

Client: Gender: CR/ID#: DX: DOB: District: TIFFE Record: Therapist:

DOMAIN / GOAL:

- 1. Family: 1a) 1b)
2. School: 2a) 2b)
3. Community: 3a) 3b)
4. Individual: 4a) 4b)
5. Social / Peer: 5a) 5b)
6. Legal: 6a)

SERVICE CODE: SA#: Month/Year: Hours Authorized:

TYPE OF SERVICE: (1) Direct (2) Collateral
PLACE OF SERVICE: (11) Office (12) Home (13) School (14) Other Community Location (23) Emergency Rm.-Hospital
(51) Inpatient Psychiatric Care Facility (56) Psychiatric Residential Treatment Center (99) Other Unlisted Facility

Date: Place of Service: Time (start/end): Length of Service: Type of Service:

D: Update on concerns from previous session:

Goals addressed:

Current status:

A: Progress toward goal(s)_____:

P: Follow-up on services:

Intervention plan:

Date of next session:

Clinician Signature:

Print Name & Credentials:

No progress notes below this line