|  |  |  |
| --- | --- | --- |
| 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:        |

**CRISIS STABILIZATION UNIT (CSU) –REASSESSMENT PROGRESS NOTE**

**CS Admit Time:**       **CS Admit Date:**

**Current Home/Placement Situation:**

**Legal Status:**

**Reason for Presenting to CSU:**

**Substance Abuse:**

**Current Medications:**

 **Start Date:**

 **Efficacy:**

 **Side Effects:**

**Health Concerns:**

**Current Medical and Psychiatric Outpatient Services:**

 **Past Psychiatric History:**

 **Inpatient Hospitalizations:**

 **Previous CSU Evaluations:**

 **Previous Suicide Attempts:**

 **Family History of Suicide:**

 **Substance Abuse:**

**CSU Course:**

 **Interview:**

 **Mood:**

 **Behavior:**

 **Evidence of DTS/DTO:**

 **PRN Medications:**

 **Discussion with Parent(s), Guardian(s), Group Home Staff, Outpatient Clinicians:**

**MSE:**

 **AO x 3:**

 **Appearance:**

 **Musculoskeletal:**

 **Psychomotor Activity:**

 **Eye Contact:**

 **Attitude:**

 **Speech:**

 **Suicidal Ideation:**

 **Homicidal:**

 **Mood:**

 **Accect:**

 **AVH:**

 **TC:**

 **TP:**

 **Associations:**

 **Concentration:**

 **Memory:**

 **Judgment:**

 **Insight:**

 **Fund of Knowledge:**

 **Impulse Control:**

**Impression:**

 **Diagnosis:**

**Plan:**

 **5150 Status (Hold or Discontinue)**

 **Medication Recommended:**

 **Psychotherapy Recommended:**

 **School Intervention:**

 **Disposition:**

 **Aftercare Plan:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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