
MEDICAL DOCUMENTATION BASIC WORKFLOW

+ USING THE PSYCH MEDICAL NOTE TEMPLATE

Updated: 11/05/25 (V3)

CalMHSA

TABLE OF CONTENTS

- Links to Key Educational Articles (3)
- Looking at historical data (4-8)
- General Medical Documentation with Psych Medical Note Template + Screens that Contribute to Template (9-33)
- Other Medical Workflows (34-36)

KEY LINKS TO GET STARTED

- [Outpatient Prescriber Quick Guide](#) and Comprehensive List
 - [Outpatient Nurses Quick Guide](#) and Comprehensive List
 - [Inpatient Comprehensive List](#)
 - [CSU Guides](#)
 - [Psych Medical Note Instructions](#)
 - [Psych Medical Note Template Associated to Procedure Codes](#)
 - [Shared Medical Care Plan](#)
 - [Keyphrases Set up for Admin](#)
 - [Users with Edit Agency Key phrases](#)
 - [How to Add, Edit, and Use Key Phrases: w/ Permission Only](#)
 - [How to document verbal medication consent in notes](#)
 - [How to Complete the AIMS Assessment](#)
 - [Client Medical Facesheet](#)
 - [CalMHSA 113 – Inpatient/CSU Client Face Sheet Report \(My Office\)](#)
 - [Abbreviated Notes Report](#)
 - [Cumulative Lab Report](#)
 - [CalMHSA MAR Report](#)
 - [How to Get a Summary of Care](#)
 - [How to Complete the Discharge Instructions](#)
 - [How to Complete the Discharge Summary](#)
 - [How to Create the Aftercare Discharge Summary Medical Report](#)
 - [Medication Reconciliation](#)
 - [CalMHSA MAR Report](#)
 - [Medication Reconciliation](#)
 - [Shift/Rounding Report](#)
 - [Nutritional Screening](#)
 - [How to Complete the Personal Effects Inventory \(PEI\)](#)
-

REVIEWING HISTORICAL DATA

- Client Facesheet Reports (5)
- Medication/Allergy Widgets (6)
- Review previous notes (7)
- Lab Results (8)

MEDICAL FACESHEETS

- [Client Medical Facesheet:](#)
High level overview of a patient's medical information
- There is also an inpatient-focused facesheet:
[CalMHSA 113 – Inpatient/CSU Client Face Sheet Report \(My Office\)](#)

Name: Child Delphine

Client ID: 1027

Age: 5



Client Medical Face Sheet

Preferred Name:

Pronoun: He

Address: 1215 20th Ave ~San Francisco 94122

Phone:

Pharmacy:

Email:

Signed Medication History Request Consent Duration:

Coverage:

Last AIMS: NO AIMS on file

Last CURES: NO CURES on file

Allergies/Intolerances/Failed Trials

Type	Allergy	Date	Severity/Reaction/Comments
Allergy	Amoxicillin	06-28-2024	S: Low R: Hives C: as a child
Allergy	Tylenol	07-09-2024	S: Low R: Low blood pressure
Failed Trial	Benadryl	06-28-2024	S: Moderate to severe R: Fainting C: can't use for sleep
Intolerance	NSAIDS (Non-Steroidal Anti-Inflammatory Drug)	06-28-2024	S: Mild to Moderate R: Abdominal cramps C: no GI bleed
Intolerance	pollen extracts	06-28-2024	S: Low R: Other

Last 3 Vitals	6/28/24 16:49	6/28/24 16:23	3/14/24 16:08
Reason for Not Obtaining Vitals		Client Refused	
No Vitals: Comments		test	
Temp. (F)	97.0	98.0	
Temp. Location		Mouth/Chest	

MEDICATION/ALLERGY WIDGETS

- Smartcare has other similar widgets CalMHSA has created our own active medication/prescription and allergy widgets. The SmartView allows a right sideview to appear on any client page without having to leave the page.
- [How to Add a Widget to Your Dashboard](#)
- [Use SmartView](#)

Delphine Huang

SmartView

Needs or Consideration)

Active Client Allergies Widget

Allergen Name	Reaction	Severity
bee pollen	Nausea and vomiting	mild
pistachio nut	Urticaria	Mild
chickpea	Hives	No Severity S
Sulfa (Sulfonamide Antibiotics)	Angioedema of tongue	Severe

Active Client Medications Widget

Drug	Directions	Reason/Ddx	Source	Start Date	Fill Date
(MULTISTEP) calamine-zinc oxide cream	Apply 1 a sm...	No Reason/D...	CalM...	No S...	No F...
lidocaine (PF), 10					

Client Dashboard

Active Client Medications Widget

Drug	Directions	Reason/Ddx	Source	Start Date	Fill Date
amoxicillin, 250 mg capsule	Take 1 capsule by mouth three times a day	No Reason/Ddx Specified	CalMHSA Rx	08/16/2024	08/16/2024
Normal Saline Flush, No Strength Specified syringe	Administer 1 ml subcutaneously once a day	No Reason/Ddx Specified	CalMHSA Rx	08/16/2024	08/16/2024
escitalopram oxalate, 10 mg tablet	Take 4 tablet by mouth once a day for 30 days Take at same time every day.	No Reason/Ddx Specified	CalMHSA Rx	08/22/2024	08/22/2024
lithium carbonate, 600 mg capsule	Take 2 capsule by mouth every night at bedtime for 60 days Take 2 at bedtime.	No Reason/Ddx Specified	CalMHSA Rx	08/22/2024	08/22/2024
purple pil, No Strength Specified No Form Specified	No Directions Specified	No Reason/Ddx Specified	CalMHSA Rx	No Start Date Specified	No Fill Date Specified

Active Client Allergies Widget

Allergen Name	Reaction	Severity	Onset Date	Last Modified By	Modified Date
Amoxicillin	Hives	Medium	No Onset Date Specified	calmhsa.delphine.huang	May 28 2024 5:07PM
Haloperidol	Neurologic Changes	High	No Onset Date Specified	calmhsa.delphine.huang	Jan 7 2025 9:31AM
Invega Hafyera	Neurologic Changes	High	No Onset Date Specified	calmhsa.delphine.huang	Jan 7 2025 9:28AM
Invega Sustenna	Low blood pressure	Low	No Onset Date Specified	calmhsa.delphine.huang	May 28 2024 5:07PM
Lithium	Dizziness	High	No Onset Date Specified	calmhsa.delphine.huang	Oct 5 2024 11:12AM
peanut	Difficulty breathing	Severe	2020	bsmith1525	Jan 3 2025 12:00PM
tree nut	Hives	Moderate	2019	bsmith1525	Jan 3 2025 12:00PM
Fish Containing Products	Hives	No Severity Specified	2013	bsmith1525	Jan 3 2025 12:00PM
amoxicillin	Angioedema	Severe	06/2024	bsmith1525	Jan 7 2025 10:00AM
haloperidol	Neuroleptic malignant syndrome	Severe	06/2024	bsmith1525	Jan 7 2025 9:45AM
antipsychotics	Neuroleptic malignant syndrome	Severe	06/2022	bsmith1525	Jan 7 2025 10:15AM

NOTES

Services (Client) List Page and/or Documents (Client) List Page will show services notes and documents, their authors, and their statuses.

