Medication Management Progress Note

Client Name:		**Date of Service:**
Length of Session:	**CPT Code:**	**Diagnosis:**

Present at session *(if others present, list name(s) and relationship to client):*

☐ Client Present ☐ Others Present: ☐ Client No Showed/Cancelled

Significant Changes in Client's Condition	
☐ No significant change from last visit	
☐ Mood/Affect	
☐ Thought Process/Orientation	
☐ Behavior/Functioning	
☐ Substance Use	
☐ Physical Health Issues	
☐ Other	

DANGER to:
☐ Self ☐ Others ☐ Property ☐ None ☐ Ideation ☐ Plan ☐ Intent ☐ Means ☐ Attempt

Specifics regarding risk assessment *(include safety planning, reports made, etc.):*

Evaluation Management*: (include required number of elements based on E/M billed):*

History:

Examination:

Current Medication(s)/Medication Change(s)

☐ Refills
☐ No side effects or adverse reactions noted or reported

Medical Decision Making:

Lab Tests :
☐ Ordered ☐ Reviewed

Describe:

Additional information *(recommendations/referrals:)*

Follow up Appointment:

Provider Signature & Credentials *(if signature illegible, include printed name):*	**Date of Signature:**

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