SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Progress Note

Client Name:_____ **MR#** _____

Provider Name & Agency (if applicable):_____

Date of Service:		**Service Time** (Face to Face minutes - billable time):	
CPT Code:		**Non-Billable Time** (documentation, travel):	
Location Code (see key below):		**Language provided in:**	

PROBLEM/INTERVENTIONS: Describe service provided and how service addresses behavioral health need (diagnosis, tx goals, risk factors). **PLAN:** Next steps, planned action steps by provider or client.

Printed Name, Signature, License Type & No. **Date signed**

Supervisor Printed Name, Co-Signature, License Type & No. **Date signed**

LOCATION CODES

A: Office
B: Field (when location is away from provider's usual place of business)
C: Jail
D: Psychiatric Hospital (lockout)
E: Homeless/Emerg Shelter
G: Health Facility: PCP/SNF (non-psych)
H: Client's Home
J: Client's Job Site
K: Voicemail/Email/Fax (non-billable)
O: Other Community Location
Q: Missed Visit (non-billable)
S: School
T: Telehealth other than home
X: SNF Psych (Lockout)
Y: PES (Lockout)
8: Telehealth Home
11: Phone: Client at home
12: Phone: Client not at home