MH 655
Revised 12/11/12

BRIEF FOLLOW-UP
MEDICATION SUPPORT SERVICE

(For use by MD/DO and NP and students of these disciplines)

Date: _____ **Rendering Provider Face-to-Face/Other Time* (Hrs:Mins):** _____

Procedure Code: ☐ **Office Visit: 99212** ☐ **Home Visit: 99347** ☐ **H2010 (telephone refill)** ***All travel and documentation time must be recorded as "Other"**

Chief Complaint /Client Goals:

Brief History of Present Illness/Problem:

Treatment Response/Medication Side Effects:

Adherence to Medication:

Mental Status:

Diagnosis: ☐ Diagnosis remains the same ☐ Diagnosis changed [complete Diagnosis Information Form (MH 501)]

Assessment/Intervention/Plan/Clinical Decision Making (Include explanation of changes in Plan and/or Medication)**:**

Laboratory Tests Ordered: ☐ CBC ☐ LFT ☐ Electrolytes ☐ Lipids ☐ Glucose ☐ HgbA1C
☐ Tox Screen ☐ Med Levels ☐ TFTs ☐ Other/Details: _____

Medication(s) Prescribed: The Outpatient Medication Review Form **(**MH556**)** must be completed by the MD/DO/NP annually and any time a new medication is prescribed or resumed following a documented withdrawal of the medication.

Name	Dosage	Frequency	Route of Administration	Amount	# of Refills

☐ **Provided by the use of Telemental Health services. Client signed the Consent for Telemental Health Services and concerns were discussed.**
☐ **Continued** (Sign & complete information on **Medication Note Addendum**)

_____ _____ _____ _____
Signature & Discipline Date Co-signature & Discipline Date

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

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