|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client:** | | | **Case#:** | | | | | | **Program:** | | |
| **Date of Service:** | | | | **Unit:** | | | **Subunit:** | | | | |
| **Server ID:** | | **Service Time:** | | | | **Travel Time:** | | | | **Documentation Time:** | |
| **Person Contacted:** | **Place:** | | | | **Outside Facility:** | | | **Contact Type:** | | | **Appointment Type:** |
| **Billing Type (Language Service Provided In):** | | | | | | | **Intensity Type (Interpreter Utilized):** | | | | |
| **Diagnosis At Service ICD-10 code(s):** | | | | | | | **Service:** | | | | |

**DAILY PROGRESS NOTE**

**Specific Service(s) Provided** (Include any groups, activities, meetings, provided to the client, or N/A if none occurred):

**Observations of Client’s Behavior** (Document any observations of client’s behavior including participation and response during treatment and/or in the milieu or N/A if client was not present):

**Possible Side Effects of Medications** (Note any possible side effects of medications or medication changes observed or N/A if none observed):

**Contact with Client family, friends, natural supports, CFT, mental health team, authorized legal representative and/or public entities involved with the client** (Document summary of any meeting[s] or N/A if none occurred)**:**

\***Signature/Title/Credential** **Date**  **Printed Name/Credential/Server ID#**

\*I certify that the service/s shown on this sheet were provided by me personally and the services were medically necessary.

**Co-Signature/Title/Credential Date Printed Name/Credential/Server ID#**