

Revised 8-4-10

Sample Nursing Clinical Service Notes

Student:	DOB:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	School District:
Medicaid #:	School Name:

BILLING CODE	SERVICE TYPE	NARRATIVE
<p>Date: ____/____/____</p> <p>ICD 9 Code: _____</p> <p># of Units _____</p> <p>Place of Service: <input type="checkbox"/> School (03) <input type="checkbox"/> Home (12)</p> <p><input type="checkbox"/> T1015-TD (less than 15 min) <input type="checkbox"/> T1015-TE (less than 15 min) <input type="checkbox"/> T1002-15 min = 1 unit <input type="checkbox"/> T1003-15 min = 1 unit</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Rehabilitative Behavioral Health Services (RBHS) Medication Management: assessment, monitoring, administration of medication according to physician's orders <input type="checkbox"/> Assessment, monitoring, administration of medication according to physician's orders <input type="checkbox"/> Assessment, monitoring <input type="checkbox"/> Assessed, provided emergency medical treatment <input type="checkbox"/> Provided health counseling <input type="checkbox"/> Assessed vision (see attached) <input type="checkbox"/> Assessed hearing (see attached) <input type="checkbox"/> Provided counseling to IEP team: medical needs and nursing interventions <input type="checkbox"/> Other (describe): _____ 	<p>Write clinical notes below or check box if notes detailed on back of this form. <input type="checkbox"/> See back for additional notes.</p> <p>Results: <input type="checkbox"/> Tolerated well <input type="checkbox"/> Poor tolerance <input type="checkbox"/> Return to class</p> <p><input type="checkbox"/> Rest: _____</p> <p><input type="checkbox"/> Sent home with: _____</p> <p><input type="checkbox"/> Other (see back)</p> <p>Nurse Signature/Title: _____</p>
<p>Date: ____/____/____</p> <p>ICD 9 Code: _____</p> <p># of Units _____</p> <p>Place of Service: <input type="checkbox"/> School (03) <input type="checkbox"/> Home (12)</p> <p><input type="checkbox"/> T1015-TD (less than 15 min) <input type="checkbox"/> T1015-TE (less than 15 min) <input type="checkbox"/> T1002-15 min = 1 unit <input type="checkbox"/> T1003-15 min = 1 unit</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Rehabilitative Behavioral Health Services (RBHS) Medication Management: assessment, monitoring, administration of medication according to physician's orders <input type="checkbox"/> Assessment, monitoring, administration of medication according to physician's orders <input type="checkbox"/> Assessment, monitoring <input type="checkbox"/> Assessed, provided emergency medical treatment <input type="checkbox"/> Provided health counseling <input type="checkbox"/> Assessed vision (see attached) <input type="checkbox"/> Assessed hearing (see attached) <input type="checkbox"/> Provided counseling to IEP team: medical needs and nursing interventions <input type="checkbox"/> Other (describe): _____ 	<p>Write clinical notes below or check box if notes detailed on back of this form. <input type="checkbox"/> See back for additional notes.</p> <p>Results: <input type="checkbox"/> Tolerated well <input type="checkbox"/> Poor tolerance <input type="checkbox"/> Return to class</p> <p><input type="checkbox"/> Rest: _____</p> <p><input type="checkbox"/> Sent home with: _____</p> <p><input type="checkbox"/> Other (see back)</p> <p>Nurse Signature/Title: _____</p>