[How to View Client Documents](#)

[Abbreviated Notes Report](#)- compilation of all notes from all clinicians and primarily where people would write their "plans" for a client.

Most of the information in the client abbreviated notes report will NOT pull into the medical / psych note, primarily just the subjective and A/P sections.

You can search for short terms to help narrow your note search.

If you are looking for full PDFs of Notes within the last 90 days, you can use the [Note Service Reviewer](#).

ProgramIDs

MH Access, MH Adult Outpatient

ProcedureCodeIDs

Assessment MD, Crisis Interventio

AuthorIDs

Watson, Chris, Nurse, Test, Huang

StartDate

EndDate

(Select All)

Assessment MD

Crisis Intervention/Mobile Cris

Individual Therapy

Medical Team Conference,Par

Medication Support Existing C

Medication Support New Clie

1 of 2 ?

Find | Next

Client Abbreviated Notes Report

Delphine, David (1024)

Author Name	Procedure Code	Service Date	FTF	Program	Status Desc
Caraveo, Sabrina	Psychosocial Rehabilitation Group	11/26/23	60.00	MH Adult Outpatient	In Progress
Progress Note Information test					
Progress Note Care Plan plan to have pt talk with his daughter and set up time with group therapy on Tuesdays					
Huang, Delphine	Crisis Intervention/Mobile Crisis	10/09/23	30.00	MH Access	Signed
Progress Note Information Pt is feeling more agitated and concerned about his well being though no SI. Talked with family including daughter who states that she will stay with pt until morning and call the psychiatrists					
Progress Note Care Plan sent to psychiatrist and therapist a message to f/u					
Huang, Delphine	Medical Team Conference,Participation by Physician. Pt and/or Family Not Pr	10/09/23	30.00	MH Adult Outpatient	Signed
Narrative met with team and discussed pt change in behavior and discussed with therapist ,nurse and case manager that he may need more frequency engagements					
Huang, Delphine	Individual Therapy	10/09/23	60.00	MH Adult Outpatient	Signed
Progress Note Information Discussed with pt how he has been having a lot of anger towards his family.					
Progress Note Care Plan plan to have pt talk with his daughter and set up time with group therapy on Tuesdays					
Huang, Delphine	Medication Support Existing Client	10/09/23	30.00	MH Adult Outpatient	Signed
Psych Note Chief Complaint Patient came in today bc he he has issues with controlling his anger at his family and feels out of control					
Psych Note Plan Plan to start pt on lexapro and risperadone to help with his depression. Follow up with his therapist and call his daughter					

LAB RESULTS

- Cumulative Lab Report-
cumulative report of labs results across time for a client
- Psych / Medical note will pull in last 2 months of labs, to view historical report of labs, please see the cumulative lab report.
- You can also look at individual lab order results if you click into the lab order itself. It is here that you can mark off if the results have been reviewed.

Pre-set, changeable dates for 2 years-current date

Can "Select All" or choose specific labs to visualize.

Lab ranges, if available, are provided next to the lab name.

"Red" labs indicate that abnormal labs based on lab range.

