MH 657
Revised 12/11/12

INITIAL MEDICATION SUPPORT SERVICE

(To be used by MD/DO and NP and students of these disciplines)

For use during the initial medication evaluation with a client.
Detailed history, assessment and decision-making is required for prescribing medication.

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

Procedure Code: Office Visit ☐ **New** Client 99204* ☐ **Established Client 99214**
Home Visit ☐ **New** Client 99344* ☐ **Established Client 99350**

***All travel and documentation time must be recorded as "Other"**

** New Client is a client who has not been seen at this Billing Provider/Reporting Unit by an MD/DO/NP within the past three years

To meet all payor documentation standards, the note must include detailed information in accord with the box checked below:

☐ **Relevant parts of the Clinical Record (i.e. Initial Assessment, Assessment Addendums, etc) were reviewed on _____. Must check "No Additional Information" *or* include additional information for BOLDED elements of this form.**

☐ **Clinical Record was not reviewed at this time. Must include detailed information in *all* BOLDED elements of this form. Checking boxes is not appropriate.**

ID/Chief Complaint/Presenting Problem/Client Goals: ☐ No Additional Information

Psychiatric History: ☐ No Additional Information

Current Psychiatric Medications (responses, side-effects):

Previous Psychiatric Medications (responses, side-effects):

Adherence to Medication:

Medication Allergies: ☐ None

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General Medical History (History and Current): ☐ No Additional Information

☐ Pregnancy	☐ Diabetes/Obesity	☐ Thyroid/Endocrine Disease	☐ Gait/Balance Disturbance
☐ STDs/Infectious Disease	☐ Coronary Artery Disease/MI/CHF	☐ Cancer	☐ Renal/Urinary Tract Disease
☐ Hypertension	☐ Lung Disease	☐ Seizure/Neurologic Disease	☐ Anemia/Blood Disorder
☐ Hyperlipidemia	☐ GI/Liver Disease	☐ Glaucoma/Visual Impairment	☐ Head Trauma

☐ Other (Please list including current complaints):

Date of Last Physical Exam: _____ MD Name and Phone: _____

Results of Last Physical Exam (Include labs, EKG, other test results and dates):

General Health (height, weight, BMI, waist circumference, etc.):

Current Physical Health Medications (prescribed, over the counter, herbal):

Other Clinically Significant General Medical Data:

Alcohol/Substance Abuse/Dependence (History and Current): ☐ No Additional Information

☐ Alcohol ☐ Marijuana ☐ Hallucinogens ☐ Psychostimulants ☐ Opiates ☐ Inhalants ☐ Other _____

Family History (Psychiatric, Medical, Substance Abuse): ☐ No Additional Information

Psychosocial History/Developmental History: ☐ No Additional Information

Mental Status:

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Assessment/Clinical Impression:

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

Intervention/Plan/Clinical Decision Making/Counseling Provided/Recommended Consultations (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 through 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 _____

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