MH 723
Revised 03/24/17

DAY REHABILITATION
WEEKLY PROGRESS NOTE

Week of: _____ Procedure Code: _____

Date of Service Claimed	Total Hours/Minutes in Attendance*	Staff Signature (Must have provided service on date)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Unavoidable Absence Entry (Claimed date(s) above in which client was not present all scheduled hours but was present at least 50% of scheduled hours. Must Specify Reason For Absence):

Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____

Summary of Activities Attended and Mental Health Interventions Provided:

Client Participation and Response:

Status of Client *(Symptoms/Behaviors/Impairments Justifying Continued DR Services)*:

Plan *(Interventions Modified, Additional Behaviors Addressed)*:

Did a family member/caregiver/significant support person contact occur this week outside of regular DR hours? (At least one contact per month required. Adult clients may refuse this option.)
☐ Yes ☐ No If yes, describe or reference other progress note.

Staff Signature*	Date	Co-Signature*/Co-Practitioner	Date

*Must include Degree/Discipline/Title and License/Certification/Registration Number (if applicable)

Name: **ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

DR WEEKLY NOTE