

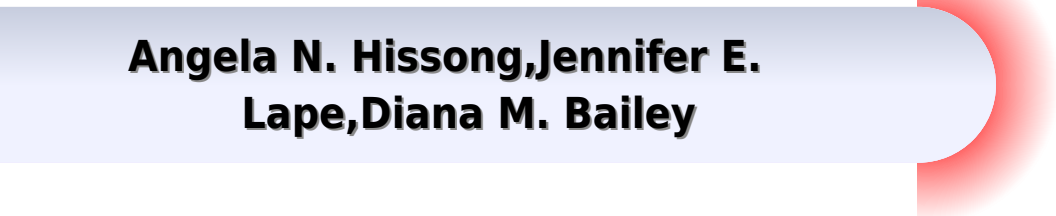
Group Psychotherapy Progress Note

The Group Psychotherapy Progress Note is used for billable outpatient psychotherapy groups. Use the Intensive Services Progress Note form to document other groups offered as part of programs such as Partial Hospitalization (PHP), Community Based Adolescent Treatment (CBAT) and Transitional Support Services (TSS).

Data Field	Identifying Information 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 to serve as another identifier.
Organization Name:	Record the organization for whom you are delivering the service.
Group Name	Give the name of the specific group. Example: Anger Management.
Number of Attendees	Enter the number of persons attending the group on this date.
Person Served Did Not Attend	Indicate the reason the person served did not attend the group session.
Data Field	Documentation of Person's Served Participation and Response to Group Treatment
Behavior in Group	Check box(es) to document the person's observed behavior during the group session.
Person's Served Mood	Check box(es) to document the person's observed or reported mood during the group session.
Stressors/Extraordinary Events/New Issues Presented Today	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that was resolved during the session check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions section and indicate the resolution in the Response section of the progress note. If services are provided during the session that have not been previously ordered in the Individualized Action plan, then an explanation of the rationale for those services should be provided. 3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. 4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same Date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form. Example: Person became uncharacteristically angry with another group member during the group session and the two began arguing loudly. Group therapist intervened and assisted person with identifying what had triggered excessive anger today. Person was able to recognize that the other group member reminded her of her abusive uncle and apologized to the other member. Example of New Issue needing CA Update: The person reported new symptoms of nightmares, intrusive memories, and

Sample Group Therapy Documentation

**Angela N. Hissong, Jennifer E.
Lape, Diana M. Bailey**



Sample Group Therapy Documentation:

Record Keeping in Psychotherapy and Counseling Ellen T. Luepker, 2012-04-27 Record Keeping in Psychotherapy and Counseling provides an essential framework for understanding record keeping within legal ethical supervisory and clinical contexts Compelling case examples identify dilemmas and strategies in protecting confidentiality More than a simple reference book this text introduces the concept of using records as therapeutic tools to strengthen the therapeutic relationship and facilitate clinical supervision Appendices and an accompanying CD offer sample forms A reader friendly style makes this new edition appropriate for undergraduate and graduate students New material on electronic records the impact of electronic communication and practitioners experiences with implementing the Health Insurance Portability and Accountability Act bring this book up to date Everyone from students to seasoned practitioners will continue to rely on it for protecting themselves their patients and their trainees Frames of Reference in Psychosocial Occupational Therapy Mary Ann Bruce, Barbara Borg, 1987 **The Nurses' Guide to Psychotherapy** Stacey Roles, Kamini Kalia, 2024-11-08 This book is a guide for nurses who plan to incorporate psychotherapy into their field of work Mental illness continues to be on the rise with increases in anxiety disorders suicidality and depression among others Psychotherapy is a well researched intervention that helps individuals to improve and maintain their mental health and well being Recently in Ontario Canada the proclamation of the controlled act of psychotherapy enabled certain members of six professional colleges including Registered Nurses to initiate and implement this controlled act Registered Nurses exist in every nook and cranny across the world from urban to rural and remote regions and can provide a far reach and excellent care bridging the gaps for those needing access to psychotherapy services Nurses have the skill ability legislative and regulatory rights to initiate the controlled act of psychotherapy Nurses can provide psychotherapy treatment and interventions to address the growing needs of the population who experience mental distress This book is unique in that the target audience is not only the experienced or expert nurse but was also created for nurses looking to shift the primary focus of their career to psychotherapy for undergraduate student nurses and for newly graduated nurses pursuing psychotherapy as part of their field of work This book will build upon the experiences of the nurse client relationship that has always been foundational to nursing and will discuss nurses clinical expertise and knowledge in relation to a holistic approach to care when implementing psychotherapy interventions *The Psychotherapy Documentation Primer* Donald E. Wiger, 2020-12-03 Everything you need to know to record client intake treatment and progress incorporating the latest managed care accrediting agency and government regulations Paperwork and record keeping are day to day realities in your mental health practice Records must be kept for managed care reimbursement for accreditation agencies for protection in the event of lawsuits to meet federal HIPAA regulations and to help streamline patient care in larger group practices inpatient facilities and hospitals The standard professionals and students have turned to for quick and easy yet comprehensive guidance to writing a wide range of mental