Workflow	1/1/2020	1/1/2021	1/1/2022	1/1/2023	1/1/2024	1/1/2025	1/1/2026	1/1/2027	1/1/2028	1/1/2029	1/1/2030	1/1/2031	1/1/2032	1/1/2033	1/1/2034	1/1/2035	1/1/2036	1/1/2037	1/1/2038	1/1/2039	1/1/2040	1/1/2041	1/1/2042	1/1/2043	1/1/2044	1/1/2045	1/1/2046	1/1/2047	1/1/2048	1/1/2049	1/1/2050
Available Labs to Include	Comprehensive Metabolic Panel (CMP)																														
21	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
For Flow Sheets Review	Lab (displayed in PDF) de-link																														
Comprehensive Metabolic Panel (CMP)	LABORATORY TESTS (PDF)																														
ABNORMAL LABS (EXCLUDED)	20	30	0		20	31		0	31		30	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51
ABNORMAL LABS (EXCLUDED)	47	48	49		49	50		49	50		50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
ABNORMAL LABS (EXCLUDED)	200	201	202		200	201		201	202		201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221
ABNORMAL LABS (EXCLUDED)	400	401	402		400	401		400	401		400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420
ABNORMAL LABS (EXCLUDED)	600	601	602		600	601		600	601		600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620
ABNORMAL LABS (EXCLUDED)	800	801	802		800	801		800	801		800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820
ABNORMAL LABS (EXCLUDED)	1000	1001	1002		1000	1001		1000	1001		1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020
ABNORMAL LABS (EXCLUDED)	1200	1201	1202		1200	1201		1200	1201		1200	1201	1202	1203	1204	1205	1206	1207	1208	1209	1210	1211	1212	1213	1214	1215	1216	1217	1218	1219	1220
ABNORMAL LABS (EXCLUDED)	1400	1401	1402		1400	1401		1400	1401		1400	1401	1402	1403	1404	1405	1406	1407	1408	1409	1410	1411	1412	1413	1414	1415	1416	1417	1418	1419	1420
ABNORMAL LABS (EXCLUDED)	1600	1601	1602		1600	1601		1600	1601		1600	1601	1602	1603	1604	1605	1606	1607	1608	1609	1610	1611	1612	1613	1614	1615	1616	1617	1618	1619	1620
ABNORMAL LABS (EXCLUDED)	1800	1801	1802		1800	1801		1800	1801		1800	1801	1802	1803	1804	1805	1806	1807	1808	1809	1810	1811	1812	1813	1814	1815	1816	1817	1818	1819	1820
ABNORMAL LABS (EXCLUDED)	2000	2001	2002		2000	2001		2000	2001		2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
ABNORMAL LABS (EXCLUDED)	2200	2201	2202		2200	2201		2200	2201		2200	2201	2202	2203	2204	2205	2206	2207	2208	2209	2210	2211	2212	2213	2214	2215	2216	2217	2218	2219	2220
ABNORMAL LABS (EXCLUDED)	2400	2401	2402		2400	2401		2400	2401		2400	2401	2402	2403	2404	2405	2406	2407	2408	2409	2410	2411	2412	2413	2414	2415	2416	2417	2418	2419	2420
ABNORMAL LABS (EXCLUDED)	2600	2601	2602		2600	2601		2600	2601		2600	2601	2602	2603	2604	2605	2606	2607	2608	2609	2610	2611	2612	2613	2614	2615	2616	2617	2618	2619	2620
ABNORMAL LABS (EXCLUDED)	2800	2801	2802		2800	2801		2800	2801		2800	2801	2802	2803	2804	2805	2806	2807	2808	2809	2810	2811	2812	2813	2814	2815	2816	2817	2818	2819	2820
ABNORMAL LABS (EXCLUDED)	3000	3001	3002		3000	3001		3000	3001		3000	3001	3002	3003	3004	3005	3006	3007	3008	3009	3010	3011	3012	3013	3014	3015	3016	3017	3018	3019	3020
ABNORMAL LABS (EXCLUDED)	3200	3201	3202		3200	3201		3200	3201		3200	3201	3202	3203	3204	3205	3206	3207	3208	3209	3210	3211	3212	3213	3214	3215	3216	3217	3218	3219	3220
ABNORMAL LABS (EXCLUDED)	3400	3401	3402		3400	3401		3400	3401		3400	3401	3402	3403	3404	3405	3406	3407	3408	3409	3410	3411	3412	3413	3414	3415	3416	3417	3418	3419	3420
ABNORMAL LABS (EXCLUDED)	3600	3601	3602		3600	3601		3600	3601		3600	3601	3602	3603	3604	3605	3606	3607	3608	3609	3610	3611	3612	3613	3614	3615	3616	3617	3618	3619	3620
ABNORMAL LABS (EXCLUDED)	3800	3801	3802		3800	3801		3800	3801		3800	3801	3802	3803	3804	3805	3806	3807	3808	3809	3810	3811	3812	3813	3814	3815	3816	3817	3818	3819	3820
ABNORMAL LABS (EXCLUDED)	4000	4001	4002		4000	4001		4000	4001		4000	4001	4002	4003	4004	4005	4006	4007	4008	4009	4010	4011	4012	4013	4014	4015	4016	4017	4018	4019	4020
ABNORMAL LABS (EXCLUDED)	4200	4201	4202		4200	4201		4200	4201		4200	4201	4202	4203	4204	4205	4206	4207	4208	4209	4210	4211	4212	4213	4214	4215	4216	4217	4218	4219	4220
ABNORMAL LABS (EXCLUDED)	4400	4401	4402		4400	4401		4400	4401		4400	4401	4402	4403	4404	4405	4406	4407	4408	4409	4410	4411	4412	4413	4414	4415	4416	4417	4418	4419	4420
ABNORMAL LABS (EXCLUDED)	4600	4601	4602		4600	4601		4600	4601		4600	4601	4602	4603	4604	4605	4606	4607	4608	4609	4610	4611	4612	4613	4614	4615	4616	4617	4618	4619	4620
ABNORMAL LABS (EXCLUDED)	4800	4801	4802		4800	4801		4800	4801		4800	4801	4802	4803	4804	4805	4806	4807	4808	4809	4810	4811	4812	4813	4814	4815	4816	4817	4818	4819	4820
ABNORMAL LABS (EXCLUDED)	5000	5001	5002		5000	5001		5000	5001		5000	5001	5002	5003	5004	5005	5006	5007	5008	5009	5010	5011	5012	5013	5014	5015	5016	5017	5018	5019	5020
ABNORMAL LABS (EXCLUDED)	5200	5201	5202		5200	5201		5200	5201		5200	5201	5202	5203	5204	5205	5206	5207	5208	5209	5210	5211	5212	5213	5214	5215	5216	5217	5218	5219	5220
ABNORMAL LABS (EXCLUDED)	5400	5401	5402		5400	5401		5400	5401		5400	5401	5402	5403	5404	5405	5406	5407	5408	5409	5410	5411	5412	5413	5414	5415	5416	5417	5418	5419	5420
ABNORMAL LABS (EXCLUDED)	5600	5601	5602		5600	5601		5600	5601		5600	5601	5602	5603	5604	5605	5606	5607	5608	5609	5610	5611	5612	5613	5614	5615	5616	5617	5618	5619	5620
ABNORMAL LABS (EXCLUDED)	5800	5801	5802		5800	5801		5800	5801		5800	5801	5802	5803	5804	5805	5806	5807	5808	5809	5810	5811	5812	5813	5814	5815	5816	5817	5818	5819	5820
ABNORMAL LABS (EXCLUDED)	6000	6001	6002		6000	6001		6000	6001		6000	6001	6002	6003	6004	6005	6006	6007	6008	6009	6010	6011	6012	6013	6014	6015	6016	6017	6018	6019	6020
ABNORMAL LABS (EXCLUDED)	6200	6201	6202		6200	6201		6200	6201		6200	6201	6202	6203	6204	6205	6206	6207	6208	6209	6210	6211	6212	6213	6214	6215	6216	6217	6218	6219	6220
ABNORMAL LABS (EXCLUDED)	6400	6401	6402		6400	6401		6400	6401		6400	6401	6402	6403	6404	6405	6406	6407	6408	6409	6410	6411	6412	6413	6414	6415	6416	6417	6418	6419	6420
ABNORMAL LABS (EXCLUDED)	6600	6601	6602		6600	66																									

NOTE TEMPLATE

- [Create a new service note using the psych medical note template](#) link
 - Transition from old psychiatric note (10)
 - Service Tab (11-12)
 - Initialization of Previous Note's Textbox (13)
 - Show/Hide Functionality: Do not Include in PDF and Delete from Note checkboxes (14)
 - Manual Refresh (15)
 - Keyphrases (16)
 - SOAP Format
 - Subjective Section (17)
 - Client History Section (18)
 - Lab Results (19)
 - Allergies (20)
 - Active Prescriptions, Home Meds and Orders (21-23)
 - Medication Consents (24-25)
 - Vitals (26)
 - MSE/PE + AIMS (27)
 - Diagnoses/Problem List (28)
 - A/P + CURES + Shared Plan Report (29-30)
 - Additional Information (31)
 - Billing Diagnosis (32)
 - Completing Note, Amend Note, Cosigning, Proxy/Reviewer (33)
-

TRANSITION FOR THE OLD PSYCHIATRIC NOTE

If there are any information in the following sections from the old “Psychiatric Note Template,” there will be a one-time push for each client regardless of procedure code to the new “Psych/Medical Note” template (if assigned to the associated procedure code). It will only initialize the push also if it is the same author, and same CDAG.

Psychiatric Note Template (OLD)	Psych/Medical Note Template (NEW)
Today's Chief Complaint	Subjective/CC/HPI/Visit Notes
History of Present Illness	Client History & Pertinent Information
Mental Status Exam Additional Comments, Descriptions. <i>(This excludes the individual sections of the MSE's radio buttons and/or their associated comments section)</i>	MSE/PE
Plan	Assessment and Plan

SERVICES TAB

What will show up on the final PDF

- Status*
- Program*
- Procedure*
- Location*
- Mode of Delivery
- StartDate*
- Start Time*
- Travel Time (if needed)
- Documentation Time
- Service Time*
- Attending (if needed)*

Psych/Medical Note

Effective 07/22/2024  Status New Author Huang, Delphine

Service	Note	Billing Diagnosis	Add-On Codes	Warnings
Service				
Status	Show			
Program	MH Adult Outpatient			
Procedure	 Prescriber New E/M (OP)			Modifier...
Location	Office			
Clinician	Huang, Delphine			
Mode Of Delivery	Face-to-face			
Cancel Reason				
Evidence Based Practices				
Transportation Service	No			
Start Date	07/22/2024			
Start Time	10:30 AM			
Travel Time				Minutes
Documentation Time				Minutes
Service Time	30			Minutes
Attending	Huang, IPCalMHSA			
Referring				
☐ Interpreter Services Needed				
Custom Fields				

PROCEDURE CODES

Psych Medical Note Template Associated to Procedure Codes- which notes will have the new template and any changes to the "Display As" name.

Which procedure code to use in which scenario is county dependent. Please talk to your admins if you have questions.

