|  |  |  |
| --- | --- | --- |
| 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 26 – MEDS EM EXPANDED LOW**

**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, problem pertinent system review, associated signs/symptoms):

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

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

**Physical Health** (Changes to non-psychotropic medication, changes in health status, medication interactions, medical referrals):

**Current Substance Use:**

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

**Current Medication Changes** (Indicate reason for change such as critical decision points, diagnosis change, symptoms worse/lack of progress, client preference, side-effects intolerable):

**Plan of Care** (Include diagnostic exam, lab tests, target symptoms, psychotherapeutic needs, progress on recovery/resiliency goals):

**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 Prescribing Physician 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# |