health documents the Fourth Edition of The Psychotherapy Documentation Primer continues to reflect HIPAA and accreditation agency requirements as well as offer an abundance of examples Fully updated to include diagnostic criteria of the DSM 5 The Psychotherapy Documentation Primer 4th Edition is designed to teach documental skills for the course of psychotherapy from the initial interview to the discharge The documentation principles discussed in the text satisfy the often rigid requirements of third party insurance companies regulating agencies mental health licensing boards and federal HIPAA regulations More importantly it provides students and professionals with the empirical and succinct documentation techniques and skills that will allow them to provide clear evidence of the effects of mental health treatment while also reducing the amount of their time spent on paperwork Physical Therapy Documentation Mia Erickson,Mia L.

Erickson,Rebecca McKnight,Ralph Utzman,2008 Complete accurate documentation is one of the essential skills for a physical therapist This book covers all the fundamentals includes practice exercises case studies throughout Recreational Therapy Assessment Thomas K. Skalko,Jerome F. Singleton,2020 Recreational Therapy Assessment is an evidence based guide connecting the recreational therapy assessment process with the International Classification of Functioning Disability and Health ICF to help therapeutic recreation professionals classify individuals functionality to better meet the needs of clients

The Crisis Counseling and Traumatic Events Treatment Planner Tammi D. Kolski,Michael Avriette,Arthur E. Jongsma, Jr.,2001-03-30 Psychologists therapists and other mental health professionals who treat clients affected by traumatic events such as natural disasters rape and assault need to develop formal treatment plans These plans must conform to requirements of managed care organizations and other third party payers Real Stories of Nursing Research Mary Maureen Kirkpatrick McLaughlin,Sally Bulla,2010-10-25 Real Stories of Nursing Research The Quest for Magnet Recognition demonstrates how direct care nurses in clinical settings can overcome their fear and conduct nursing research studies that impact and improve patient care Highlighting research in Magnet designated hospitals located in all types of settings this reference includes studies that have used quantitative qualitative and mixed method designs This text takes real nurses stories and their research abstracts and shows that staff nurses really can do research Including helpful hints from experts like librarians statisticians and IRB reviewers who show the reader how to make the research journey smoother Real Stories of Nursing Research addresses overcoming fears of research and is an essential text for any nurse or hospital seeking magnet status **Mental Health Services in Nursing Facilities** ,1996 **The Clinical Documentation Sourcebook**

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Restorative Care Nursing for Older Adults Barbara Resnick,2004-07-28 The purpose of restorative care nursing is to take an active role in helping older adults maintain their highest level of function thus preventing excess disability This book was written to help formal and informal caregivers and administrators at all levels to understand the basic philosophy of restorative care and be able to develop and implement successful restorative care programs The book provides a complete 6 week education program in restorative care for caregivers many suggestions for suitable activities and practical strategies for motivating both older adults and caregivers to engage in restorative care In addition the book provides an overview of the requirements for restorative care across all settings the necessary documentation and ways in which to complete that documentation

The First 1000 Days in the Nordic Countries: Psychosocial Interventions and Psychological Tests: A Review of the Evidence Breivik, Kyrre,Eng, Helene,Kaiser, Sabine,Karjalainen, Piia,Kurki, Marjo,Kyrrestad, Henriette,Laajasalo, Taina,Martinussen, Monica,Merikukka, Marko,Peltonen, Kirsi,Pettersen, Susann Dahl,Rasmussen, Lene-Mari P.,Reedt, Charlotte,Rye, Marte,2021-06-22 Available online <https://pub.norden.org/nord/2021/037> The report provides an overview and short systematic review of the psychosocial interventions and psychological tests used in the Nordic countries during the first 1000 days of a child s life i e from the prenatal period until two years of age A total of 63 interventions and 33 tests were reviewed Findings reveal that although a large number of interventions and tests are available for the target groups in the Nordic countries evidence regarding their effectiveness or psychometric properties is often lacking or insufficient Thus it is important that research efforts be enhanced in the Nordic region to strengthen the evidence base of the interventions and instruments that practitioners rely upon in order to assess and support mental wellbeing for Nordic children and families during this critical period in their lives

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