San Luis Obispo County
MH Medication Support Progress Note

CLIENT NAME:	CLIENT ID:	SERVICE DATE:

PROGRAM:	PROVIDED AT:	CONTACT TYPE:
PROVIDER:	**START TIME:**	**DURATION:**

FOCUS OF SESSION - DESCRIBE RELEVANT ASPECTS OF CLIENT CARE/TREATMENT (Target symptom and functional impairment; client/family presenting problem(s) today; significant mood, appearance, behavioral or other observations; health risk factors, including SI/HI, if present; indicate any signs which might be related to medication side effects):

CURRENT MEDICATIONS:	REFILL REQUESTS:
LAST MD MED EVAL:	**NEXT MD MED EVAL:**
MED CONSENTS:	
LABS REQUESTED:	

CLINICAL DECISIONS AND INTERVENTIONS (mark all that apply):
☐ Assessed for medication efficacy and side effects (describe):
☐ Assessed for medical issues (describe):
☐ Assessed health risk factors, including SI/HI (describe):

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☐ Educated client regarding medication risks and benefits (describe):
☐ Assessed medication adherence (describe):
☐ Administered medication (specify medication, dose, route, etc.):
☐ Reviewed chart:
☐ Obtained verbal/written orders from MD (specify):
☐ Refill called in to pharmacy (unbillable) Specify medication, dosage, quantity, route and pharmacy:
☐ Other (specify):
CLIENT'S RESPONSE (Describe how the client/family responded to your questions regarding efficacy of medication, adherence, side effects, symptoms, medical issues, etc. Describe client's progress toward his/her objective[s]):
DESCRIBE PLAN / REFERRALS / FOLLOW-UP CARE NEEDED (Next planned contact, next MD appointment, plan for dealing with side effects or medical concerns, etc.):

Clinician Name	**Title/License**	**Date**

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