SUD Treatment Progress Note Instructions

REQUIRED FORM:

This form is a required document in the client file to document SUD services provided and includes progress toward achieving the client's recovery or treatment plan goals.

WHEN:

This form is to be completed to document individual services provided to a client.

This form must be completed within the following guidelines:

- Outpatient programs must document a progress note for each client service attended (except for group services; see dot point below) within 7 calendar days from the date of service.
    - Group services must be documented on the **Outpatient Group Progress Note (Form F604)**; all other services may be documented on this form (F601)**.**
    - Services with progress notes documented after 7 calendar days will not be billable.
- A Residential program may use this form if the program does not use the **Weekly SUD Treatment Progress Note – Narrative/Services record (Forms F602a and F602b)** or the **Residential or Withdrawal Management Daily Progress Note (Form F603)**.
    - Residential programs **must** use this form to document **Case Management, Physician Consultations, and MAT** (these services cannot be documented on the Residential Weekly Progress Note – Narrative/Service Record (Forms F602a and F602b) or on the Residential or Withdrawal Management Daily Progress Note (Form F603)).
    - If a residential program is using this form (F601) to document client services, group services must be documented on the **Outpatient Group Progress Note (Form F604).**
    - Services with progress notes documented after 7 calendar days will not be billable.

COMPLETED BY:

Each progress note is written by the SUD counselor or LPHA who provided the service.

REQUIRED ELEMENTS:

Progress notes shall be legible

- **Client Name:** Complete client's full name
- **Client ID:** Complete the client ID number by entering the client's SanWITS' Unique Client Number (UCN)
- **Date:** Complete date of the service
- Start time of Service
- End time of Service
- Total Service time in minutes
- Is service billable? (to the County or DMC)
- If yes, is service DMC billable?

- Document Start time/End time *
- Total Documentation time in minutes *
- Travel to Location Start time/End time *
- Travel from location Start time/End time *
- Total travel time in minutes*
- Total time (including: service, documentation, travel) in minutes *
- Language of Service (if other than English)
- Translator Utilized (if applicable)
- Contact Type (F-F = Face to Face, TEL = Telephone, TH = Telehealth, COM = In Community)
- Service Type (AS= Assessment, CM = Case Mngt, TP = Tx Planning, DC = Discharge, CR = Crisis, MAT = Med Assisted Tx, CO = Collateral, IND = Ind. Counseling, FT = Family Therapy, PC = Physician Consultation, PE= Patient Education, O = Other)
- Topic (describe the purpose of the service or specific group topic)
- EBP Utilized (progress note must document specifics of how EBP was utilized the narrative)

Progress Note Narrative Section: A complete progress note addresses:

1. Provider support intervention including specific EBP technique utilized.
2. Client's progress towards one or more goals in the client's recovery or treatment or plan, action steps, and/or referrals.
3. New issues or problems that affect the client's recovery or treatment plan.
4. Other appropriate health care providers support.
5. Next steps in plan of care and referrals, if applicable.

Counselor/LPHA Printed Name and Signature: All entries must include the printed name with title, signature with credentials and date staff completed the progress note.

Date of completion: Must be completed within 7 days of service to be billable.

*For residential programs – documentation time and travel time are not required elements, except when the service is for Case Management, Physician Consultation or MAT.