

NURSING HOME PSYCHIATRIC PROGRESS NOTE

COUNSELING AND/OR COORDINATION OF CARE Initial _____ or Follow-Up _____

Patient's Name: _____ **Date of Visit:** _____

History of Present Illness (Initial/ Interval): _____

Psychiatric Assessment/ Mental Status Examination (Initial/ Interval): _____

Current Diagnosis: _____

Diagnosis Update: _____

Current Medication(s)/Medication Change(s) – No side effects or adverse reactions noted or reported

Lab Tests: Ordered Reviewed : _____

Counseling Provided with Patient / Family / Caregiver (circle as appropriate and check off each counseling topic discussed and describe below:

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Diagnostic results/impressions and/or recommended studies | <input type="checkbox"/> Risks and benefits of treatment options | |
| <input type="checkbox"/> Instruction for management/treatment and/or follow-up | <input type="checkbox"/> Importance of compliance with chosen treatment options | |
| <input type="checkbox"/> Risk Factor Reduction | <input type="checkbox"/> Patient/Family/Caregiver Education | <input type="checkbox"/> Prognosis |

Coordination of care provided with (check off as appropriate and describe below):

Coordination with: Nursing Staff Treatment Team Social Work Physician/s Family Caregiver

Additional Documentation (if needed): _____

Duration of face to face visit with patient and floor time (in minutes): _____ **CPT Code** _____

Greater than 50% of patient time and floor time spent providing counseling and/or coordination of care:

Initial Nursing Facility E&M Code:

- 99304 (approx. 25 min.)
- 99305 (approx. 35 min.)
- 99306 (approx. 45 min.)

Subsequent Nursing Facility E&M Code:

- 99307 (approx. 10 min.)
- 99308 (approx. 15 min.)
- 99309 (approx. 25 min.)
- 99310 (approx. 35 min.)