|  |  |  |
| --- | --- | --- |
| 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 25 – MEDS EM MINOR PROBLEM**

**Diagnosis** (Include rule out(s). Include status: improved, well controlled, resolving or resolved; or inadequately controlled, worsening, or failing to change as expected):

**Chief Complaint:**

**History** (Brief history of present illness or problem, associated signs/symptoms):

**Vitals** (See nursing progress note or Doctor’s Homepage entry from today’s visit):

**Current Substance Use:**

**Psychiatric Exam** (Description of speech, thought process, associations, abnormal or psychotic thoughts, judgment and insight, MSE, SI/HI, etc.):

**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 Questions 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)

**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# |