CalMHSA Procedure Code ID	CPT	Planned Changes to the Procedure Code Label and add new Template	Current procedure code label	Suggested Facility Type/Role or License/Use Case
80	90792	Prescriber Assessment E/M (OP)	Assessment MD	Outpt: Prescriber, Initial Assessment
74	99201-99205	Prescriber New E/M (OP)	Medication Support New Client	Outpt: Prescriber
73	99212-99215	Prescriber Progress E/M (OP)	Medication Support Existing Client	Outpt: Prescriber
107	99441-99443	Prescriber Telephone E/M (OP)	Medication Support Telephone	Outpt/IP/PHF/CSU/Res: Prescriber
72	99242-99245	Prescriber Consult (OP)	Consult for New and Established Patients	Outpt: Prescriber
49	99451	Physician-to-Physician Consult	Physician Consultation	Outpt/IP/PHF/CSU/Res: only MD/DO to MD/DO Consultation

INITIALIZATION OF PREVIOUS NOTE'S TEXTBOX

Textbox Data will only initialize If:

- Same Client
- Same Author

Within different programs and different procedures (that also meet the same client, same author criteria) and use the psych medical note template, will initialize from last signed.

If this is not intended, then user will need to manually remove data.

If you go to a different screen that data will hold if you don't close out the note, BUT we highly recommend that you also "Save" often.

Psych/Medical Note

Effective: 07/22/2024 Status: New Author: Huang, Delphine

Service Note Billing Diagnosis Add-On Codes Warnings

Show PDF Sections Hide PDF Sections ☐ Select ALL "Do not include in PDF"

* Subjective/CC/HPI/Visit Notes

Client History & Pertinent Information ☐ Do not include in PDF

Recent Labs/Tests ☐ Do not include in PDF

Labs	Date	Flag	Value	Range	Comments	Reviewed
------	------	------	-------	-------	----------	----------

Allergies/Intolerances/Failed Trials ☐ NKDA ☐ Do not include in PDF

Type/Drug	Severity	Reaction	Comments
orange	High		
dog dander	High		
Penicillins			severe hives, DO NOT GIVE
Strawberry			client informed of reactions
cat dander	Severe	Wheezing	anaphylaxis allergy
Intolerances			
Failed Trials			

Current Medications ☐ Do not include in PDF

Medication Consent?	Drug Name	Instructions	Start Date	Refills	Ordered By
---------------------	-----------	--------------	------------	---------	------------

Current Self-Reported Medications ☐ Do not include in PDF

Drug Name	Instructions	Start Date	Comments	Source
-----------	--------------	------------	----------	--------

Vitals ☐ Do not include in PDF

Vital

MSE/PE ☐ AIMS completed during visit ☐ Do not include in PDF

SHOW AND HIDE PDF SECTIONS FUNCTIONALITY

The reason why we included this functionality is :

- 1) To appease lumpers and splitters writers and give agency to end users about what type of note they want to use.
- 2) Can choose because having a comprehensive note with multiple sections or less sections depending on the user and type of visit.
- 3) Can preview ahead of time the pdf by toggling between Show and Hide PDF Sections
- 4) Remove checkbox for "Do not include in PDF"/Delete from Note" if you want have new information that was added to the section.
- 5) If there is no checkbox for "Do not include in PDF/ Delete from Note" then, the data in that textbox will initialize to subsequent note.
- 6) If there is a mark in the checkbox, then the data will NOT initialize to the subsequent note, only the last signed section will show up next time.

"Do Not Include in PDF" Functionality

The screenshot shows a web interface with a tabbed header containing 'Service', 'Note' (which is selected), 'Billing Diagnosis', and 'Warnings'. Below the tabs, there is a toolbar with three items: a 'Show PDF Sections' button, a 'Hide PDF Sections' button, and a checkbox labeled 'Select ALL "Do not include in PDF"'. The checkbox is currently unchecked. Below the toolbar is a large text area with a placeholder text '* Subjective/CC/HPI/Visit Notes'. A vertical scrollbar is visible on the right side of the text area.

MANUAL REFRESH

If you leave the note's screen, the system will refresh automatically. However, if you added data from a different source and this information is pushing to tables (eg Diagnosis/Problem List, Orders, Allergies) and you do not see the information automatically show up, you may need to manually refresh to push the new data in.

Psych/Medical Note

Effective

09/28/2025

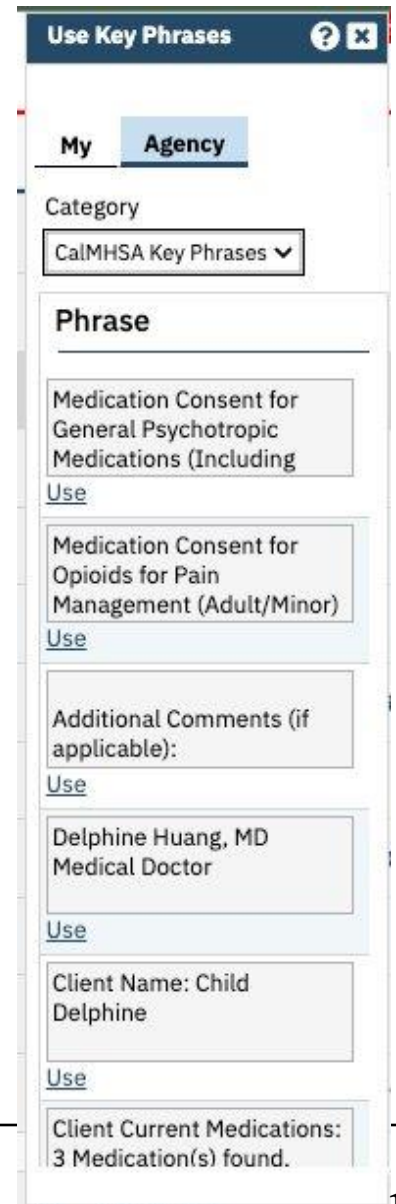
Service	Note	Billing Diagnos
---------	------	-----------------

Refresh Data

S

LEVERAGING KEY PHRASES

- Keyphrases can be used to take preset text and autoloading into their note
- It allows customization of the template
 - Creating Assessment as Key Phrases
 - Functional Keyphrases are available for use to pull in specific data (*digital instructions pending for end users*)
 - Counties should make and organize county level/agency level key phrases to support their end users and standardize as they see necessary.
 - End users should learn how to create key phrases to expedite their documentation.
 - Instructions
 - [Keyphrases Set up for Admin](#)
 - [Users with Edit Agency Key phrases](#)
 - [How to Add, Edit, and Use Key Phrases: w/ Permission Only](#)
 - [How to document verbal medication consent in notes](#)



The screenshot shows a web application window titled "Use Key Phrases" with a help icon and a close button. Below the title bar, there are two tabs: "My" and "Agency", with "Agency" selected. A "Category" dropdown menu is set to "CalMHSA Key Phrases". The main content area is titled "Phrase" and lists several phrases, each with a "Use" button. The phrases are:

- Medication Consent for General Psychotropic Medications (Including)
- Medication Consent for Opioids for Pain Management (Adult/Minor)
- Additional Comments (if applicable):
- Delphine Huang, MD Medical Doctor
- Client Name: Child Delphine
- Client Current Medications: 3 Medication(s) found.

