***Psychiatry/Psychotherapy follow-up SOAP note TEMPLATE***

*Replace all highlighted sections with your data for the assignment (\*\*\*insert an APA formatted title page as well)*

**Follow-up Session SOAP Note**

Patient Name: XXX

MRN: XXX

**Date of Service: 01-27-2020**

**Start Time:** 10:00

**End Time:** 10:54

**Billing Code(s):** 90213, 90836

*(be sure you include strictly psychotherapy codes or both E&M and add on psychotherapy codes if prescribing provider visit)*

**Accompanied by:** Brother

**CC:** follow-up appt. for counseling

**HPI:** 1 week from inpatient care to current partial inpatient care daily individual psychotherapy session and extended daily group sessions

**S-** Patient states that he generally has been doing well with depressive and anxiety symptoms improved but he still feels down at times. He states he is sleeping better, achieving 7-8 hours of restful sleep each night. He states he feels the medication is helping somewhat and without any noticeable side-effects.

Crisis Issues: He states he has no suicide plan and has not thought about suicide since the recent attempt. He states has no access to prescription medications, other than the fluoxetine. He believes the classes he participated in while inpatient have helped him with coping mechanisms.

 Reviewed Allergies: NKA

 Current Medications: Fluoxetine 10mg daily

 ROS: separate psych and all other ROS (what patient states) full list not by exception

**O-**

Vitals:

Ht: 61”, Wt: 127lbs, BMI: (calculate), T 98.4, P 82, R 16, BP 122/78, Pain: 0/0-10 scale

PE: (not always required and performed, especially in psychotherapy only visits)

Heart- RRR, no murmurs, no gallops

Lungs- CTA bilaterally

Skin- no lesions or rashes

Labs: CBC, lytes, and TSH all within normal limits

Results of any Psychiatric Clinical Tests: BAI=34

MSE:

Gary Davis, a 36-year-old white male, was disheveled and unkempt on presentation to the outpatient office. He was wearing dirty khaki pants, an unbuttoned golf shirt, and white shoes and appeared slightly younger than his stated age. During the interview, he was attentive and calm. He was impatient, but polite in his interactions with this examiner. Mr. Davis reported that today was the best day of his life, because he had decided he was going to be better and start his own company. His affect was labile, but appropriate to the content of his speech (i.e., he became tearful when reporting he had “bogeyed number 15” in gold yesterday). His speech was loud, pressured at times then he would quickly gain composure to a more neutral tone. He exhibited loosening of associations and flight of ideas; he intermittently and unpredictably shifted the topic of conversation from golf, to the mating habits of geese, to the likelihood of extraterrestrial life. Mr. Davis described grandiose delusions regarding his sexual and athletic performance. He reported no auditory hallucinations. He was oriented to time and place. He denied suicidal and homicidal ideation. He refused to participate in intellectual- or memory-related portions of the examination. Reliability, judgment, and insight were impaired.

**A -** with (ICD-10 code)

**Differential Diagnoses:**

**1.** choose 3 differential diagnoses (give rationale for diagnoses to support DSM5 criteria)

**2.**

**3.**

**Definitive Diagnosis:**

Major Depressive Disorder, recurrent, without psychotic features F33.4

Generalized Anxiety Disorder F41.1

**P-**

Pharm: Continue Fluoxetine increasing dose to 20mg.

Non/Pharm: Continue outpatient counseling: partial inpatient program continued with individual and group sessions

Psychotherapy Modality used: CBT

Interventions/Homework: 2 distortion worksheets, keep track of physical symptoms of anxiety or depression and triggers associated

Educations: discussed smoking cessation

Reviewed medication side effects and adherence importance

Safety Plan: gave hotline and clinic numbers to patient

Follow-up: in one week or earlier if any depressive symptoms worsen.

Outpatient counseling sessions to continue weekly until further notice.

Referrals: none at this time

**Provider Signature:** *ANNA SMITH, PMHNP-BC.* **Date:** 01-23-2021

Reflection from Session with Partner/Group:

1. Which skills did you use in the session? How?
2. How did the assigned Corey readings, PowerPoints, Handouts, and videos inform your therapy session? Please explain in detail.
3. What were your strengths in the interview?
4. What were your weaknesses/areas in need of further development in the interview?
5. How could you improve your interviewing skills? Are there steps you plan on taking? What are those steps?
6. Was there any time when you felt stuck or uncertain how to respond? Describe what was happening then. Were there times you felt more confident in your responses with the client? Times you were less confident? How? Does this come through in the session?
7. How were you impacted by the client…your emotions, thoughts, physical reactions, transference, and countertransference, body language?
8. What was your overall response to the interview? Did you feel connected to the client? Distracted? Disengaged?
9. What was the quality of your engagement, your empathy?
10. If you were to continue seeing this particular client, what future directions would you take? How would you conceptualize the case and what would be some of your treatment goals? How would you pursue these goals?

In relation to your partner:

1. What were your partner’s strengths in the interview?
2. What were your partner’s weaknesses/areas in need of further development in the interview?
3. How could your partner improve his/her interviewing skills?