MEDICATION NOTE

Practitioner Name: _____ **Face-to-Face Time:** _____ **Other Time:** _____ **Total Duration:** _____

Co-Practitioner Name: _____ **Face-to-Face Time:** _____ **Other Time:** _____ **Total Duration:** _____

Co-Practitioner Name: _____ **Face-to-Face Time:** _____ **Other Time:** _____ **Total Duration:** _____

Date of Service: _____ **Service/Procedure Code:** _____

Location of Service: _____ **If No-Show, indicate type:** ☐ **No-Show Med Appt (H0034)**

☐ **No-Show Non-Billable (00000)**

If other than Office or Home, enter the Service Address: **Facility Name:** _____

Street: _____ **City:** _____ **State:** _____ **Zip:**_____

Columbia Suicide Screener ☐ Screening Completed ☐ Screening Not Completed

Since last visit (or past 30 days if never previously asked)

1. Have you wished you were dead or wished you could go to sleep and not wake up? ☐ Yes ☐ No
2. Have you actually had any thoughts of killing yourself? ☐ Yes ☐ No

If YES to #2, ask questions 3, 4, 5, and 6; if NO to #2, go directly to question 6

3. Have you been thinking about how you might do this? ☐ Yes ☐ No
4. Have you had these thoughts and had some intention of acting on them? ☐ Yes ☐ No
5. Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan? ☐ Yes ☐ No

Since last visit (or lifetime if never previously asked)

6. Have you done anything, started to do anything, or prepared to do anything to end your life? ☐ Yes ☐ No

All known current medications, including supplements and OTC, are documented in OrderConnect? ☐ Yes ☐ No

Cures Reviewed? ☐ Yes ☐ No

Medications Prescribed? ☐ Yes ☐ No

If yes, medications prescribed:

Naloxone prescriber offered?

☐ Education provided, patient accepted Rx
☐ Education provided, patient declined Rx
☐ Education provided, patient possess Rx
☐ Patient meets no AB 2760 criterion
☐ N/A No patient contact

Problem List:

Language Service Provided In: _____

Medication Progress Note Text:

_____ _____ _____ _____

Signature & Discipline Date Co-signature & Discipline Date

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: _____ **DMH ID#:** _____

Agency: _____ **Provider #:** _____

Los Angeles County – Department of Mental Health

MEDICATION NOTE