SUBJECTIVE SECTION

Refresh Data	Show PDF Sections	Hide PDF Sections	☐ Select ALL "Do not include in PDF" / "Delete from the Note"
Subjective/CC/HPI/Visit Notes			☐ Delete from the Note
30 year old man with hx of S1x2 in the last year and depression. Trouble with school and concentrating on the job. Depression has been well controlled on medications but recently his anxiety has worsen.			

This section can be used to capture the subjective part of a patient visit. It can also be used to record visit notes, and if you choose to not document using any other sections. The "Delete From Note" functionality is available.

CLIENT HISTORY

PH

t Plan - DH

Client History & Pertinent Information Last Updated On: 06/28/2024

☒ Do not include in PDF

Psychiatric History:

Medical History:

Substance Use History:

Social History:

Family History:

Recent Labs/Tests

☒ Do not include in PDF

This section can be used to capture the patient’s history such as their previous psychiatric, medical, medication, or program history. It can also be used to capture any social, substance use, family history, pertinent tests. The “Do Not Include in PDF” functionality can be utilized.

We highly recommend creating Key Phrase Templates (slide 12) to assist with what client history you want your staff to collect. It is different for every user, clinic, and county.

LAB RESULTS

This section pushes two months of lab data into the note.

It includes the lab name, result date, if any abnormality (H = high, L= low, N=Normal), the lab value, the range, lab comments, and if it has been reviewed by staff.

The “Do Not Include in PDF” functionality can be utilized.

Psych/Medical Note

Effective07/22/2024

StatusNew

AuthorWatson, Chris

07/01/2024

Service

Note

Billing Diagnosis

Add-On Codes

Warnings

Recent Labs/Tests

☐ Do not include in PDF

Labs	Date	Flag	Value	Range	Comments	Reviewed
BASOPHILS	5/31/2024	N	0.3			
EOSINOPHILS	5/31/2024	N	1.0			
MONOCYTES	5/31/2024	N	9.1			
LYMPHOCYTES	5/31/2024	N	36.0			
NEUTROPHILS	5/31/2024	N	53.6			
ABSOLUTE BASOPHILS	5/31/2024	N	17	0-200		
ABSOLUTE EOSINOPHILS	5/31/2024	N	58	15-500		
ABSOLUTE MONOCYTES	5/31/2024	N	528	200-950		
ABSOLUTE LYMPHOCYTES	5/31/2024	N	2088	850-3900		
ABSOLUTE NEUTROPHILS	5/31/2024	N	3109	1500-7800		
MPV	5/31/2024	N	10.3	7.5-12.5		
PLATELET COUNT	5/31/2024	N	199	140-400		
RDW	5/31/2024	N	12.0	11.0-15.0		
MCHC	5/31/2024	L	31.3	32.0-36.0		
MCH	5/31/2024	N	27.5	27.0-33.0		
MCV	5/31/2024	N	87.8	80.0-100.0		
HEMATOCRIT	5/31/2024	L	33.2	38.5-50.0		
HEMOGLOBIN	5/31/2024	L	10.4	13.2-17.1		
RED BLOOD CELL COUNT	5/31/2024	L	3.78	4.20-5.80		
WHITE BLOOD CELL COUNT	5/31/2024	N	5.8	3.8-10.8		
WHITE BLOOD CELL COUNT	6/14/2024	N	8.7	3.8-10.8		
RED BLOOD CELL COUNT	6/14/2024	L	3.84	4.20-5.80		
HEMOGLOBIN	6/14/2024	L	10.0	13.2-17.1		

ALLERGIES

Allergies/Intolerances/Failed Trials ☐ DrFirst NKDA ☐ SmartCare NKDA ☐ Do not include in PDF

Type/Drug	Severity	Reaction	Comments
<u>Allergies</u>			
bee pollen	mild	Nausea and vomiting	
chickpea		Hives	
pistachio nut	Mild	Urticaria	
Sulfa (Sulfonamide Antibiotics)	Severe	Angioedema of tongue	
<u>Intolerances</u>			
<u>Failed Trials</u>			

Authors can input or edit from the [Allergies, Intolerance and Failed Trials from Medication Rx](#) and/or the [Allergies \(Client\) screen](#). It will list the type of allergy (Allergy, Intolerance, Failed Trial), severity, reactions and comments.

[Allergies from CalMHSA Rx](#) also push into this note. It will list severity and reactions.

The Do Not Include in PDF” functionality can be utilized.

MEDICATIONS/PRESCRIPTIONS

Current Medications

☐ Do not include in PDF

Consent?	Drug Name	Instructions	Start Date (Fill Date)	Refills	Ordered By	Source
☐	Invega Hafyera 1,092 mg/3.5 mL intram...	Inject 1092 mg intramuscularly once a ...	5/2/2025 (5/30/2...	2.00	Smith, Bonnie	CalMHSA Rx
☐	aspirin 81 mg tablet	Take 1 tablet by mouth once a day for 3...	5/3/2025 (5/13/2...	2.00	Smith, Bonnie	CalMHSA Rx
☐	Acetaminophen	80mg, TbDi, oral 1 each Twice A Day	5/27/2025	0.00	Huang, Delphine	Client Orders
☐	Bupropion HCl	150mg, SR12, oral 1 each Twice A Day	9/28/2025	0.00	Huang, Delphine	Client Orders

This section will pull prescriptions/medications from [Client Orders/Medication Rx](#) or [CalMHSA Rx](#) modules. It will only display medications that are active, and the end date has not expired within 1 year. It will include the number of refills and who prescribed the medications.

The “Do Not Include in PDF” functionality can be utilized.

HOME MEDICATIONS

Current Self-Reported Medications ☐ Do not include in PDF

Drug Name	Instructions	Start Date (Last Writte...	Comments	Info Provided By
calamine 3 %-zinc oxide 20 % topical cream	Apply 1 a small amount to skin twice a day as ...			
risperidone 1 mg/mL oral solution				
lidocaine (PF) 10 mg/mL (1 %) injection solution				
lidocaine (PF) 3.5 % eye gel	Apply 2 drop into affected eye once a day for 1...			
risperidone 1 mg/mL oral syringe (FOR ORAL U...	Take 120 mg by mouth twice a day for 10 days...	1/1/2018 (4/20/2025)		Patient
albuterol sulfate HFA 90 mcg/actuation aeroso...	Inhale 2 vial using inhaler once a day as neede...	8/3/2016 (4/24/2025)		PBM/Pharmacy
prednisone 1 mg tablet	Take 5 tablet by mouth for 10 days			

This section will push non-prescribed/home medication from Medication Rx module’s [“Add Medication”](#) section and [CaIMHSA Rx](#) module. It will only display medications that are active and the end date has not expired. It will include “Comments” and “Source”. The initiated date is displayed here.

