Community Psychiatric Support Treatment Program Progress Note (EXAMPLE)

Client Name __________________________ Client Number __________________________ Date __________________

Start Time _______ AM   PM   End Time _______ AM   PM   Billable time _______ Location Code: _______ Type of Contact Code: _______
Start Time _______ AM   PM   End Time _______ AM   PM   Billable time _______ Location Code: _______ Type of Contact Code: _______
Start Time _______ AM   PM   End Time _______ AM   PM   Billable time _______ Location Code: _______ Type of Contact Code: _______
Start Time _______ AM   PM   End Time _______ AM   PM   Billable time _______ Location Code: _______ Type of Contact Code: _______

Location: Code: C = Community A = Agency CH = Client’s Home O = Other (Fill in above)
Contact Code: FC = F-T-F w/ Client   TC = Phone w/ Client   FEO = F-t-F with Essential Other   TEO = Phone w/ Essential Other
Non-Billable Time: □ No show   □ Cancellation   □ Other non-billable activity

1. Additional Notes (Optional)

2. GOAL:

3. Description of CPST Rehabilitative and Environmental Support Activities Provided (Check all that apply)
(Note: Agency should individualize the activity section according to need based on client population, diagnosis and service provided)

☐ 1. ISP development, review or revision
☐ 2. Teaching to develop the skills to access needed services, support systems & resources for him/herself
☐ 3. Restorative interventions to improve independent living skills
☐ 4. Assessment of psychiatric, physical health, housing, income support & vocational needs
☐ 5. Teaching consumer how to advocate for him/herself
☐ 6. Rehabilitative interventions to address psychiatric, physical health, housing, income & vocational needs
☐ 7. Education & training to manage impact of psychiatric symptoms on school/home/work functioning
☐ 8. Teaching/providing assistance in skill-building to develop psychiatric support systems
☐ 9. Crisis support and/or development of a crisis management and contingency plan, and/or crisis stabilization
☐ 10. Teaching interventions to address deficits in socialization skills, including communication, interpersonal relationships and conflict resolution
☐ 11. Teaching methods to acquire psychiatric self-monitoring and symptom management skills
☐ 12. Teaching to develop stress and anger management skills
☐ 13. Mental illness, recovery and wellness management education and training to client and/or family
☐ 14. Employment readiness interventions to address identified psychiatric deficits which impact employment
☐ 15. Other (specify) ______________________________

4. □ Yes □ No Activity/Service Provided is Medically Necessary as Documented in Mental Health Assessment & Authorized by ISP

Brief Description of service(s) provided: ____________________________________________________________

5. Assessment of Progress:
☐ No Progress   ☐ If Progress, specify: ______________________________________________________________

6. Significant Changes or Events in the Life of the Client, if applicable:
___________________________________________________________________________________________

7. ☐ Recommend Modification to ISP, if applicable (Explain):
___________________________________________________________________________________________

8. □ No Change Noted in Client’s Behavior, Actions or Statements as it Relates to Harming Self or Others OR
☐ Yes, Change Noted in Risk of Harm to ☐ Self  ☐ Others (Check one, Complete Below & Explain any “Yes” Answers) OR
☐ Yes, Change Noted in Risk of Harm to ☐ Self  ☐ Others (Check one, See “Duty to Protect” Form)

Thoughts to harm self/others ☐ No  ☐ Yes, specify: ___________________________ Intention to harm self/others ☐ No  ☐ Yes, specify: ___________________________
Past attempts to harm self or others? ☐ No  ☐ Yes, specify: ___________________________ Plan ☐ No  ☐ Yes, specify: ___________________________
Access to planned method? ☐ No  ☐ Yes, specify: ___________________________
What is the action plan to ensure safety?
___________________________________________________________________________________________
Plan agreed to by client?  ☐ Yes  ☐ No, specify: ___________________________

___________________________________________________________________________________________

STAFF SIGNATURE (Name and Credentials) or Initials (Signature/Credential Sheet must be Present in ICR)   DATE

Ohio Department of Mental Health EXAMPLE CPST Progress Note - May 2010