FRESNO COUNTY MENTAL HEALTH PLAN
PROGRESS NOTE

Consumer Name: ______________________________ **CIN:** ____________

Type of Treatment: Individual ☐ Group ☐ Family ☐ Case Management ☐ Other: ____________

Service Date: __________ Duration: ________ Service Location: __________ Phone Contact: Yes ☐ Billable: Yes ☐

Appointment Cancellation: ☐ No show: ☐ Action Taken: ____________

Diagnosis:

____

B

____

I:

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O:

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P:

____

Clinician/Provider Name: ______________________________
(Printed Name) (Title)

ID#

Clinician/Provider Signature: ______________________ Date: ____________
(Signature and Title)

09/01/10, 06/13/13, 10/5/15