CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

Progress Note / Service Entry Form

NAME/MRN

Facility Name: _____ ID: _____
Program Name: _____ ID: _____
Provider: _____ ID: _____
Number in Group: _____
Group ID: _____

Elapsed Time (Total Minutes): _____
Travel Time (Total Minutes): _____

Service (Begin) Date: _____
Begin Time: 12:00 am

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

Service Code (check one)

☐ **371** Crisis Intervention	☐ **358** IHBS	☐ **331** Assessment	☐ **355** Group Rehab
☐ **300** No Show	☐ **564** ICC	☐ **341** Individual Therapy	☐ **357** Group Collateral
☐ **400** Client Cancel	☐ **565** ICC-CFT	☐ **351** Group Therapy	☐ **541** CM Placement Services
☐ **700** Staff Cancel	☐ **311** Collateral	☐ **319** Family Therapy-Clt present	☐ **561** CM Linkage
☐ **540** Non-Bill	☐ **313** Evaluation	☐ **320** Family Therapy Without Clt present	☐ **571** CM Plan Dev
☐ **580** IMD/JAIL/JUV SVC Lock-out	☐ **315** Plan Dev	☐ **317** Rehabilitation Support	

Location of Services (Please check one)

☐ Office	☐ Satellite	☐ Emergency Shelter	☐ Skilled nursing facility
☐ Field	☐ Inpatient Psychiatric	☐ Primary Care Health Clinic	☐ Mobile Service
☐ Phone	☐ Inpatient Health	☐ Res Tx Ctr (child)	☐ Job Site
☐ Home	☐ Emergency Room	☐ Res Tx Ctr (adult)	☐ Age Specialty Center
☐ School	☐ Jail	☐ Hospice	☐ Faith-Based Location
☐ Telehealth-Clt Home	☐ Telehealth-Other than Clt Home		

☐ Nontraditional Location ☐ Other _____ ☐ Unknown

Language

Language service provided in other than English: ☐ Spanish ☐ Other _____

☐ Interpreter Name of Interpreter: _____

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

Diagnosis:

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

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

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

NAME/MRN

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).

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

2. List actions/interventions.

NAME/MRN

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:

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.

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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 ☐

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

Data Entry Clerk Initials _____