**A/P Section**

1. In the A/P portion of the encounter:
2. Under "Diagnosis", there is a slot which opens up when you click on "Plan/Comments". That is where the following comments are inserted:

At the present time, this patient is considered fully competent to be discharged to own custody and does not constitute an acute danger to self or others.

Treatment Plan: The patient has been educated on various treatment modalities for depression/ anxiety including individual psychotherapy, group psychotherapy, and medication management.

Medications have been reviewed and reconciliation completed. Potential adverse side effects including suicide risk, worse clinical condition, sexual dysfunction, involuntary movements and weight gain have been discussed. The patient has acknowledged this information and indicated agreement with the proposed treatment based on the potential benefits, limitations and risks.

1. Next, a Procedure code must be entered:

**90792 - for Intake** (choose the one with Medical Evaluation and Management included)

**90833** - for medication management notes, treatment plan update notes, and discharge summary notes for encounters taking less than 30 minutes. (choose the one which reads: Psych Ther Indiv Interactive) (90836 for 45 minutes, 90838 for 60 minutes)

Upon entering the code, in the top slot under description, select **GC** as the specifier, and in the comments section, enter one of the below as appropriate:

I, Dr.[xxxxxxx], attending psychiatrist on PCS saw the patient with the resident Dr. [xxxxxx], and I have reviewed and I approve the resident's findings and plan.

Or enter:

I, NP Thomas, attending clinician on PCS saw the patient with the resident Dr. Fisher, and I have reviewed and I approve the resident's findings and plan

**Disposition**

1. In the Disposition portion of the encounter:
2. In the right upper quadrant, click the boxes which read: [ ] with PCM [ ] PRN [ ] in Clinic. Above it, in the box which reads "WHEN" put in the number of days when the patient will return: usually 1, 2, 3 or 4 days, corresponding to your next planned encounter with the patient.
3. Under that is the slot, "Comments". Enter the statement:

The patient agrees to seek treatment at or call the WRNMMC Emergency Room (301) 295-4810/11 should there be a significant worsening in symptoms, intense distress, or thoughts about harming self or others.

1. Below that is another box, "Discussed". Click the box saying "all items discussed"

**Hints and Tips**

**Patient Encounter Note**

* At the Ready Attendence List: Dr. Bahroo, NP Thomas, Dr. Friedlander, Anna Drabkina, Margaret Hardy, Jennifer Zumwalde, Cynthia Gragnani, Kerrie Earley
* Safety Line to ALWAYS include below your subjective of Interval History:
	+ Patient currently denies thoughts of wanting to harm self or others. Discussed safety plan and ways to mitigate risk, denies access to weapons. Agreed to inform staff if SI/HI worsens or persists. Patient is future oriented and treatment focused. Supportive psychotherapy provided to the patient.
* Treatment Planning (Optional at the end of an intake note when they're asking for treatment and goals):
	+ -Decrease intake PHQ9 score by 10 (clinically significant response) by time of discharge from PCS.
	+ -Decrease intake GAD7 score by 10 (clinically significant response) by time of discharge from PCS.
	+ -Decrease intake PCL5 score by 10 (clinically significant response) by time of discharge from PCS