OUTPATIENT/OFFICE PSYCHIATRIC PROGRESS NOTE
COUNSELING AND/OR COORDINATION OF CARE

Patient’s Name: ___________________________ Date of Visit: _______________________

Interval History: ________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Interval Psychiatric Assessment/ Mental Status Examination:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Current Diagnosis: __________________________________________________________________

Diagnosis Update: __________________________________________________________________

Current Medication(s)/Medication Change(s) – No side effects or adverse reactions noted or reported □
______________________________________________________________________________

Lab Tests: Ordered □ Reviewed □ :
______________________________________________________________________________

Counseling Provided with Patient / Family / Caregiver (circle as appropriate and check off each counseling topic discussed and describe below):

□ Diagnostic results/impressions and/or recommended studies
□ Risks and benefits of treatment options

□ Instruction for management/treatment and/or follow-up options
□ Importance of compliance with chosen treatment

□ Risk Factor Reduction
□ Patient/Family/Caregiver Education

□ Prognosis

Coordination of care provided (with patient present) with (check off as appropriate and describe below):
Coordination with: □ Nursing □ Residential Staff □ Social Work □ Physician/s □ Family □ Caregiver

Additional Documentation (if needed):
______________________________________________________________________________
______________________________________________________________________________

Duration of face to face visit w/patient: ________ min. Start Time ___________ Stop Time __________ CPT ________

Greater than 50% of face to face time spent providing counseling and/or coordination of care: □

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Psychiatrist’s Signature: ____________________________ Date: ____________________