SHASTA COUNTY MENTAL HEALTH

Date: Location: ☐ Office ☐ Field ☐ Phone CPT/Billing Code: Time Spent:

Reason for Visit/Relevant History/Prior Lab Results/Change from a Treatment: _____

_____

*Medication Compliance: ☐ Yes ☐ No ☐ Partial Dual Diagnosis Issues: ☐ Yes ☐ No ☐ Denies ☐ Substance:

*Reported Medication side effects: ☐ none ☐ describe:

*Reported Risk Behaviors: ☐ none ☐describe:

Observation of Client Symptoms/Mental Status:	**Current Medications:**

Assessment: *Condition: ☐ Stable ☐ Unchanged ☐ Improved ☐ Other:

_____

_____

***Assessed Medication Response: ☐ good ☐ marginal ☐ partial ☐ poor ☐ other:**

***Active Risk Behaviors:** ☐ none

Diagnosis (Axis I):

Treatment Plan: _____

_____

***Education - ☐ related to medications, side effects, risks, benefits and alternatives ☐ med consent given ☐ sleep hygiene ☐ diet and nutrition ☐ exercise as tolerated ☐ hydration ☐ Patient/Caregiver educated about increased risk of suicide with use of ☐ other:**

☐ Appointment ☐ Medication Nurse ☐ NP/PA ☐ Psychiatrist in: _____ ☐ week(s) ☐ month(s)

RN Signature:_____MD/PA/NP Signature: _____

Consult Date: _____Time: _____ CPT Code: _____Time: _____

Consult Results: _____

_____

_____

Medication Support Services Record

* Required items Page 1 of 1 7/2009 LB

Client			
Chart #		DOB	