The “Do Not Include in PDF” functionality can be utilized

ORDERS

Current Orders - Non-Medications

☐ Do not include in PDF

Type	Description	Date	Ordered By
Additional	5150 - Legal	5/20/2024	Caraveo, Sabrina
Additional	Rx Order	4/14/2025	Huang, Delphine
Additional	5150 - Legal	6/6/2025	Huang, Delphine
Additional	5150 - Legal	8/18/2025	Ngo, Lam
Additional	5150 - Legal	8/5/2025	Ngo, Lam
Labs	pregnancy test (Lab Corp - 83456)	8/19/2025	Caraveo, Sabrina

This section will push non-medication active Client Orders (eg lab, nursing, legal, additional order types) from Client Order screen.

The “Do Not Include in PDF” functionality can be utilized

MEDICATION CONSENTS

Current Medications

Consent? Prev	Drug Name	Instructions	Start Date (Fill Date)	Refills	Ordered By	Source
☐	Y Prozac 10 mg capsule	Take 1 capsule by mouth once a day fo...	11/3/2025	0.00	Smith, Bonnie	CalMHSA Rx
☒	Y carvedilol 3.125 mg tablet	Take 2 tablet by mouth every morning f...	11/4/2025	0.00	Smith, Bonnie	CalMHSA Rx
☒	N Albuterol Sulfate 0.63mg/3 mL, nebu, i...	1 Puff Inhalation Every 4 Hours	11/4/2025	0.00	Watson, Chris MD ...	Medication Rx
☐	N Lithium Carbonate 300mg, cap, Oral	1 each Oral Once A Day	11/5/2025	0.00	Watson, Chris MD ...	Medication Rx

- If verbal or written consent is captured for certain medications, you can check off that you captured this under the medication consent column.
 - [How to Document Medication Consents within the Psych Medical Note Template or Any Textbox](#)
- If you want to see a compiled medication list from all providers, please use [CalMHSA 116 – Medication Consent From Psych Medical Note Template](#).

Test,Cw (1112)
DOB: 02-10-1980

CalMHSA
California Workforce Solutions

**Medication Consent
From Psych Medical Note Template**

Medication Name ↕	Date First Consent Was Obtained	Provider ↕
Ozempic	10/30/2025	Test, Cw
lithium carbonate	10/07/2025	Test, Cw
Lexapro	10/07/2025	Test, Cw
Paxil	10/30/2025	Test, Cw

~v19

Page 1 of 1

MEDICATION CONSENT KEYPHRASES

My Agency

Category

CalMHSA Key Phrases

Phrase

Medication Consent for General Psychotropic Medications (Including

Use

Medication Consent for Opioids for Pain Management (Adult/Minor)

Use

Medication Consent for MAT (OTP/NTP)

Use

Use Key Phrases

My Agency

Category

CalMHSA Key Phrases

Phrase

Medication Consent for General Psychotropic Medications (Including

Use

Medication Consent for Opioids for Pain Management (Adult/Minor)

Use

Medication Consent for MAT (OTP/NTP)

Use

Delphine Huang, MD Medical Doctor

Client Name: Carlos Delphine

Use

Psych/Medical Note

Effective 07/22/2024 Status New Author Huang, Delphine 06/07/2024

Service Note Billing Diagnosis Add-On Codes Warnings

MSE/PE ☐ AIMS completed during visit ☐ Do not include in PDF

38 year old man presenting with depression and seen in clinic for management. He has been failing on taking his medications due to side effects. Plan is to switch to Sertraline today.

Medication Consent for General Psychotropic Medications (Including Antipsychotics)

Explained to patient that I will be prescribing the following medication(s) for treatment of their presenting symptoms:

6 Medication(s) found.
Medication #1: sertraline 25 mg tablet, 1.00 Tab- Oral, Once A Day, Take with food, 07/22/2024 - 08/20/2024.
Medication #2: dexamethasone 0.5 mg tablet, 1.00 Tab- Oral, Once A Day, N/A, No Medication Start Date - No Medication End Date.
Medication #3: lisinopril 10 mg tablet, 1.00 Tab- Oral, Once A Day, Take with food, 07/22/2024 - 08/20/2024.
Medication #4: ibuprofen 400 mg tablet, 1.00 Tab- Oral, Once A Day, N/A, No Medication Start Date - No Medication End Date.
Medication #5: amoxicillin 250 mg capsule, 1.00 Cap- Oral, Once A Day, N/A, 07/01/2024 - No Medication End Date.
Medication #6: Tylenol 325 mg tablet, 1.00 Tab- Oral, Once A Day, N/A, No Medication Start Date - No Medication End Date.

Additionally, we reviewed the nature of the patient's medical condition: the reasons/goals for taking such medication(s), including the likelihood of improving or not

improving without such medication(s), and that consent, once reasonable alternative treatments available, if any; the probable side effects of these drugs known to commonly occur, any particular side effects likely to occur to this particular patient, and the possible additional side effects which may occur to patients taking such medication beyond three months. The patient was advised of the following side effects include:

[INSERT RELEVANT SIDE EFFECTS DISCUSSED]

[Patient or guardian/parent] verbally indicated understanding: noted above.

Additional Comments (if applicable):

38 year old man presenting with depression and seen in clinic for management. He has been failing on taking his medications due to side effects. Plan is to switch to Sertraline today.

Medication Consent for General Psychotropic Medications (Including Antipsychotics)

Explained to patient that I will be prescribing the following medication(s) for treatment of their presenting symptoms:

Medication #1: sertraline 25 mg tablet, 1.00 Tab- Oral, Once A Day, Take with food, 07/22/2024 - 08/20/2024.

Additionally, we reviewed the nature of the patient's medical condition; the reasons/goals for taking such medication(s), including the likelihood of improving or not improving without such medication(s), and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff. Reasonable alternative treatments available, if any; the probable side effects of these drugs known to commonly occur, any particular side effects likely to occur to this particular patient, and the possible additional side effects which may occur to patients taking such medication beyond three months. The patient was advised of the following side effects include:

nausea, diarrhea, constipation, dry mouth, loss of appetite, weight changes, sexual issues

[Patient verbally indicated understanding the nature and effect of the medications noted above and consents to administration of the medication(s) noted above.

Additional Comments (if applicable):

Use vetted Medication Consent Keyphrases to be efficient to document consents. Remove any medications that are not relevant if using CalMHSA's template

VITALS

Vitals		☐ Do not include in PDF	
Vital	3/14/2024	3/12/2024	
Temp. (F)	98.0 F		
Pulse (bpm)	100 bpm	80 bpm	
Blood Pressure	180 / 100 (mmHg)	120 / 80 (mmHg)	
BP Position	Standing	Sitting	
Breaths/Min	20	30	
Oxygen level	100		
Height (in)	60.00 In	60.00 In	
Weight (lbs)	200.00 lb	150.00 lb	
BMI (lbs/in2)	39.06 lbs/in2	29.29 lbs/in2	
Pain Level	5		
Pain Location	Mouth		

This section will pull the last 3 vitals within a CDAG from the “Vitals/Meaningful Use” Flowsheet or “Enter Vitals”. This information will refresh the note automatically with any added information. The “Do Not Include in PDF” functionality can be utilized.

