CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

Nursing Progress Note/Billing 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** _____

This service was provided via telehealth with the consent of the client or authorized representative. ☐

Interim History And Observations

NAME / MRN

Mental Status Exam

CURRENT MEDICATIONS: *Please list all Psychiatric and non-Psychiatric medications at each visit.*
☐ *Medication Consents are current* ☐ *Adherence / Side Effects / Adverse Effects Discussed*

Medication or non-medication allergies/serious reactions? ☐ No ☐ Yes (if so, please describe):

OBJECTIVE DATA
AIMS Performed ☐ Ht _____ Wt _____ BMI _____ Waist _____ BP/P _____
Labs/Other Studies Reviewed ☐
Results:

Diagnosis

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

NAME / MRN _____

Patient-Stated Goals and Concerns

Nursing Intervention

Plan For Continued Service (Include care plan, if needed)

Medications Administered This Visit

Future Appointments

with MD/DO: _____ With RN: _____ With Case Manager/Other: _____

Is this late documentation? ☐ Yes ☐ No

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

Signature: _____ DATE: _____

Printed Name and Licensure: _____

Data Entry Clerk Initials _____