SUD TREATMENT PROGRESS NOTE

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

Service Date*:	**Start Time of Service:** ☐am ☐pm	**End Time of Service:** ☐am ☐pm	**Total Service Time:**
Is service billable? ☐Yes ☐No / **If yes, is service DMC-billable?** ☐Yes ☐No	**Doc Start Time:** ☐am ☐pm	**Doc End Time:** ☐am ☐pm	**Total Doc 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:**
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 ☐Other ☐Relapse Prevention ☐N/A	

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

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.