OUTPATIENT/OFFICE PSYCHIATRIC PROGRESS NOTE
COUNSELING AND/OR COORDINATION OF CARE

Patient's Name: _____ **Date of Visit:** _____

Interval History: _____

_____

_____

_____

Interval Psychiatric Assessment/ Mental Status Examination:

_____

_____

_____

Current Diagnosis: _____

Diagnosis Update: _____

Current Medication(s)/Medication Change(s) – No side effects or adverse reactions noted or reported ☐

_____

_____

Lab Tests: Ordered ☐ Reviewed ☐ : _____

_____

Counseling Provided with Patient / Family / Caregiver (circle as appropriate and check off each counseling topic discussed and describe below:

☐ Diagnostic results/impressions and/or recommended studies

☐ Risks and benefits of treatment options

☐ Instruction for management/treatment and/or follow-up options

☐ Importance of compliance with chosen treatment

☐ Risk Factor Reduction

☐ Patient/Family/Caregiver Education

☐ Prognosis

_____

_____

_____

_____

_____

_____

Coordination of care provided (with patient present) with (check off as appropriate and describe below):

Coordination with: ☐ Nursing ☐ Residential Staff ☐ Social Work ☐ Physician/s ☐ Family ☐ Caregiver

_____

_____

_____

Additional Documentation (if needed): _____

_____

_____

Duration of face to face visit w/patient : _____ min. **Start Time** _____ **Stop Time** _____ **CPT** _____

Greater than 50% of face to face time spent providing counseling and/or coordination of care: ☐

Psychiatrist's Signature: _____ **Date:** _____