Print Form

CLICK HERE FOR LINED VERSION OF THIS FORM

1 – Office	4 – Home	8 - Correctional Facility	11 - Faith-based	14 - Client's Job Site	17 - Non-Traditional	20 - Telehealth
2 – Field	5 – School	9 - Inpatient	12 - Health Care	15 - Adult Residential	18 - Other	21 - Unknown
3 – Phone	6 - Satellite Clinic	10 - Homeless	13 - Age-Specific	16 - Mobile Service	19 - Childrens Residential	**Face to Face time (Medicare Providers Only)**

SIGN ALL ENTRIES WITH NAME AND TITLE - HEAD ALL SERVICE ENTRIES WITH SPECIFIC SERVICE

(include **1** - client current condition **2** - dysfunction being addressed in session **3** - interventions **4** - client response)

DATE:	BILLING TIME:	Face to Face	**Total**	Service Type	LOCATION

Current Diagnosis (Check Blue Diagnosis Sheet):	Client Plan End Date (Check Client Plan):

Service Provider:
(printed first and last name
Including discipline)
Signature:

INTERDISCIPLINARY NOTES

County of San Bernardino

Department of Behavioral Health

Confidential Patient Information
See W & I Code 5328

NAME:

CHART NO:

DOB:

PROGRAM: