

**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:

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Diagnostic results/impressions and/or recommended studies | <input type="checkbox"/> Risks and benefits of treatment options | |
| <input type="checkbox"/> Instruction for management/treatment and/or follow-up options | <input type="checkbox"/> Importance of compliance with chosen treatment | |
| <input type="checkbox"/> Risk Factor Reduction | <input type="checkbox"/> Patient/Family/Caregiver Education | <input type="checkbox"/> 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: