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| --- | --- |
| Client Name: | Date of Service: |
| Length of Session: | Location of Service: |
| CPT Code: | Diagnosis/ICD Code: |
| **Services Needed or Problem Being Addressed** |
| (Documentation should support why this service is necessary as it relates to current impact on client mental health impairments and/or progress toward goals) |
| **Action Taken** |
| (Describe actions or interventions taken to address the client’s current need for services and how service addresses impact to client’s mental health problem list or progress toward goals) |
| **Response** |
|  |
| **Plan of Care** |
|  |
| **Follow up** |
|  |
| Client agreed to plan of care: [ ]  Yes [ ]  No |
| Clinician Signature: |
| Clinician Printed Name: | Date: |