1 - Office **2** - Field **3** - Phone **4** - Home **5** - School **6** - Satellite Clinic **20** - Telehealth

MEDICATION VISIT	DATE:	BILLING TIME:	Face to Face	Total	LOCATION

Target Symptoms/Response to Meds	Service Type:

S/I ☐ Yes ☐ No H/I ☐ Yes ☐ No

Evaluation of Side Effects/Action Taken: ☐ N/A ☐ T.D. Absent ☐ T.D. Present (specify):

Client Compliance to Medication Plan:

Lab Check: ☐ N/A ☐ Findings:

Diagnosis (Check Blue Diagnosis Sheet):

Interventions: ☐ see Outpt. Medication Record

Follow-Up: RTC:

Recovery Update:

Additional Actions Taken and Comments:

OTHER MEDICATION SUPPORT SERVICES (in person or by phone)	DATE:	BILLING TIME:	LOCATION	SERVICE TYPE

(giving advice re: meds; collateral information to family, caretaker, etc. Document information discussed and specify person contacted).

Signature:	Printed Name & Discipline:
MEDICATION VISIT INTERDISCIPLINARY NOTE Confidential Patient Information See W&I Code 5328	NAME: DOB: CHART NO: PROGRAM: