

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	<p>There are four options available for staff using this section of the progress note:</p> <ol style="list-style-type: none"> 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. <p>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.</p> <p>Example of New Issue needing CA Update: The person reported new symptoms of nightmares, intrusive memories, and</p>

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