

**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     | <input type="checkbox"/> Importance of compliance with chosen treatment options |                                    |
| <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 Code** \_\_\_\_\_

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