Magellan HEALTHCARE SM

EAP Progress Notes

CLIENT NAME: _____ **CASE #:** _____

SESSION DATE: _____ **ATTENDEES:** _____
SESSION TIME: _____
Check box if present:
☐ Significant change in medical condition and/or medications ☐ High Risk/ TOV issues presented
☐ Significant change in mental status ☐ **New stressors and/or extraordinary events**

Describe: _____

TARGET PROBLEM(s) PROGRESS OR CHANGES*:

REVISED OR NEW GOAL(s)*:

SPECIFIC STRATEGIES, INTERVENTIONS, AND UPDATE*:

Clinician Signature **Credentials** **Date**

SESSION DATE: _____ **ATTENDEES:** _____
Check box if present:
☐ Significant change in medical condition and/or medications ☐ High Risk/ TOV issues presented
☐ Significant change in mental status ☐ **New stressors and/or extraordinary events**

Describe: _____

TARGET PROBLEM(s) PROGRESS OR CHANGES*:

REVISED OR NEW GOAL(s)*:

SPECIFIC STRATEGIES, INTERVENTIONS, AND UPDATE*:

Clinician Signature **Credentials** **Date**

SESSION DATE: _____ **ATTENDEES:** _____
Check box if present:
☐ Significant change in medical condition and/or medications ☐ High Risk/ TOV issues presented
☐ Significant change in mental status ☐ **New stressors and/or extraordinary events**

Describe: _____

TARGET PROBLEM(s) PROGRESS OR CHANGES*:

REVISED OR NEW GOAL(s)*:

SPECIFIC STRATEGIES, INTERVENTIONS, AND UPDATE*:

Clinician Signature **Credentials** **Date**

*Use blank pages if more notes are needed.