Organization Name:	**Program Name:**	
Individual's Name (First / MI / Last):	**Record #:**	**DOB**:

Modality	☐ Individual ☐ Family ☐ Couple ☐ Phone ☐ Brief Treatment Visit	☐ Admission Note (Check only once per episode of care)
Individuals Present	☐ Individual Present / Contact Type: ☐ Onsite ☐ Offsite ☐ Phone Conversation ☐ Others Present (please identify name(s) and relationship(s) to individual): ☐ No Show ☐ Person Canceled ☐ Provider Canceled Explanation:	

Individual's Condition	No Significant Changes Reported or Observed	Notable	If Notable, List the Changes in Individual's Condition
Appearance and Behavior:	☐	☐	
Mood and Affect:	☐	☐	
Speech:	☐	☐	
Thought Process:	☐	☐	
Thought Content:	☐	☐	
Cognition*- If Impaired do Folstein Mini-Mental Status Exam	☐	☐	

Risk Assessment
Danger To: ☐ None Reported or Observed **OR:**
☐ **Self**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt / ☐ **Others**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt
Comments:

New Issues / Stressors / Extraordinary Events Presented Today: ☐ New Issue Resolved, No Update Required
☐ New Issue, CA/IAP Update Required ☐ None Reported
Explanation:

Goal(s)/Objective(s) Addressed As Per Individualized Action Plan or ☐ Based on Initial Plan for Services

Goal ___ Objective ___ Objective ___ Objective ___ Objective ___	Goal ___ Objective ___ Objective ___ Objective ___ Objective ___	Goal ___ Objective ___ Objective ___ Objective ___ Objective ___	Goal ___ Objective ___ Objective ___ Objective ___ Objective ___

Intervention(s) / Methods provided:

Response to Intervention(s) and Progress toward goals and objectives:

Plan / Additional information (OASAS-any recommendations or determinations for continued or revised treatment / ACT: also identify gaps in services):

Completed By - Print Staff Name/Credentials:	**Staff Signature**:	**Date:**
Supervisor - Print Name/Credentials (if applicable):	**Supervisor Signature**:	**Date:**
Individual's Signature (Optional):		**Date:**
Guardian's Signature (Optional):		**Date:**

☐ Medicare "Incident to" Services Only	**Name and Credentials of Medicare Supervising Professional on Site**

Date of Service	Staff Identifier	Loc. Code	Service Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Duration in Minutes