COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
PROGRESS NOTE FORM

PATIENT INFORMATION			
1. Name (Last, First, and Middle):		2. Date of Birth (MM/DD/YYYY):	3. Medi-Cal or MHLA number:
4. Address:			
5. Sage Client number:	6. Gender:	7. Preferred Language:	8. Race/Ethnicity:
9. Phone Number:		Ok to Leave a Message? ☐ Yes ☐ No	

PROVIDER AGENCY		
10. Agency Name:	11. Contact Person:	12. Phone Number:
13. Address:	14. Email:	15. Fax:

PROGRESS NOTE INFORMATION	
16. Date of Service:	17. Program (site):
18. Service Start Time:	19. Service End Time:
20. Method of Service Delivery: ☐ Face-to-Face ☐ Field Based Services ☐ Telehealth ☐ Telephone ☐ Not Applicable	21. Note Type: ☐ Individual ☐ Family ☐ Crisis ☐ Non-Residential Group ☐ Residential Group ☐ Non-Billable
22. Service Type:	23. Location:
24. LPHA Specific Procedure (Only for LPHA use of CPT procedures):	
25. Provider Name:	26. Provider Name (Optional):
Travel Time (Field Based Service Method of Service Delivery Only)	
27. Date of Travel:	28. Field Based Service Location:
29. Time to Destination Start Time:	30. Time to Destination End Time:
31. Time from Destination Start Time:	32. Time from Destination End Time:
Group Details (Group Note Type Only)	
33. Number of Counselors in Group:	34. Number of Clients in Group:
Residential Summary Group Details Only	
35. Total Session Time:	36. Number of Sessions:

Documentation Time	
37. Date of Documentation:	
38. Documentation Start Time:	39. Documentation End Time:

Note
40. Note:

Supplemental/Additional Services	
41a. If patient's preferred language is NOT English, were services provided in the patient's preferred language? ☐ N/A ☐ Yes ☐ No	42a. Was an interpreter used? ☐ Yes ☐ No
41b. Language in which service was provided:	42b. Name of interpreter or service used:
41c. Please explain why services were not provided in patient's preferred language:	
43a. Was a supplemental service provided in addition to the primary service? ☐ Yes ☐ No	
43b. Supplemental Service (select all that apply): ☐ Sign Language/Oral Interpreter (T1013) ☐ Interactive Complexity (90785) ☐ Interpretation of Explanation of Results (90887) ☐ Health Behavioral Intervention, family without patient (96170/96171)	
44. Duration of Supplemental Service in minutes (cannot exceed the service time):	
45. Co-Signature Use Only- Draft Ready to Submit: ☐ Yes	46. Form Status: ☐ Final

47a. Staff Name and Credential:	47b. Staff Signature:	47c. Date/Time:
48a. LPHA Name and Credential (if applicable):	48b. LPHA Signature:	48c. Date/Time:

PROGRESS NOTE FORM INSTRUCTIONS

Red fields are required

PATIENT INFORMATION

1. Enter the patient's name in the order of last name, first name, and middle name.
2. Enter the patient's date of birth.
3. Enter the patient's Medi-Cal or MHLA number, leave blank if not applicable.
4. Enter the patient's address.
5. Enter Sage Client number.
6. Enter the patient's gender.
7. Enter the patient preferred language.
8. Enter the patient race/ethnicity.
9. Enter the patient phone number. Check box to indicate if it is okay to leave a message at this phone number.

PROVIDER AGENCY

10. Enter the agency name.
11. Enter the agency contact person.
12. Enter the agency phone number.
13. Enter the agency address.
14. Enter the agency or contact person's email.
15. Enter the agency or contact person's fax.

