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| --- |
| Client Name: |
| Date of Service: | Length of Session: |
| CPT Code: | Diagnosis/ICD Code: |
| **Present at Session** |
| [ ]  Client Present [ ]  Client No showed/Cancelled [ ]  Others Present, List name(s) and relationship to client: |
| **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, Explain: |
| **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[ ]  ReviewedDescribe:  |
| **Recommendations and/or Referrals** |
|  |
| Follow-up Appointment: |
| **Provider Information** |
| Provider Signature & Credentials (if signature illegible, include printed name): | Date of Signature: |