**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 - Land  Assisted Living Facility  Ambulatory Surgical Center  Ambulance - Air or Water  Birthing Center  Prison/Correctional Facility  Custodial Care Facility  Comprehensive Inpatient Rehab Facility  Community Mental Health Center  Comprehensive Outpatient Rehab Facility  Emergency Room - Hospital  End - Stage Renal Disease Tx Facility  Federally Qualified Health Center  Group Home  Home | Homeless Shelter  Hospice  Intermediate Care Fac./Mentally Retarded  Independent Clinic  Inpatient Hospital  Indian Health Service Free-standing Facility  Indian Health Service Provider-Based Facility  Inpatient Psychiatric Facility  Mass Immunization Center  Mobile Unit  Military Treatment Facility  Nursing Facility  Non-residential Substance Abuse TX Facility  Office | Outpatient Hospital  Other Place of Service  Psychiatric Facility Partial Hospitalization  Pharmacy  Psychiatric Residential Treatment Center  Rural Health Clinic  Residential Substance Abuse TX Facility  School  Public Health Clinic (State or Local)  Skilled Nursing Facility  Tribal 638 Free-standing Facility  Tribal 638 Provider-Based Facility  Temporary Lodging  Urgent Care Facility  Walk-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: