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| **Progress Note – Group Service OS IOS RS** |
| Client: |   |   |   |
|  | InSyst # | Last Name | First Name |
| Procedure Code and Name: |   | Service Date: |   |
| Location: |   |
| Agency: |   | RU:  |   |
| Services were provided in:  |   | by [ ]  interpreter or [ ]  clinician |
|  |  |  |  |  |  |
| **Group Facilitator Information/Time** |
| Group Count: |   | # of group facilitators: |   |  |
|  |  |  |  |
| Group Facilitator: |   | InSyst ID:  |   |   |
|  |  | Doc. Date: |   |  |  |  |
| FF Start: |   | Doc. Start: |   | Travel 1 Start: |   | Travel 2 Start: |   |  |
| FF End: |   | Doc. End: |   | Travel 1 End: |   | Travel 2 End: |   |  |
| **Total FF Time:** |  | Total Doc. Time: |   | **Staff 1 Total Travel Time:** |  |  |
| **Total Time** (group claiming time entered into InSyst) = **Total FF Time** + **Total Travel Time** + **All Group Clients’ Doc Time** |  |
| **Total of All Group Clients’ Doc Time:** |   |  | **Total Time:** |  |  |
|  |  |  |  |  |  |  |
| Group Co-Facilitator: |   | InSyst ID:  |   |
|  |  |  |  |
| FF Start: |   | Travel 1 Start: |   | Travel 2 Start: |   |  |  |  |
| FF End: |   | Travel 1 End: |   | Travel 2 End: |   |  |  |  |
| **Total FF Time:** |  | Staff 2 Total Travel Time: |   |  |  |  |
| **Total Time** (group claiming time entered into InSyst) = **Total FF Time** + **Total Travel Time** | **Total Time:** |  |  |
|  |  |  |  |  |  |  |
|  |
| **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. |
| **Topic of the Session** |
|   |
| **Provider Support & Interventions** |
|   |
| **Progress (Client’s specific progress on treatment plan problems, goals, action steps, objectives, and/or referrals)** |
|   |
| **Client’s Plan (including new issues or problems that affect diagnosis/treatment plan. Diagnosis/Plan must be updated.)** |
|   |
|  |   |  |
| LPHA/SUD Counselor Signature | Printed Name/Credentials | Date |