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  ☐ Importance of compliance with chosen treatment options

☐ 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 Code___________

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

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