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| --- | --- | --- | --- | --- | --- | --- |
| Client: | | Case#: | | | Program: | |
| Date or 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: | | |

**NURSING NOTE**

**TRAVEL TO/FROM:**

**REASON FOR VISIT:** (Routine, emergency/walk-in, medication adjustment, treatment team update, etc. related to mental health symptoms.)

**CURRENT CONDITION:** (Reported/observed mental health symptoms, orientation, appearance, eye contact, affect, appetite, sleep, energy level, substance use, tobacco use, safety assessment, etc.)

**PRESENTING CONCERNS:** (Ongoing and/or new medical conditions that are affecting mental health, last visit to PCP or planned follow-up, psychosocial factors, ect. Medical Conditions should be updated via the Medical Conditions Tab.)

**THERAPEUTIC INTERVENTIONS:** (Interventions need to tie back to mental health symptoms/impairments. Any teaching/education/referrals related to assessed/reported concerns such as safety, sleep, diet, weight, smoking cessation, substance use, medical conditions, educating clients on medications and dosing times, etc. All vitals, weight, etc. should be documented via the Medical Conditions Review.)

**TREATMENT/RESPONSE TO TREATMENT:** (Progress/lack thereof and improvements to mental health symptoms, medication adherence or non-adherence reported side-effects, demonstrated level of understanding, preparation of medications to be dispensed, medication schedules.)

**PLAN OF CARE:** (Next steps, medication delivery, pharmacy information, coordinating with PC, continued monitoring of issues such as safety, mental health symptoms, adherence to medication regimen, substance use, etc.)

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| \*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# |