Psychiatry/Medication Progress Note

This note is to be completed **ONLY** by a psychiatrist or advanced practice nurse with prescribing privileges for a psychopharmacology service.

Data Field	Identifying Information Instructions
Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Date of Admission	Record the date of admission per agency policy (this should be the first service date for this service episode).
Organization/Program Name	Record the organization and Program for whom you are delivering the service.
ров	Record the person's date of birth
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box also complete box of current gender designation for insurance purposes.
List of Names of Persons Present	Check appropriate box: Person Present, No Show: Person Canceled: If Provider Canceled is checked, document explanation as relevant. If Others Present is checked, identify name(s) and relationship(s) to person.
Interim History	Document an interval history of client including progress made since last session, effectiveness of medications, progress retained to symptoms, substance use, significant new issues, changes in family and social history and overall functioning.
Mental Status	Comment on current areas of mental status evaluation, including significant changes since last visit. Document any risk issues and if present, document action plan to address.
Takes meds as prescribed	Record whether medication was taken as prescribed since last session, yea/no or n/a. Provide additional relevant information after Comments.
Side Effects	Record whether side effects are present or occurred since last session, yearho or ra's. Provide additional relevant information after Comments, e.g. increased thirst, disciness, decreased sexual function.
Allergic Reactions	Record any reported or observed allergic reactions to medications. As appropriate, provide additional relevant information after Comments.
Changes in Medical Status	Record whether there have been any changes in medical status since last session, yes/no or n/s. Provide additional relevant information after Comments.
Other Meds	Record any new medications the person has been taking since the last session, e.g. over the counterherbail noneither. Provide additional information after Comments.
Goal(s) Addressed as Per Psychopharmacology Plan	Identify the specific goal(s) and objectives in the Psychopharmacology Action Plan or Individual Action Plan being addressed during this intervention.

Psychiatric Rehabilitation Progress Notes Examples

Maggi A. Budd, Sigmund Hough, Stephen T. Wegener, William Stiers

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The Clinical Documentation Sourcebook Donald E. Wiger, 2010-02-02 All the forms handouts and records mental health professionals need to meet documentation requirements fully revised and updated The paperwork required when providing mental health services continues to mount Keeping records for managed care reimbursement accreditation agencies protection in the event of lawsuits and to help streamline patient care in solo and group practices inpatient facilities and hospitals has become increasingly important Now fully updated and revised the Fourth Edition of The Clinical Documentation Sourcebook provides you with a full range of forms checklists and clinical records essential for effectively and efficiently managing and protecting your practice The Fourth Edition offers Seventy two ready to copy forms appropriate for use with a broad range of clients including children couples and families Updated coverage for HIPAA compliance reflecting the latest The Joint Commission TJC and CARF regulations A new chapter covering the most current format on screening information for referral sources Increased coverage of clinical outcomes to support the latest advancements in evidence based treatment A CD ROM with all the ready to copy forms in Microsoft Word format allowing for customization to suit a variety of practices From intake to diagnosis and treatment through discharge and outcome assessment The Clinical Documentation Sourcebook Fourth Edition offers sample forms for every stage of the treatment process Greatly expanded from the Third Edition the book now includes twenty six fully completed forms illustrating the proper way to fill them out Note CD ROM DVD and other supplementary materials are not included as part of eBook file The OTA's Guide to Writing SOAP Notes Sherry Borcherding, Marie J. Morreale, 2007 Written specifically for occupational therapy assistants The OTA's Guide to Writing SOAP Notes Second Edition is updated to include new features and information This valuable text contains the step by step instruction needed to learn the documentation required for reimbursement in occupational therapy With the current changes in healthcare proper documentation of client care is essential to meeting legal and ethical standards for reimbursement of services Written in an easy to read format this new edition by Sherry Borcherding and Marie J Morreale will continue to aid occupational therapy assistants in learning to write SOAP notes that will be reimbursable under Medicare Part B and managed care for different areas of clinical practice New Features in the Second Edition Incorporated throughout the text is the Occupational Therapy Practice Framework along with updated AOTA documents More examples of pediatrics hand therapy and mental health Updated and additional worksheets Review of grammar documentation mistakes Worksheets for deciphering physician orders as well as expanded worksheets for medical abbreviations Updated information on billing codes HIPAA management of health information medical records and electronic documentation Expanded information on the OT process for the OTA to fully understand documentation and the OTA s role in all stages of treatment including referral evaluation intervention plan and discharge Documentation of physical agent modalities With reorganized and shorter chapters The OTA's Guide to Writing SOAP Notes Second Edition is the essential

