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.

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):

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Adherence to Medication:

Medication Allergies: ☐ None

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 ________________

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

Psychosocial History/Developmental History: ☐ No Additional Information

Mental Status:

Assessment/Clinical Impression:

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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**)

By signing my name below, I attest that I have provided the mental health services recorded on this NCR note form and that all information is accurate, complete & truthful to the best of my knowledge. I further attest that the services provided by me, as reflected on this NCR Note form, were consistent with the client's treatment plan, and, if services are to be claimed to Medicare and/or Medi-Cal, were reasonable and medically necessary. Claim for services submitted as a result of this NCR Note form are supported by documentation.

Service is Medi-Cal Claimable (Check One): ☐ **Y** ☐ **N**

Signature & Discipline ______ Date ______ Co-Signature & Discipline ______ Date ______

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

**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

Place of Service: **Plan:**

1. Address:

Evidenced Based Practice (EBP) Service Strategy (SS) (See IS Codes Manual for a listing of Codes): _____ _____ _____

Rendering Provider Name: **Staff Code:** ***Face-to-Face/Other Time (Hrs:Mins):**

Client Present: ☐ **Y** ☐ **N** **# Collaterals:** **Relationship(s):** *All travel and documentation time must be recorded as "**Other Time**".

2. EPSDT Screening Referral: ☐ Y ☐ N **3. Pregnancy:** ☐ Y ☐ N **4. Emergency:** ☐ Y ☐ N **5. SED:** ☐ Y ☐ N **6. Share of Cost:** ☐ Y ☐ N

(FOR SUPPORT STAFF ONLY) Data Entry Initials:

Medi-Cal: Y N **Medi-Cal Late Code: A B C** **Medicare: Y N** **Crossover Code: X B P H N E**

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