**Treatment Encounter**

##  Identifying Information

1. Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rendering Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Provider Client ID (chart number): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Program Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Service Location (where the service was provided): ***Select the closest match from the list below*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Ambulance - LandAssisted Living FacilityAmbulatory Surgical CenterAmbulance - Air or WaterBirthing CenterPrison/Correctional FacilityCustodial Care FacilityComprehensive Inpatient Rehab FacilityCommunity Mental Health CenterComprehensive Outpatient Rehab FacilityEmergency Room - HospitalEnd - Stage Renal Disease Tx FacilityFederally Qualified Health CenterGroup HomeHome | Homeless ShelterHospiceIntermediate Care Fac./Mentally RetardedIndependent ClinicInpatient HospitalIndian Health Service Free-standing FacilityIndian Health Service Provider-Based FacilityInpatient Psychiatric FacilityMass Immunization CenterMobile UnitMilitary Treatment FacilityNursing FacilityNon-residential Substance Abuse TX FacilityOffice | Outpatient Hospital Other Place of ServicePsychiatric Facility Partial HospitalizationPharmacyPsychiatric Residential Treatment CenterRural Health ClinicResidential Substance Abuse TX FacilitySchoolPublic Health Clinic (State or Local)Skilled Nursing FacilityTribal 638 Free-standing FacilityTribal 638 Provider-Based FacilityTemporary LodgingUrgent Care FacilityWalk-in Retail Health Clinic |

## Treatment Encounters Log

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Note Type:**Case Management (CM)Crisis Intervention (CI)ISA Youth/Adult (ISA)Medication Admin. (MA)Med Management (MM) Progress Note (PN)Non-Billable (NB)Recipient Support (RSS) | **Billable** | **Service Code**  | **Start Date** | **Duration**(Select one timeframe and specify amount) | **Units** |
| □ CM □ CI □ ISA □ MA □ MM □ PN □ NB □ RSS | □ Yes □ No |  | \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_ | □ Minutes #\_\_\_\_\_\_□ Hours #\_\_\_\_\_\_□ Days #\_\_\_\_\_\_ | # of Units: \_\_\_\_\_\_\_\_\_\_ |

Problem/Goals:

Objectives:

Interventions:

Notes: