

DAY REHABILITATION WEEKLY PROGRESS NOTE

Week of: _____ Procedure Code: _____

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

*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)

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

ID#:

Agency:

Provider #:

Los Angeles County – Department of Mental Health

DR WEEKLY NOTE