INITIAL MEDICATION SUPPORT SERVICE (90862)

(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 using 90862.

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

Procedure Code: ☐ **90862**
☐ **H2010 (When no medication is prescribed)** *** All travel and documentation time must be recorded as "Other" by the Rendering Provider.**

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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Agency: **Provider #:**

Los Angeles County – Department of Mental Health

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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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INITIAL MEDICATION SUPPORT SERVICE (90862)

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Assessment:

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

Intervention/Plan/Clinical Decisions/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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DIAGNOSIS INFORMATION

Type of Diagnosis Information:

☐ Admission Diagnosis ☐ Clerical Revision to Admission Diagnosis ☐ Clerical Revision to Current Diagnosis
☐ Clinical Update to Current Diagnosis ☐ Other (please specify): ________________________________

New/Updated Diagnosis: (include full *Current* Five Axes Diagnosis)

Note: The medication monitoring computer program will compare both the Principle and Secondary Diagnosis with any prescribed medication. A diagnosis consistent with the usual use of a given medication MUST appear as either the Principle or Secondary Diagnosis in the current/discharge diagnosis fields of the IS. If a diagnosis is inconsistent for the usual use of a medication, the medication MUST be specifically authorized through review and approval procedures.

Axis I ☐ Prin ☐ Sec Code _______ Nomenclature ______________________________
(Medications cannot be prescribed with a deferred diagnosis)
☐ Sec Code _______ Nomenclature ______________________________
Code _______ Nomenclature ______________________________
Code _______ Nomenclature ______________________________
Code _______ Nomenclature ______________________________

Axis II ☐ Prin ☐ Sec Code _______ Nomenclature ______________________________
☐ Sec Code _______ Nomenclature ______________________________
Code _______ Nomenclature ______________________________

Axis III ____ Code ___________
____ Code ___________
____ Code ___________

Axis IV Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis
Check as many as apply:
1. ☐ Primary Support Group 2. ☐ Social Environment 3. ☐ Educational 4. ☐ Occupational
5. ☐ Housing 6. ☐ Economics 7. ☐ Access to Health Care 8. ☐ Interaction with Legal System
9. ☐ Other Psychosocial/Environmental 10. ☐ Inadequate information

Axis V Current GAF: ______ DMH Dual Diagnosis Code: __________

Justification:

☐ See Initial Medication Support Service dated ______________ ☐ See Assessment Addendum dated _______________
☐ Justification from current Diagnostic Manual:

_______________________________ Signature & Discipline ________ Date _______________________________ Co-signature & Discipline (when required) ________ Date

☐ Diagnosis has been entered in the IS by ______ (initials) on __________ (date).

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MH 651
Revised 05/12/09

SPECIAL PROGRAM CCCP

Annual Cycle Month: **(Due prior to the 1st day of the Month)**

☐ **Jan** ☐ **Feb** ☐ **Mar** ☐ **Apr** ☐ **May** ☐ **Jun** ☐ **Jul** ☐ **Aug** ☐ **Sep** ☐ **Oct** ☐ **Nov** ☐ **Dec**

Client Long Term Goals: (use client direct quote)

Short-term Goals / Objectives: Must be **SMART**: **S**pecific, **M**easurable/Quantifiable, **A**ttainable within this year, **R**ealistic, and **T**ime-bound. Must be linked to the client's functional impairment and diagnosis / symptomatology as documented in the Assessment.

Objective # 1 Effective Date: ________

Clinical Interventions: Must be related to the objective and achievable within the time frame of this Plan. Describe proposed intervention and duration (specify if time frame is less than 1 yr).

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup Other ____________________

Client Involvement - Client agrees to participate by:

Signature(s)

____________	____________	______	____________	______
Print Name	Signature & Discipline	Date	Co-signature & Discipline	Date

Outcomes: To be completed either when the objective is obtained or prior to the beginning of the next cycle month.

Initials: Date:

Short-term Goals / Objectives:

Objective # 2 Effective Date: ________

Clinical Interventions:

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup Other ____________________

Client Involvement - Client agrees to participate by:

Signature(s)

____________	____________	______	____________	______
Print Name	Signature & Discipline	Date	Co-signature & Discipline	Date

Outcomes:

Initials: Date:

*MHS includes individual, group, psychological testing, collateral and consultation services.

Family Involvement: ☐ Biological ☐ Other

Name: ____________ Telephone Number: ____________ Date of contact: ____________

Family agrees to participate? ☐ Yes ☐No (If yes, please specify):

Additional Client Contacts / Relationships:	**Interpretation**	**Client's Signature to the Care Plan**
☐ DCFS ☐ Probation ☐ DPSS ☐ Health ☐ Outside Meds ☐ Regional Center ☐ Substance Abuse/12 Step ☐ Consumer Run ☐ Education/AB 3632 ☐ Other ____________	Prefer a language other than English: ☐ Yes ☐No This plan was interpreted: ☐Yes ☐No Language: ____________	Client's Signature: ____________ Date: ______ Client offered a copy: ☐ Yes ☐No Staff Initials: ______ Date: ______

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Special Program Client Care Coordination Plan