[How to Document Vitals](#)

MSE/PE

Use Key Phrases ? x

My Agency

Category

MSE/PE Key Phrases

Phrase

General/Appearance: Well-groomed
Attention: Normal Attention
[Use](#)

General/Appearance:
Attention and Perception:
Mood and Affect:
[Use](#)

Tylenol325mg, Tab, Oral each Once A DaySpanish SpeakerPatient Verbal

Vitals

Do not include in PDF

Vital	3/15/2024	3/15/2024	3/15/2024
Temp. (F)			98.0 F
Pulse (bpm)		90 bpm	120 bpm
Systolic BP (mmHg)		150	180
Diastolic BP (mmHg)		90	90
Breaths/Min			100

MSE/PE

AIMS completed during visit

Do not include in PDF

General/Appearance: Well-groomed
Attention: Normal Attention
Perception: Normal Perception
Mood and Affect: Euthymic mood, Appropriate affect
Speech: Clear and Coherent Speech
Behavior: Calm, Cooperative, Engaged, Good Eye Contact
Thought Process: Organized and Linear Thought Content
Thought Content: No Auditory Hallucinations, No Visual Hallucinations, No Delusions,
Suicidal/Homicidal: Has SI- plans shoot himself
Insight: Normal Insight

This is a section that can be used to document the Mental Status Exam or Physical Exam. We **highly recommend creating Key Phrases** to improve efficiency.

The “Do Not Include in PDF” functionality can be utilized.

AIMS Completed During Visit: The data collection should be done in the [AIMS Assessment Document](#) separately.

A user can choose to then mark the checkbox "AIMS completed during visit. This information will be displayed on the [Client Medical Facesheet](#) to notify users when it was last completed. This checkmark will NOT be retained for the subsequent note.

27

DIAGNOSES AND PROBLEMS LIST

- This section captures the [client's diagnoses](#) and [problem list](#) from any programs that are within the same CDAG. The active diagnosis captured by [Diagnosis Document](#) is included in the diagnosis sub-section. Also, any problems that are documented in the [Client Problem List](#) are demarcated in the Problem's subsection.
- Any common ICD10s are grouped together.
- The date represents the most recent entry for that ICD10 code.
- You can checkmark the issues that were addressed at the visit.
- Any selection will NOT retain its checkmark for the subsequent note.

Active Diagnoses (D) and Problem List (P) within Program

☐ Do not include in PDF

Addressed Today?	ICD10	Description	Date	Program
<u>Diagnoses</u>				
☒	F41.0	Panic disorder	3/13/2024	MH Access
☐	F32.A	Depression, unspecified	3/12/2024	MH Adult Outpatient
<u>Problems</u>				
☐	Z59.01	Sheltered homelessness	3/14/2024	MH Adult Outpatient

ASSESSMENT AND PLAN

* Assessment and Plan

☐ CURES reviewed during visit

☐ Add to Shared Care Plan

38 year old man presenting with depression and seen in clinic for management. He has been failing on taking his medications due to side effects. Plan is to switch to Sertraline today.

Medication Consent for General Psychotropic Medications (Including Antipsychotics)

Explained to patient that I will be prescribing the following medication(s) for treatment of their presenting symptoms:

Medication #1: sertraline 25 mg tablet, 1.00 Tab- Oral, Once A Day, Take with food, 07/22/2024 - 08/20/2024.

Additionally, we reviewed the nature of the patient’s medical condition; the reasons/goals for taking such medication(s), including the likelihood of improving or not

- This section can be used to capture the Assessment / Plan.
- There is a checkbox for you to capture if "CURES was reviewed during visit". This information will also be displayed in the [Client Medical Facesheet](#) so other users know when it was last completed. The check. Any selection will NOT retain its checkmark for the subsequent note.
- When the "Add to Shared Care Plan" checkbox is marked, it compiles any author that wants to contribute this visit's plan to a singular report, [CalMHSA 100 Shared Care Plan Report](#), to help consolidate important plans in one place. It also will be pushing to a future "Shared Treatment Plan" that will allow multidisciplinary teams to share their plans and to help with minimizing redundancy. The "Shared Treatment Plan" is planned to be released in 2026.
- The "Delete From Note" functionality is available.

CURES + ADD SHARED CARE PLAN

- **Documentation of CURES** being reviewed can be checked. This information will be displayed on the Client Medical Facesheet. This checkmark will NOT be retained for the subsequent note.
- **Add to Shared Care Plan:** This is optional, as we are still building out a future-state Shared Care Plan/Treatment Plan to be more collaborative and efficient in data collecting and data sharing.
 - The goal is that for facilities that use a shared care plan or treatment plan, individual's plans can feed into the document to reduce the need for double entry.
 - For now, if the box is checked, this saves to the [Shared Care Plan Report](#) which is a compilation of individual's psych medical note's A/P sections to facilitate ease of reading of all provider's A/Ps

https://calmhsasctt.smartcarenet.com/CalMHSA_SmartcareSandbox/ShowReport.aspx?ReportId=1ykcJmOPZk%3D&ReportServerId=RUNPkrllD3Q%3D&Sta

1 of 1 Find Next

Shared Care Plan of Medical Providers' Assessment and Plan 

Client Name	Adult, Sabrina
Client ID	1078
DOB	02-03-2000

Signed Date	Author	License	Program Name	Procedure Code
07/12/2024	Vera, Monique	MD Medical Doctor, MD Medical Doctor		Pysch Note Test

Assessment & Plan

your assessment and plan here

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. v2

Page 1 of 1

ADDITIONAL INFORMATION

This section is a flexible section for authors to capture information that does not fit in any above section but should be included. (For example: attending attestation, client's timeline within the program, family conversations, follow-up information). The "Delete From Note" functionality is available.

