Consultation- Collateral Contact Progress Note –

Use the Consultation - Collateral Contact Progress Note to document Case Consultation, Family Consultation and Collateral Contact services. This form can be used for either billable or non-billable services.

Data Field	Person's Name, Record Number, Type of Scheduled Contact, Service, and Purpose Instructions
Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth.
Organization Name:	Record the organization for whom you are delivering the service.
Type of Scheduled Contact	Indicate if contact was and *in-person meeting* or via *telephone.*
Service	Check **one** of the following services provided: **Case Consultation** (Code 90882)- a face-to-face or telephonic communication of at least 15 minutes duration, between the primary behavioral health clinician and another treating provider (not within the same agency) in order to identify, plan and coordinate treatment. Ex. PCP or Pediatrician, outside psychiatrist or therapist, state agency (DCF, DYS and DMH). Case consultation can be for persons of any age (both children and adults in treatment.) ***Please note****: Clinical supervision or consultation with other clinicians within the same provider agency are not billable.* **Family Consultation** (Code 90887) – a face-to-face or telephonic communication of at least 15 minutes duration between primary behavioral health clinician and the person's family in order to identify, plan and coordinate treatment. **Consultation or Collateral Contact (Code H0046?)-** is a face-to-face or telephonic communication of at least 15 minutes duration by the primary behavioral health clinician and an individual or agency, in order to support and/or reinforce the treatment plan for Medicaid **members who are under 19 years of age.** Collateral contacts include: teachers, principals, guidance counselors, day care providers, previous therapists, after school programs and community centers.
Purpose:	Check any of the following as relevant to the purpose(s) of this contact: *Assessment of the appropriateness of current services; Coordination/planning; Termination/Aftercare planning; Clinical consultation/Second Opinion (not supervision); Supporting Treatment objectives for the person's care; Other.* If *Other*, provide relevant information.

Data Field	List of Participants, Summary, Actions, and Responsible Party Instructions
List of Participants	Identify all who participated in the contact. List name(s), agency represented, and relationship(s) to person served.
Summary of IAP goals/objectives/interventions addressed with this contact	Indicate treatment goals, objectives, or interventions addressed during contact.
Actions that will occur as a result of this contact	Indicate any resulting actions to occur from this contact, e.g., "New appointment scheduled with PCC, change in frequency of therapy," etc.
Responsible Party	Indicate the person(s) responsible for carrying out the resulting action from this contact.
Data Field	**Staff Signatures Instructions**
Provider Name:	**Legibly** print the provider's name.
Provider Signature/ Credentials/ Title & Date:	**Legibly record provider's** signature, credentials and date. Example: William Jones, LICSW, 6/23/2008 Mary Calcaterra, Counselor
Supervisor Name	If required, **legibly** print name of supervisor. Check if "N/A". **Example: Jerry Smith, LMHC**
Supervisor Signature/Credentials & Date	If required, **legibly record supervisor's** signature, credentials and date.