Person's Name (First / MI / Last):	**Record #:**	**DOB:**
Organization Name:		
List Name(s) of Person(s) Present:	☐ Person Present ☐ No Show ☐ Person Cancelled ☐ Provider Cancelled Explanation: ☐ Others Present (please identify name(s) and relationship(s) to person):	

Interim History (Include the person's and collateral's report on his/her status, the effectiveness of medications, progress related to symptoms, substance use, any significant new issues and overall functioning since last visit):

Prescriber's Evaluation

Mental Status Exam *(If risk issues are present, document the actions taken)*:

Takes meds as prescribed: ☐ yes ☐ no ☐ n/a ☐ Comments:

Side effects: ☐ yes ☐ no ☐ n/a Comments:

Allergic Reactions: ☐ yes ☐ no ☐ n/a Comments:

Changes in Medical Status: ☐ yes ☐ no ☐ n/a Comments:

Other meds: ☐ Over the counter ☐ herbal ☐ none ☐ other Comments:

Goal(s)/Objective(s) Addressed As Per Psychopharmacology Plan:

☐ Goal ___ ☐ Objective 1 ___ ☐ Objective 2 ___ ☐ Objective 3 ___ ☐ Objective ___		☐ Goal ___ ☐ Objective 1 ___ ☐ Objective 2 ___ ☐ Objective 3 ___ ☐ Objective ___

Therapeutic Interventions Delivered in Session:
☐ Medication Management ☐ Medication Education/Symptom /Illness Management ☐ Injections ☐ Coordination ☐ Minimal Psychotherapy ☐ Other:
Describe Interventions:

Lab Tests Ordered ☐ Yes ☐ No ☐ NA - Labs Reviewed ☐ Yes ☐ No
If Labs not received, describe action to be taken:

AIMS findings (if applicable)**:**
Weight / Height / Waist Measurement / BMI (if applicable)**:** **Blood Pressure/VS's** (if applicable)**:**
If Appropriate Contact PCP - Comments:

Response to Intervention/ Progress Toward Goals and Objectives:

Diagnosis since last visit: ☐ No change ☐ Yes, CA Updated Required

Medication Orders Today ☐ None Prescribed

Rationale for changes in medication(s): ☐ Not Indicated

Renew/ Change	New	D/C	MED	DOSE	Freq.	# of Days	QTY	Refills	If New, Informed Consent?
☐	☐	☐							☐Yes ☐No
☐	☐	☐							☐Yes ☐No
☐	☐	☐							☐Yes ☐No
☐	☐	☐							☐Yes ☐No
☐	☐	☐							☐Yes ☐No
☐	☐	☐							☐Yes ☐No

Instructions/Comments, as applicable:		
Next Appointment: Return in approximately days weeks months		
Prescriber (Print Name)	**Prescriber Signature & Credentials**	**Date:**
Supervisor - Print Name/Credential (if needed):	**Supervisor - Signature** (if needed):	**Date:**

Date of Service	Provider Number	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code