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context How do the readers of assessment construct their own meanings of the assessment Based on an ongoing collaboration between composition studies specialists and mental health practitioners this book presents research of value not only to writing scholars and teachers but also to professional clinicians their teachers and those who read mental health records in order to make critically important decisions It can also be valuable as a model for other scholars to follow when conducting similar long range studies of other writing intensive professions Fundamentals of Psychiatric Treatment Planning James A. Kennedy, 2008-05-20 First published in 1992 Fundamentals of Psychiatric Treatment Planning outlines an approach that quickly became the definitive standard for writing treatment plans Developed by clinical psychiatrist James A Kennedy this practical intuitive method organizes psychiatric problems into seven categories psychological impairment social skills violence activities of daily living substance abuse medical impairment and ancillary impairment Treatment plans are developed using information gathered with the Kennedy Axis V an instrument that has proven more successful than both the Global Assessment of Functioning GAF scale and the Brief Psychiatric Rating Scale BPRS in establishing baselines and determining outcome measures Fundamentals of Psychiatric Treatment Planning serves as a powerful highly effective tool that Promotes a cohesive approach By using a consistent approach to planning the clinical team works in concert toward uniform goals and outcomes Helps staff gather critical information to improve outcomes For establishing baselines and determining outcome measures the Kennedy Axis V instrument has proven more successful than both the GAF and the BPRS Includes many examples to help staff write their own plans Rich with real life examples to guide staff including problem names and descriptions treatment modalities and samples of individual plans for each of the seven problem categories In addition to the Kennedy Axis V questionnaire Fundamentals of Psychiatric Treatment Planning includes blank forms for treatment planning and tabbed sections to allow for quick reference New features in the second edition include the integration of nursing care plans into master treatment plans new systematic steps for building goals and modalities refinements to the questionnaire and the introduction of online support via the author's website With its readily adaptable uniform approach to a complex subject Fundamentals of Psychiatric Treatment Planning Second Edition is a powerful highly effective planning tool for all members of the clinical staff

Partnering for Recovery in Mental Health Janis

Partnering for Recovery in Mental Health Janis Tondora, Rebecca Miller, Mike Slade, Larry Davidson, 2014-05-19 Partnering for Recovery in Mental Health is a practical guide for conducting person and family centered recovery planning with individuals with serious mental illnesses and their families It is derived from the authors extensive experience in articulating and implementing recovery oriented practice and has been tested with roughly 3 000 providers who work in the field as well as with numerous post graduate trainees in psychology social work nursing and psychiatric rehabilitation It has consistently received highly favorable evaluations from health care professionals as well as people in recovery from mental illness. This guide represents a new clinical approach to the planning and delivery of mental health care It emerges from the mental health recovery movement and has been developed in the

process of the efforts to transform systems of care at the local regional and national levels to a recovery orientation It will be an extremely useful tool for planning care within the context of current health care reform efforts and increasingly useful in the future as systems of care become more person centered Consistent with other patient centered care planning approaches this book adapts this process specifically to meet the needs of persons with serious mental illnesses and their families Partnering for Recovery in Mental Health is an invaluable guide for any person involved directly or indirectly in the provision monitoring evaluation or use of community based mental health care **The Probation and Parole Treatment Planner** Brad M. Boque, Anjali Nandi, David J. Berghuis, 2003-05-12 The Probation and Parole Treatment Planner provides all the elements necessary to quickly and easily develop formal treatment plans that satisfy the demands of HMOs managed care companies third party payors and state and federal review agencies Saves you hours of time consuming paperwork yet offers the freedom to develop customized treatment plans for clients on parole or probation Organized around 29 main presenting problems from probation parole noncompliance and vocational deficits to violent aggressive behavior and childhood trauma abuse and neglect Over 1 000 well crafted clear statements describe the behavioral manifestations of each relational problem long term goals short term objectives and clinically tested treatment options Easy to use reference format helps locate treatment plan components by behavioral problem or DSM IV TR TM diagnosis Includes a sample treatment plan that conforms to the requirements of most third party payors and accrediting agencies including HCFA ICAHO and NCQA

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