agreed to keep AOD counselor updated on status of paperwork/decisions. Client agrees to request assistance in the future, if needed, as it was helpful this time.

The service was provided in the community at Family Resource Center in El Cajon. Confidentiality was maintained as staff had no identifying badges that were visible to others and the client and the AOD counselor spoke in a private room at the FRC when completing the forms and meeting with the FRC worker.

\*NOTE: THIS SAMPLE IS FOR EDUCATIONAL PURPOSES ONLY. IT IS NOT THE ONLY WAY TO DOCUMENT AN INDIVIDUAL PROGRESS NOTE. ALL PROGRESS NOTES NEED TO BE INDIVIDUALIZED AND SPECIFIC TO THE CLIENT'S PARTICIPATION IN TREATMENT. COPYING/PASTING (or "CLONING" DOCUMENTATION) FROM SAMPLES, FROM ONE PROGRESS NOTE TO ANOTHER IN A CLIENT'S CHART, OR FROM ONE PROGRESS NOTE TO ANOTHER IN DIFFERENT CLIENT CHARTS RISKS DISALLOWANCE OF SERVICES AS DHCS HAS SAID THIS PRACTICE DOES NOT ESTABLISH MEDICAL NECESSITY FOR SERVICE.

<b>Counselor/LPHA Printed Name, Title</b> Sally Sue/AOD Counselor	<b>Signature, Credentials</b> <i>Sally Sue, CAODC</i>	<b>Date of Completion*</b> 7/2/18
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\*The date of service may be different than the date note is signed. Notes must be legibly printed, signed and dated by the counselor/LPHA within 7 days of the services provided.