PROGRESS NOTE INFORMATION

16. Enter the date of service.
17. Enter program site name.
18. Enter time service started (format HH:MM AM/PM).
19. Enter time service ended (format HH:MM AM/PM).
20. Select method of service delivery.
21. Select note type.
22. Enter type of service from the following list: Assessment; Care Coordination; Case Conference/Review; Collateral Contact; Consultation; Contingency Mgmt- UDT Stimulant Positive; Contingency Mgmt- UDT Stimulant Negative; Counseling; Discharge Planning/Summary; Drug Testing; Education; Medical Necessity Justification; Medication Handling/Safeguarding; Med Services - Admin and Observation; Med Services- Training and Support; Medication Services (MAT); Naloxone Handling/Distribution; No Show; Other; Peer Services- BH Prevention Education; Peer Services- Self-Help; Peer Support Services-Plan of Care; Peer Support Services-Plan of Care; Prenatal Care, at risk assessment; Problem List-Treatment Plan Development/Review; Recovery Services- Community support; Recovery Services- Psychosocial Rehab; Residential-Mental Health Services; Residential-Physical Health Services; Residential- Support Services; Residential- Therapeutic Services; Therapy; Screening.
23. Enter location from the following list: Ambulance- Air or Water; Ambulance- Land; Ambulatory Surgical Center; Assisted Living Facility; Birthing Center; Community Mental Health Center (CMHC); Comprehensive Inpatient Rehabilitation Facility; Comprehensive Outpatient Rehabilitation Facility; Custodial Care Facility; Emergency Room Hospital; End Stage Renal Disease Treatment Facility; Federally Qualified Health Center; Group Home; Homeless Shelter; Home; Hospice; Independent Clinic;

Independent Laboratory; Indian Health Service Free-Standing Facility; Indian Health Service Provider Based Facility; Inpatient Hospital; Inpatient Psychiatric Facility; Intermediate Care Facility/Individuals with Intellectual Disabilities; Mass Immunization Center; Military Treatment Facility; Mobile Unit; **Non-Residential Opioid Treatment Facility**; **Non-Residential Substance Abuse Treatment Facility**; Nursing Facility; Off Campus Outpatient Hospital; Office; On Campus Outpatient Hospital; Other Place of Service; Pharmacy; Place of Employment-Worksite; **Prison/Correctional Facility**; Psychiatric Facility-Partial Hospitalization; Psychiatric Residential Treatment Center; Public Health Clinic; **Residential Substance Abuse Treatment Facility**; Rural Health Clinic; School; Skilled Nursing Facility; **Telehealth Provided in Patient's Home**; **Telehealth Provided Other than in Patient's Home**; Temporary Lodging; Tribal 638 Free-Standing Facility; Tribal 638 Provider Based Facility; Urgent Care Facility; Walk-In Retail Health Clinic.
24. Only for LPHA use if applicable. LPHA to enter specific CPT Procedures according to the rate matrix and the type of service provided.
25. Enter provider staff name.
26. If applicable, enter additional provider staff name (optional).

TRAVEL TIME (ITEMS 25-30 REQUIRED FOR FIELD BASED SERVICES)
27. Enter date of travel.
28. Enter destination location/address.
29. Enter time of departure to destination.
30. Enter time of arrival to destination.
31. Enter time from departure to destination.
32. Enter time from arrival to destination.

GROUP DETAILS (ITEMS 31-32 ONLY TO BE COMPLETED FOR FIELD BASED SERVICE METHOD ONLY)
33. Enter number of counselors in group.
34. Enter number of clients in group.

RESIDENTIAL SUMMARY (ITEMS 33-34 FOR DOCUMENTING RESIDENTIAL GROUP SUMMARY ONLY)
35. Enter total session time.
36. Enter number of sessions.

DOCUMENTATION TIME
37. Enter date of documentation.
38. Enter documentation start time.
39. Enter documentation end time.

NOTE
40. Enter details relating to the service provided.

SUPPLEMENTAL/ADDITIONAL SERVICES
41a. Select whether linguistically appropriate services were provided.
41b. Enter the language in which services were provided.
41c. If applicable, enter explanation for why services were not provided in patient's preferred language.
42a. Select whether an interpreter was used.
42b. If applicable, enter name of interpreter or service provided.

43a. Select whether a supplemental service was provided.
43b. If applicable, select which supplemental services were provided.
44. Enter the duration that Supplemental Service was provided in minutes.
45. Select whether draft is ready to submit to LPHA to be finalized.
46. Select whether form has been finalized by LPHA.
47a. Enter the name and credentials of provider staff signing form.
47b. Enter the provider staff signature.
47c. Enter date and time at time of staff signing.
48a. If applicable, enter the name and credentials of LPHA signing form.
48b. If applicable, enter the LPHA signature.
48c. If applicable, enter date and time at time of LPHA signing.

FOR ADDITIONAL SAPC DOCUMENTATION PLEASE SEE
http://publichealth.lacounty.gov/sapc/providers/network-providers.htm

FOR SAGE PCNX RESOURCES PLEASE SEE
http://publichealth.lacounty.gov/sapc/providers/sage/sage-pcnx.htm