BEHAVIORAL HEALTH AIDE/PRACTITIONER
PROGRESS NOTE

Encounter Summary

Patient Name: _____ **D.O.B**: _____
First *M.I.* *Last* *DD / MM / YYYY*

Provider Name: _____
First *Last* *Credentials* *BHA Cert. #*

Service Provided: _____ **Location**: _____

Date: _____ **Start time**: _____ **Stop time**: _____

Informed Consent: ☐ Signed during this encounter ☐ On file (expiration date:_____)

Presenting Problem

Presenting Problem (including medical necessity): _____

Intervention

Describe intervention: _____

Response

Describe client response: _____

Follow-up Plan

Provider Signature: _____
First *Last* *Date*

Clinical Supervisor Signature:

(Signature optional and can be required at the discretion of the organization)

_____
First *Last* *Date*