|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Client: | | | Case #: | | Program: | |
| Date of Service: | | Unit: | | | SubUnit: | |
| Server ID: | Service Time: | | | | Travel Time: | Documentation Time: |
| Person Contacted: | Place: | Outside Facility: | | | Contact Type: | Appointment Type: |
| Billing Type (Language Service  Provided In): | | | | Intensity Type (Interpreter Utilized): | | |
| Diagnosis At Service: ICD-10 Code(s): | | | | | Service: | |

**MEDICATION PROGRESS NOTE – SERVICE CODE 24 – MEDS EM MINIMAL PROBELM**

**Diagnosis:**

**Chief Complaint/Current Condition:**

**Current Substance Use:**

**Response to** **Medication** (Include effectiveness/compliance/side effects):

**Service Provided:** (Provide justification for continued medication use or any other changes to the medication plan):

**Other Information** (Review of CURES Database)**:**

**Answer the Following Question(s) for Children or Youth Residing in a Short-Term Residential Therapeutic Program** (Not applicable if client is not residing in an STRTP. The client plan is used in place of the Needs and Services Plan for the purpose of the STRTP Mental Health Program):

**1.The Psychiatrist has considered the goals and objectives of the Client Plan and**

**medication prescribed is consistent with this Plan** (Provide a YES or NO answer)

**2. If No, provide an explanation of needed updates to the Client Plan**:

|  |  |  |
| --- | --- | --- |
|  |  |  |
| \*Signature/Title/Credential Date |  | Printed Name/Credential/Server ID# |
| \* I certify that the service/s shown on this sheet was provided by me personally and the service/s were medically necessary. | | |
|  |  |  |
| Co-Signature/Title/Credential Date |  | Printed Name/Credential/Server ID# |