CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

Progress Note / Service Entry Form

NAME/MRN _____

Facility Name: _____ ID: _____ Program Name: _____ ID: _____

Provider: _____ ID: _____ Service Date: _____

Direct Service Time (Min): _____ Documentation Time (Min): _____ Travel Time (Min): _____

Number in Group: _____ CPT/HCPC Code: _____ Quantity: _____

Location of Service (Please check one)

- ☐ Age-Specific Community Center
- ☐ Client's Job Site
- ☐ Correctional Facility
- ☐ Faith-Based
- ☐ Field
- ☐ Health Care/Primary Care
- ☐ Home
- ☐ Homeless/Emergency Shelter
- ☐ Inpatient
- ☐ Mobile Service
- ☐ Non-Traditional service location
- ☐ Office
- ☐ Other Community Location
- ☐ Phone–provided in client's home
- ☐ Phone–provided other than in client's home
- ☐ Residential Care - Adults
- ☐ Residential Care - Children
- ☐ School
- ☐ Telehealth/Video-provided in client's home
- ☐ Telehealth/Video-provided other than in Client's home
- ☐ Unknown/Not Reported
- ☐ Nontraditional Location
- ☐ Other _____
- ☐ Unknown

Is this a billable service? ☐ **Yes** ☐ **No**

Did this service involve interactive complexity? ☐ **Yes** ☐ **No**

Was an Interpreter used? ☐ **Yes** ☐ **No**

Name of Interpreter: _____

Language

Language service provided

in other than English: ☐ Spanish ☐ Other _____

Is the client pregnant? ☐ **Yes** ☐ **No (If yes, please document how service was pregnancy-related)**

EBP/Service Strategies:

- ☐ Assertive Community Treatment
- ☐ Supportive Employment
- ☐ Supportive Housing
- ☐ Family Psychoeducation
- ☐ Integrated Dual Diagnosis Treatment
- ☐ Illness Management and Recovery
- ☐ Medication Management
- ☐ New Generation Medications
- ☐ Therapeutic Foster Care
- ☐ Multisystemic Therapy
- ☐ Functional Family Therapy
- ☐ Peer/Family Delivered Services
- ☐ Psychoeducation
- ☐ Family Support
- ☐ Supportive Education
- ☐ In Partnership w/ Law Enforcement
- ☐ In Partnership w/ Health Care
- ☐ In Partnership w/ Social Services
- ☐ In Partnership w/ SA Services
- ☐ Integrated Services for MH/Aging
- ☐ Integrated Services for MH/DD
- ☐ Ethnic-Specific Service Strategy
- ☐ Age-Specific Service Strategy
- ☐ Unknown Service Strategy

(COUNTY STAFF ONLY) Evidence-based practice/tracking program? ☐ **Yes** ☐ **No** **Program** _____

Telehealth consent obtained (if applicable): ☐ **Yes** ☐ **No**

Diagnosis:

Primary
ICD-10 Code: _____ DSM-5 Narrative: _____

Secondary
ICD-10 Code: _____ DSM-5 Narrative: _____

NAME/MRN

Problem/Behavioral Health Need Addressed. Describe problem/need, reason for contact, status update, clinical impression.

Focus of Activity. Describe type of service rendered, how the service addressed client's behavioral health need, how the client responded – symptoms, condition, diagnosis, and/or risk factors.

Plan. Describe next steps – action steps by provider or client, collaboration with the client or other providers, updates to the problem list as appropriate.

Targeted Case Management Care Plan (if applicable).

Client or legal representative participated and agreed ☐

1. Describe goals, including client's participation in development goals.

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2. List actions/interventions.

3. Describe transition plan for when client has achieved goals.

LEVEL OF CARE DETERMINATION

Specialty Mental Health Services

1. Symptoms due to mental health disorder:

2. Impairment or reasonable probability of impairment:

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3. **(Under 21 years of age only)** Condition placing at high risk for mental health disorder – significant trauma, child welfare involvements, juvenile justice involvement, or experiencing homelessness.

4. **(Under 21 years of age only)** Reasonable probability of not progressing developmentally as appropriate.

Non-specialty Mental Health Services or **Other Health Services**

Plan for transition (to a different level of care, if applicable):

Is this late documentation? ☐ Yes ☐ No

The problem list/Care Plan has been updated as needed: ☐ **Yes** ☐ **No**

Signature/License/Designation	Printed Name	Date
Co-Signature/license (if applicable)	Printed Name	Date

Data Entry Clerk Initials _____