Additional Information

☐ Do not include in PDF

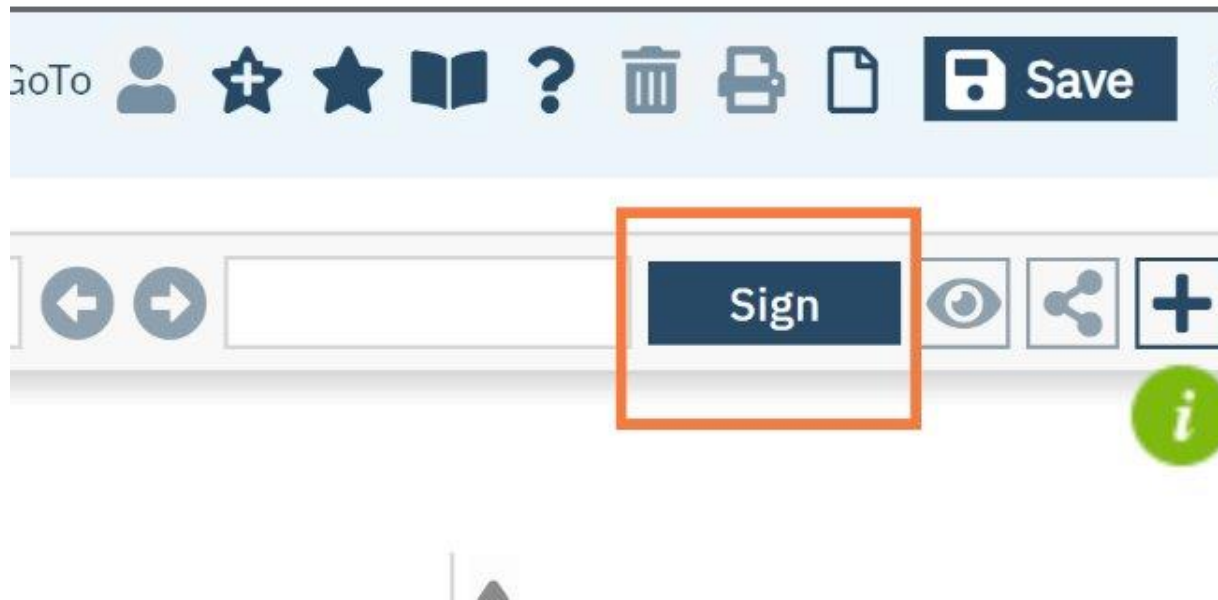
BILLING DIAGNOSIS

Service	Note	Billing Diagnosis	Add-On Codes	Warnings
Billing Diagnosis ICD 10... Order 1 Re-Order Diagnosis ICD/ DSM - Description F32.A - Depression, unspecified Refresh Diagnosis				

- Autopopulates from Diagnosis Document and is program specific
- No change in functionality here, as previously done.

COMPLETING NOTE

- Sign note by clicking on "Sign"
- Review PDF



Amend, Assign Co-signer and Proxy/Reviewer Functionality

- [How to Amend a Signed Document](#)
- [How to Add a Co-Signer to a Document](#)
- [Various Proxy Roles Functionalities](#)
- [Reviewer Process Add On for End Users](#)
- [Reviewer Process Add On for Supervisors and Reviewers](#)

OTHER MEDICAL WORKFLOWS

- Medication Reconciliation/Adherence
- Discharge/Aftercare Summary
- Assigned Documents
- Key inpatient/CSU Specific Screens

MEDICATION RECONCILIATION

Nursing/ medical staff can use this screen capture if a patient is taking medications or not. It will pull current medications or expired medications within last 1 year.

How to Complete a Medication Reconciliation

Delphine, Child (1027)

Delphine Huang

Client Medication Reconciliation List Page (3)

Med Name	Quantity	Form	Route	Schedule	Special Instructions	Start Date	End Date	Taking Med	Date Last Taken	Comments	Reconciled By	Last Reconciled Date
sertraline 25 mg tablet	1	Tab	Oral	Once A Day	N/A	06/28/2024	07/27/2024	?	N/A	N/A	N/A	07/16/2024
Tylenol 325 mg tablet	1	Tab	Oral	Once A Day	N/A	06/28/2024	N/A	?	N/A	N/A	N/A	07/16/2024
Ritalin 5 mg tablet	1	Tab	Oral	Once A Day								

Medication Reconciliation Questions

Actively Taking Medication?

☒ Yes ☐ No ☐ Unknown

Date Last Taken:

Medication Reconciliation Comments:

Pt is taking medication but having side effects.

DISCHARGE/ AFTERCARE SUMMARY

[How to Get a Summary of Care](#) - very extensive details

[How to Complete the Discharge Instructions](#) - pt focused

[How to Complete the Discharge Summary](#)- Text with some medical data

[How to Create the Aftercare Discharge Summary Medical Report](#) includes the Discharge Summary's text + medical relevant information (including changes to medications) , can be used for patients and/or transfer of care to other providers.

ASSIGNED DOCUMENTS

Use this to see what to-do's you may need including outstanding notes /documents under Assigned Documents Widget on the provider dashboard.

You can view any document that you are the author under:

[How to View Your Documents](#)

Assigned Document(s)				
	Notes	ISP	Assessment	ALL
Due Now	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
In Progress	<u>9</u>	<u>0</u>	<u>0</u>	<u>17</u>
Due in 14	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Co-Sign	<u>2</u>	<u>0</u>	<u>0</u>	<u>2</u>
To-Sign	<u>1</u>	<u>0</u>	<u>0</u>	<u>1</u>

INPATIENT SPECIFIC DOCS

- [Inpatient Comprehensive List](#)
- [CSU Guides](#)
- [CalMHSA 113 – Inpatient/CSU Client Face Sheet Report \(My Office\)](#)
- [CalMHSA MAR Report](#)
- [Medication Reconciliation](#)
- [Shift/Rounding Report](#)
- [Nutritional Screening](#)
- [Personal Effects Inventory](#)

Start Date6/6/2024End Date6/8/2024View Report

UnitCSU Adult, Inpatient A, Inpatient BClientsTest, Client, Test, Entry, Test, MariOrder TypesMedication, Additional, Nursing

1 of 1FindNext

MAR for 6/6/2024 through 6/8/2024

Unit(s): CSU Adult, Inpatient A, Inpatient B

Order Type(s): Medication, Additional, Nursing

		Thursday, June 6, 2024			Friday, June 7, 2024				Saturday, June 8, 2024							
Client	Order	08:00	20:00		08:00	17:17:00	17:21:00	21:00	01:00	05:00	08:00	09:00	13:00	17:17:00	17:21:00	21:00
Test, Client 788367041 DOB: 01/01/78	haloperidol 2 mg tablet 2.00 Tab, Oral, Twice A Day Medication ~ Active	?	?		?	✓										
	acetaminophen 325 mg capsule 2.00 Cap, Oral, Every 4 Hours Medication ~ Active						✓									
Test, Mona 800008717 DOB: 03/01/17	acetaminophen 325 mg capsule 1.00 Cap, Oral, Every 6 Hours As Needed Medication ~ Active															
Test, Reina 800000538 DOB: 02/22/00	acetaminophen 325 mg capsule 1.00 Cap, Oral, Once A Day As Needed Medication ~ Active															

Page 1 of 1v2

UnitCSU-Adult, IP-A, IP-B

Census for CSU-Adult, IP-A, IP-B

Unit/Bed	Client Name	Admit Date	Precautions	Legal/Pending Orders	Observations	Care Team	Coverage	Flags
IP-B 217A Psychiatric Inpatient Day - Adult	Client Test 788367041 DOB: 01-01-78 Age: 46	04/06/24 LOS: 8	B		Q30m Safety Check		DMH From: 03/02/24 To: NO END	Client Diagnosis Update Due: 04/09/24 Client Information Due: 04/16/24
IP-B 219A General Inpatient - Admin Day	Entry Test 758277000 DOB: 07-04-82 Age: 41	04/02/24 LOS: 12	U	5270-30 Day Cert Start: 04/14/24 13:36 End: 05/14/24 23:59 Pending at Lab: 1 Pending Review: 0	Diet Type Diabetic Other (add comments) Pureed Food Preference: Vegetarian	Heidi Allen Glen Xiong John Sawyer Panfilo Ibarra	DMH From: 12/01/23 To: NO END Managed Care-Aetna (601) From: 12/01/23 To: NO END MH County Funds From: 12/01/23 To: NO END	
IP-A 204A Psychiatric Inpatient Day - Adult	Mariana Test 800000128 DOB: 03-03-93 Age: 31	04/10/24 LOS: 4	S		Diet Type Cardiac/Low Sodium Diabetic			Client Diagnosis Update Due: 04/11/24 Client Information Due: 04/18/24