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| **Progress Note – RES Daily Note** |
| Client: |   |   |   |
|  | InSyst # | Last Name | First Name |
| Service Date: |   | Procedure Code: |   | EOD: |   |
|  |  |  |  |  |
| Services were provided in:  |   | by [ ]  interpreter or [ ]  clinician |  | Total Time (no doc. time): |
| Agency: |   | RU: |   |  |   |
| Location: | Residential Substance Abuse Treatment Facility |
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| **Instructions and Pre-Existing Diagnoses** |
| When writing progress notes, respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client’s functioning. If there is little progress, include an explanation of the limited progress. Reminder: Providers are required to establish and maintain a sign-in sheet for every group counseling session, independent from CG. Sign-in sheet shall contain: 1) legibly printed counselor/therapist name & signature who conducts the session; 2) start & end time of group session; 3) date of group session 4) topic of session; and, 5) client legibly printed name and signature. |
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| **Daily Service 1 – Reimbursable Services ONLY** |
| Topic/Purpose: |   |
| Service Type: |   | Location: |   |
| Counselor/LPHA: |   | Group Co-Facilitator: |   |
| Start Time:  |   | End Time:  |   | Duration: |   |
| Travel 1 Start: |   | Travel 1 End: |   | Total Travel Time: |   |
| Travel 2 Start: |   | Travel 2 End: |   |
|  |
| **Daily Service 2 – Reimbursable Services ONLY** |
| Topic/Purpose: |   |
| Service Type: |   | Location: |   |
| Counselor/LPHA: |   | Group Co-Facilitator: |   |
| Start Time:  |   | End Time:  |   | Duration: |   |
| Travel 1 Start: |   | Travel 1 End: |   | Total Travel Time: |   |
| Travel 2 Start: |   | Travel 2 End: |   |
|  |
| **Daily Service 3 – Reimbursable Services ONLY** |
| Topic/Purpose: |   |
| Service Type: |   | Location: |   |
| Counselor/LPHA: |   | Group Co-Facilitator: |   |
| Start Time:  |   | End Time:  |   | Duration: |   |
| Travel 1 Start: |   | Travel 1 End: |   | Total Travel Time: |   |
| Travel 2 Start: |   | Travel 2 End: |   |
|  |
| **Daily Service 4 – Reimbursable Services ONLY** |
| Topic/Purpose: |   |
| Service Type: |   | Location: |   |
| Counselor/LPHA: |   | Group Co-Facilitator: |   |
| Start Time:  |   | End Time:  |   | Duration: |   |
| Travel 1 Start: |   | Travel 1 End: |   | Total Travel Time: |   |
| Travel 2 Start: |   | Travel 2 End: |   |
|  |
| **Daily Service 5 – Reimbursable Services ONLY** |
| Topic/Purpose: |   |
| Service Type: |   | Location: |   |
| Counselor/LPHA: |   | Group Co-Facilitator: |   |
| Start Time:  |   | End Time:  |   | Duration: |   |
| Travel 1 Start: |   | Travel 1 End: |   | Total Travel Time: |   |
| Travel 2 Start: |   | Travel 2 End: |   |
|  |
| **Daily Service 6 – Reimbursable Services ONLY** |
| Topic/Purpose: |   |
| Service Type: |   | Location: |   |
| Counselor/LPHA: |   | Group Co-Facilitator: |   |
| Start Time:  |   | End Time:  |   | Duration: |   |
| Travel 1 Start: |   | Travel 1 End: |   | Total Travel Time: |   |
| Travel 2 Start: |   | Travel 2 End: |   |
|  |
| **Daily Service 7 – Reimbursable Services ONLY** |
| Topic/Purpose: |   |
| Service Type: |   | Location: |   |
| Counselor/LPHA: |   | Group Co-Facilitator: |   |
| Start Time:  |   | End Time:  |   | Duration: |   |
| Travel 1 Start: |   | Travel 1 End: |   | Total Travel Time: |   |
| Travel 2 Start: |   | Travel 2 End: |   |
|  |
| **Daily Summary** |
| Note includes 1) Progress (Client’s specific progress on treatment plan problems, goal, action steps, objectives, and/or referrals. 2) Provider Support and Interventions, 3) Client’s Plan (including new issues or problems that affect treatment plan). |
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| **Additional Service Information (add information or description of activities if needed)** |
|   |
| **Daily RES Progress Note Documentation Time** |
| Date: |   | Start: |   | End: |   | Total Doc. Time: |   |
| **Documentation Log (Use when documenting time completing clinical forms. Do not include this time above)** |
| Start: |   | End: |   | Time: |   | Type: |   |
| Start: |   | End: |   | Time: |   | Type: |   |
| Start: |   | End: |   | Time: |   | Type: |   |
| Start: |   | End: |   | Time: |   | Type: |   |
| Start: |   | End: |   | Time: |   | Type: |   |

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| Signature of SUD Counselor/LPHA | Printed Name/Credential | Date |