

<p><b>Name of Policy:</b> <b>Progress Notes</b></p> <p><b>Policy Number:</b> 3364-160-CR-106</p> <p><b>Approving Officer:</b> Chief Executive Officer – UTMC</p> <p><b>Responsible Agent:</b> Chair, Department of Psychiatry Administrative Director, Department of Psychiatry</p> <p><b>Scope:</b> OP-Clinic-Psychiatry</p>	 <p><b>Effective date:</b> September 22, 2025</p> <p><b>Original effective date:</b> August 2004</p>
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Key words: psychiatry, progress note, documentation, patient record

<input type="checkbox"/>	New policy proposal	<input checked="" type="checkbox"/>	Minor/technical revision of existing policy
<input type="checkbox"/>	Major revision of existing policy	<input type="checkbox"/>	Reaffirmation of existing policy

(A) Policy statement

Documentation shall be completed for each instance that a service is provided for the specific service type and in a timely manner as required by the Legal Ambulatory Medical Record Policy.

(B) Purpose of policy

Progress notes shall reflect progress or lack of progress toward the achievement of specified treatment outcomes identified on the individual service plan (ISP).

(C) Procedure

(1) When the same staff person provides more than one type of service in the same day to an individual, the staff shall complete a separate progress note for each of the different types of services provided.

(2) At minimum, documentation shall include the following information:

- (a) The date of the service contact and the date of documentation of the progress note, if different;
- (b) Time of day and duration of each service contact;
- (c) The location of each service contact;

- (d) A description of the service(s) rendered;
- (e) Whether or not the intervention provided is specifically authorized by the service plan that was developed based on a mental health assessment. The exception shall be the following circumstances:
  - (i) Crisis intervention mental health service when not listed on the treatment plan.
  - (ii) The assessment of the patient's progress or lack of progress, and a brief description of progress made, if any.
  - (iii) Significant changes or events in the life of the patient, if applicable.
  - (iv) Recommendation for modifications to the ISP, if applicable.
  - (v) The signature and credentials, or initials, of the provider of the service and the date of the signature; and documented evidence of clinical supervision of staff completing the review, as applicable.

(3) Documentation in the progress note, or elsewhere in the individual patient record, may include a notation that there is no change in the patient's risk of harm to self or others, or, if there is a change, the results of a review of the patient's ideation, intent, plan, access, and previous attempts.

<p>Approved by:</p> <p>/s/ <span style="float: right;">9/22/2025</span></p> <hr/> <p>Daniel Barbee <span style="float: right;">Date</span> Chief Executive Officer</p> <p>/s/ <span style="float: right;">9/11/2025</span></p> <hr/> <p>Robert Smith, MD, Ph.D. <span style="float: right;">Date</span> Chair - Department of Psychiatry</p> <p>/s/ <span style="float: right;">9/11/2025</span></p> <hr/> <p>Stephanie Calmes, Ph.D., LPCC-S, <span style="float: right;">Date</span> LICDC-CS Administrative Director - Department of Psychiatry</p> <p><i>Review/Revision Completed by: Department of Psychiatry Administration</i></p>	<p><b>Policies Superseded by this Policy</b></p> <ul style="list-style-type: none"> <li>• <i>ODMH-CR-106</i></li> </ul> <p>Initial effective date: August 2004</p> <p>Review/Revision Date:</p> <ul style="list-style-type: none"> <li>July 2002</li> <li>June 2004</li> <li>August 2005</li> <li>August 2007</li> <li>January 14, 2013</li> <li>January 6, 2014</li> <li>September 16, 2016</li> <li>September 2, 2022</li> <li>September 22, 2025</li> </ul> <p>Next review date: September 22, 2028</p>
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