MSDP

Consultation-Collateral Contact Progress Note
Revision Date: *3-7-09*

Person's Name (First / MI / Last)**:**	**Record #:**
Organization Name:	
Type of Scheduled Contact: ☐ In-person meeting ☐ Telephone	

Service *(check ONE service only)*	**Purpose** *(check purpose(s) for the indicated service)*
☐ **Case Consultation** ☐ **Family Consultation** ☐ **Collateral Contact**	☐ Assessment of the appropriateness of current treatment ☐ Treatment coordination/planning ☐ Termination**/**Aftercare planning ☐ Clinical consultation/Second opinion (*not* supervision) ☐ Supporting treatment objectives for the person's served care ☐ Other**:**

	Name:	**Agency/Relationship to Person Served:**
List of Participants		

Summary of treatment goals/objectives/ interventions addressed with this contact:

Actions that will occur as a result of this contact:	**Responsible Party:**
1. **2.** **3.** **4.**	**1.** **2.** **3.** **4.**

Provider - Print Name/Credential:	**Date:**	**Supervisor - Print Name/Credential** (if needed):	**Date:**
Provider Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**

Next Appointment: Date: / / - Time: ☐ **am** ☐ **pm**

Date of Service	Provider Number	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code