SUD TREATMENT PROGRESS NOTE

Client Name:_____ **Client ID:**_____

Service Date*:	**Is service billable?** ☐ Yes ☐ No	**If yes, is service DMC-billable?** ☐ Yes ☐ No	**Start Time of Service:** ☐ am ☐ pm	**End Time of Service:** ☐ am ☐ pm	**Total Service Time:**

Travel To Location Start Time: ☐ am ☐ pm	**Travel To Location End Time:** ☐ am ☐ pm	**Travel From Location Start Time:** ☐ am ☐ pm	**Travel From Location End Time:** ☐ am ☐ pm	**Total Travel Time:**

Date Documentation Completed:	**Documentation Start Time:** ☐ am ☐ pm	**Documentation End Time:** ☐ am ☐ pm	**Total Documentation Time:**

Language of Service (if other than English): ☐ N/A	**Translator Utilized?** ☐ Yes ☐ No ☐ N/A	**Contact Type:**		**Service Type:**		**Total Time (including service, doc, travel):**

Topic of Session or Purpose of Service:	**EBP Utilized:** ☐ Motivational Interviewing ☐ Relapse Prevention ☐ Other ☐ N/A

Contact Type: **F-F** = Face-to-Face **TEL** = Telephone **TH** = Telehealth **COM** = In Community **NC** = No Contact

Service Type: IND = Ind. Counseling **GR** = Group Counseling **CM** = Case Mgmt **MAT**= MAT Prescribing **PC =** Physician Consultation
(For associated visit types see DMC-ODS Provider Services Guide)

Narrative Must Include: 1) provider support and interventions 2) description of client's progress on treatment plan problems, goals, action steps, objectives, and/or referrals 3) client's ongoing plan including any new issues 4) if service was provided in the community, identify location and how confidentiality was maintained.

Counselor/LPHA Printed Name, Title	**Signature, Credentials**	**Date of Completion***

*The date of service may be different than the date note is signed. Notes must be legibly printed, signed and dated by the counselor/LPHA within 7 days of the services provided.